Our Healthier South East London
Joint Health Overview & Scrutiny Committee

MINUTES of the virtual meeting of the Our Healthier South East London Joint Health Overview & Scrutiny Committee held on 2 September 2020 at 4.30 pm.

PRESENT:

Councillor Judi Ellis (Chairman)
Councillor Gareth Allatt
Councillor Richard Diment
Councillor Alan Downing
Councillor Mark James
Councillor Marianna Masters
Councillor David Noakes
Councillor Victoria Olisa

NHS PARTNERS: Dr Angela Bhan, South East London Clinical Commissioning Group
Andrew Bland, South East London Clinical Commissioning Group
Andrew Eyres, South East London Clinical Commissioning Group
Kate Moriarty-Baker, South East London Clinical Commissioning Group
Stuart Rowbotham, South East London Clinical Commissioning Group
Usman Niazi, South East London Clinical Commissioning Group
Christina Windle, South East London Clinical Commissioning Group

46 APPOINTMENT OF VICE-CHAIRMAN

The Committee noted that the former Vice-Chairman, Councillor Philip Normal, was no longer a member of the joint committee and therefore it was necessary for a new Vice Chairman be appointed. Councillors Mark James and Marianne Masters both expressed an interest in the Vice Chairmanship.

RESOLVED that Councillors Mark James and Marianne Masters both be appointed as Vice-Chairmen.

47 APOLOGIES

Apologies for absence had been received from Councillor Robert Mcilveen from LB Bromley, and Councillor Gareth Allatt attended as substitute. Apologies were also received from Councillor Chris Lloyd from RB Greenwich and Councillors

John Muldoon and Liz Johnson-Franklin from LB Lewisham.

48 DISCLOSURE OF INTERESTS AND DISPENSATIONS

Councillor Richard Diment declared an interest as a governor of Oxleas NHS Foundation Trust.

49 NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

It had been drawn to the attention of the Chairman that the Committee's terms of reference were in need of being reviewed and updated. It was suggested that members give direct instructions to officers concerning this, and then a redraft could be drawn up.

The Chairman expressed the view that matters often came to the Joint Committee late in the day, and it would be preferable if issues could be drawn to the attention of the Joint Committee for scrutiny at the pre-consultation stage. The Chairman reminded members that the Joint Committee did not have decision making powers, but nevertheless it would be good if the Joint Committee could make comments and recommendations at an early stage, offering a strategic overview from the various London Boroughs represented on the Committee.

Councillor Diment considered that, just as CCGs had moved on and had been restructured, the JHOSC should be restructured and undertake a different role.

Councillor James expressed the view that the primary level of scrutiny should still be maintained and undertaken by the local boroughs. He said that it should be made very clear in the new terms of reference what matters should come to the Joint Committee for consultation/consideration. His understanding was that the Joint Committee should be focusing on matters relating to service change, and he welcomed input and comments from NHS colleagues regarding this.

Andrew Bland suggested using a template for the terms of reference that would make clear what was the responsibility of individual boroughs. Mr Bland agreed with Cllr James that the primary issue for the Joint Committee to deal with should be matters relating to service change.

50 MINUTES - 25TH SEPTEMBER 2019

The Joint Committee noted that since the last meeting a workshop had been held on 30th October 2019 to discuss issues of concern about the CCG merger and how this affected scrutiny and the JHOSC.

The Chairman referred to a note in the minutes of the previous meeting relating to the South East London engagement process for the NHS Long Term Plan that

BAME people were not well represented in the engagement process. Christine Windle responded that the concern at the time had been to ensure that there was widespread engagement with people across all the boroughs; an Equalities Committee had been set up and they were looking at engagement processes and working with Councils to support more diverse engagement in future. The Chairman commented that in Bromley the primary demographic taking up hospital beds were the over 65's, so the focus was different depending on the borough, and it was important therefore that engagement or consultation took place across all these demographics.

The Chairman commented that it would be helpful if a schedule of local CCG board meetings could be disseminated going forward - Christina Windle offered to do this.

Agreed that the minutes of the meeting held on 25th September 2019 be confirmed as a correct record.

51 UPDATE FROM SOUTH EAST LONDON CCG

Andrew Bland attended the meeting to provide an update on the South East London CCG merger.

The Committee was informed that the merger had taken place on 1st April 2020; this established the NHS South East London CCG as the formal body for the commissioning of health services for local residents across the six South East London Boroughs. NHS England had approved the merger application without any conditions or reservations. This had been part of a series of mergers nationally, including South West London and North Central London. The first major task of the newly formed body had been to co-ordinate the response to the Covid pandemic.

The Joint Committee was pleased to note that, in a relatively short space of time, the six South East London CCGs had merged to form the largest CCG in London, whilst at the same time ensuring a local borough focus for health and social care integration.

Mr Bland stated that it was important to maintain borough-based decision-making, as well as decision-making by the merged CCG body and this would be achieved through the work of the borough-based boards and by delegation. Borough-based board meetings were advertised on the merged CCG website in case members of the public wanted to observe the meetings.

Mr Bland explained that another important objective for the combined CCG was to promote the development of joined up health and social care. Membership of all of the borough-based boards had been incorporated into a single document for information, and the list was extensive. It brought together health and social care

decision makers from the health sector and from local government. It was noted that in four of the borough-based boards joint appointments now existed between both the CCG and the local authority. He expressed the view that considerable strides had been made regarding health and social care joined up working.

The Joint Committee heard that another important objective of the merger was to see if providers could work with the CCG in a more blended way - less transactional and more cooperative.

It was noted that since 1st April, the merged CCG had undertaken all of its required statutory functions, as well as focusing its efforts on dealing with the pandemic, and also the relocation of staff as required. At the time of the meeting, the severity of the pandemic seemed to have eased somewhat, which had enabled staff to be put back into their normal posts, and to enable more normal business activities to take place. Borough-based boards were working in operation and were considering how to develop and implement borough recovery plans.

In terms of governance, the merged CCG was operating on the basis of subsidiarity, so it was anticipated that much would happen at a borough level.

The decision was taken nationally for allocations of money to be controlled more at a central level. This had been extended to the first seven months of this financial year which meant that not only could the CCG not make its particular delegation to boroughs under the national arrangements, it was actually operating in a more nationally directed way as an entire organisation.

Mr Bland was pleased to report that ‘in public’ meetings of the CCG Governing Body, Primary Care Commissioning Committee and borough-based boards had still taken place virtually through the use of digital technology.

Cllr James acknowledged the tremendous pressures the NHS had been under and the various concerns expressed in relation to finance, and asked if recovery plans were now being agreed. He pointed out that many NHS Trusts had been in a difficult position financially before the pandemic, and he presumed that now the situation would be worse. He asked whether work was still being undertaken in the normal way, or if the NHS tariff had been suspended; he further enquired if any NHS Trusts were in danger of failing due to pressure on their finances.

Reassurance was given that providers within the NHS system had been allocated top up funding to ensure that every organisation would be supported to at least maintain a break-even position. This would be continued until the end of September. Assurance was provided that financial constraints would not be a reason for being unable to provide the resources necessary to deal with the pandemic. An updated briefing regarding financial processes and budgets was awaited, and this would be shared with local authority partners.

An update on response and recovery planning was provided by Dr Angela Bhan. The minutes of the Governing Body contained details of the Covid updates and fortnightly fact sheet updates were being provided for local authority leaders and MPs. There had been around 8,000 documented cases of Covid 19 in London and 1,650 deaths. Total deaths to date in Bromley were 345 which was the highest in south east London. Some of this could be attributed to the elderly demographic of the borough. Most of the deaths occurred either in hospital or in care homes. As soon as the outbreak had been declared as a category four incident, all local health and social care partners reacted very promptly. South East London CCG set up an incident control centre and this was replicated by all NHS organisations. There was a clear gold, silver and bronze command structure used by CCGs which was also used by local authorities. It was important that the chain of command was effective and robust, so that instructions and guidance from the centre could be disseminated effectively through different parts of the chain. It had been imperative that clear and effective communication channels remained open between all involved. The local authorities played an active part in this chain of command, particularly with regard to the work undertaken by place-based directors. South East London CCG set up a joint forum that incorporated the Gold Command of the CCG, the Directors of Public Health and the Directors of Adult Services. This joint forum met once a week and discussed issues that at the time were very problematical. At these meetings, issues that were discussed included testing, how to best support care homes, infection control/prevention; the meetings were attended by the major providers of health services.

Kate Moriarty-Baker (CCG Chief Nurse) and she updated on the situation with respect to Care Homes. She stressed how they were an integral part of the health care system. She explained that a forum had been set up across SE London, which included nominated leads from other boroughs. The forum focused on identifying areas where support may be required and the sharing of learning and provided a co-ordinated response in line with national guidance. The forum provided training across London to care homes in matters such as swabbing and the correct use of PPE. Across the sector, training was provided to 224 out of 240 care homes—the remainder provided their own in-house training and support.

Through that process a ‘train the trainer’ model was developed. The CCG looked at the resource that existed within the CCG to support Infection Protection and Control (IPC), and investment had taken place in additional IPC specialist nursing support which was currenly being recruited to. The CCG monitored the testing facilities that were being provided for care homes, and explained how they could take advantage of them.

The CCG was continuing with this work and continued to support care homes with testing. Since the beginning of the Pandemic, the CCG had tested in 83 care homes and this work was ongoing. The CCG ensured that end of life care was undertaken with dignity, to the correct professional standards, and facilitated medication supplies as required. This included having rapid access to end of life

medication, delivering medication reviews for existing and new residents and providing more accessible support to care homes with medication queries. The services provided included the undertaking of proactive reviews, virtual ward rounds and access to support and advice from a range of health and care professionals.

This work had provided an opportunity to strengthen the relationship between the CCG, councils and public health colleagues around how best to support the care home market which was a shared and jointly owned endeavour. The CCG was continuing to work with colleagues across South East London, particularly with the possibility of a second wave of the pandemic.

Dr Bhan explained that the final two slides of the presentation contained an overview of the work of the Incident Control Team which was continuing to meet at 8.00am every morning. The ICT currently was working with two main objectives, the first of these was to protect the population by undertaking winter preparation and providing flu vaccinations and that services were available to manage people as and when needed. The CCG was closely monitoring the data and the early surveillance systems were stronger than they had ever been. Monitoring was taking place to monitor a variety of issues including the number of people testing positive for the virus, the occupancy of ITU facilities and the number of people being admitted to hospital suffering with COVID-19.

Cllr Diment raised the matter of the alleged pressure (in the early days of the pandemic) that was put on care homes to receive patients from hospitals who had not been tested for Covid 19. He expressed concern regarding this and quoted a comment from the Public Accounts Committee which described this approach as ‘appalling’. He wondered what the implications of that approach had been - it had caused much concern amongst care homes.

Cllr Diment also raised the issue of the proposal that one emergency department in each NHS area would be operating a system whereby you had to pre-book to attend the emergency department, rather than just being able to walk in. He wondered how this would work in practice, and in which areas it was proposed to be introduced in. He further expressed concern regarding patients who had not received the treatment they required because of the pandemic - he enquired as to what the future held for them and how they would be updated going forward.

Dr Bhan acknowledged that there were problems at the start and that everyone involved had been on a steep learning curve. She stated that at the start of the pandemic, it was a national policy that patients would not be retested after being discharged from hospital. This process continued up until roughly mid April. However, very quickly after that, the policy changed and patients were tested before discharge; this policy was continuing. She commented that in her view, care homes had not been pressurised to take untested patients, and in fact some had refused to do so.

At the moment, South East London was undertaking a project to look at direct bookings from the 111 system (by a clinician) direct into A&E - it did not mean that A&E was closed to people who walked in and who needed services or were coming in by ambulance.

It was clear that the A&E departments could not carry on as they had been as in previous winters where there were very full A&E Departments. If the country was in the middle of a second wave of a Covid outbreak, it would not be good to have crowded waiting rooms - no one would want people to be further exposed to infection. As a result, a national proposal had been suggested that from the 1st December, all A&E's would have the ability to to be linked to 111, and if people rang 111 they could be directly booked in to the emergency department; they would also have the ability to be directed to the urgent care centres and indeed booked into specialist care beyond the emergency department if required. A pilot scheme had commenced with the Queen Elizabeth Hospital. The 111 Commissioning Team was working with the hospitals so that these systems would be fully embedded by December. Cllr Diment made a plea that any phone lines that the public needed to call to make appointments for services were properly staffed to avoid long waiting times. Dr Bhan said that the capacity of the 111 system was being increased.

Dr Bhan gave assurances that work was now being undertaken at pace to catch up on the elective surgeries and other treatments that had been put on hold because of the pandemic.

Cllr Downing asked what was happening with the emergency eye department at Queen Mary's Hospital. He narrated the story of a member of the public who had attended the emergency Eye Department at St Mary's, only to be told that he could not be seen; he was given an A4 form with a number on it to ring. This number referred him to three local opticians. He was told by one of the opticians that they could only see him to give him advice, but would not be able to treat him. He was then made an appointment to see the optician 10 days later.

Dr Bhan responded by saying that the West Kent Eye Centre would have to find a permanent home. It was intended that as part of the preparations for wave two of the pandemic, it would be located somewhere in between Orpington Hospital and the PRUH. Dr Bhan asked for the specific details of the incident to be provided so that the matter could be taken up with the eye centre.

Cllr James raised the issue of the number of disproportionate deaths that had occurred within the BAME community, and to the analysis that had been undertaken by Professor Kevin Fenton - he enquired how the South East London CCG was proposing to act on his findings going forward.

An Equalites Committee had now been established that was reporting directly to

the CCG governing body, and they had noted the recommendations outlined in the Kevin Fenton report. Not all of the recommendations were able to be implmented by the CCG, and collaboration was required with other organisations.

A discussion took place about the Mental Health Improvement Standard funding allocation and how this was reported on and audited. These audited findings would be subsequently published on the web.

Andrew Ayers updated the Committee concerning the Covid recovery planning process. The Committee was informed that national recovery planning guidance had been received and that this would be acted upon in conjunction with a local planning recovery process. Mr Ayers noted that in the initial stages of the pandemic concern was expressed not only about the abilty of the NHS to provide services, but also the fact that the public were not accessing services and also were not attending A&E departments.

Local recovery plans were being developed from the bottom-up and were not solely being developed by the CCG, but were also being a developed in partnership with local authorities, hospitals, GPs, community providers, and social care providers. The plans aimed to provide a recovery response that was not simply reactive, but which was also preventative. In the process of developing the plans, an effort was made to understand the needs of local people. The aim of the local recovery plans was to get a feel for what people had experienced and how they felt. The Committee heard that borough recovery plans were driven by Public Health, the needs of the local community and by the inequalites that had existed for some time. The local recovery plans would endeavour to provide a pathway for the return of the provision of normal services, along with the desire to capitalise on new ways of working.

Mr Ayers commented that there was a need to live within resources but in this uncertain climate it was difficult to pinpoint exactly what those resources were. He said that the Covid pandemic had brought into sharp focus those who were vulnerable in society along with better ways of partnership working. A discussion took place regarding waiting times for services, and demand in relation to capacity.

It was noted that clinicians would be keeping in close contact with patients in order to keep them updated regarding their treatment and the reopening of services.

Action reviews would be undertaken to understand what learning had been achieved, and what could be used as best practice in the future as a result. Planning for recovery was made difficult because at the same time there could be a surge in cases and transition into a second wave. Additionally, winter flu planning was also being undertaken.

A discussion took place around communications going forward regarding the flu vaccination and Covid communications aimed at younger people. It was explained

that as well as vaccinating the traditional group of people aged over 65, it was also intended to try and vaccinate the vulnerable in society who were under 65. It was noted that a communications campaign concerning the flu vaccination would be commenced at the end of September. Dr Bhan also explained that plans were in place to increase the number of people eligible for the vaccination. It was also the case that later on in the year it was hoped to extend the vaccination programme to those aged between 50 and 64. The vaccination programme would also be extended to those caring for the vulnerable. She explained that a joint flu vaccination programme was being co-ordinated between all six boroughs, and the plan was to vaccinate the most vulnerable first.

Dr Bhan explained that the flu vaccination communication programme would aim to encourage people to attend GP surgeries to get their flu vaccination. It would explain the process that would be set up so that they would be safe. For those who were not able to leave their houses for whatever reason, all boroughs would seek to set up a home visiting vaccination programme.

The Chairman thought it was likely that matters relating to the recovery plans would need to come back to the Joint Committee for scrutiny. It was anticipated that matters relating to mental health would also come back to the Joint Committee and also issues relating to the funding of community based treatment and 'in bed treatment'; both areas were suggesting that they needed extra funding. The Chairman also raised the matter of poor quality housing, with landlords not undertaking the requisite repairs, and so some people were living in poor quality housing. Dr Bhan felt that it was primarily a local authority issue, but that there was some overlap with Public Health. The Chairman raised the matter of mould in houses and the associated health problems that this caused in terms of lung and respiratory disease; linked with this and also linked with Covid was the matter of poor ventilation. For these reasons, she was reluctant to dismiss the matter as a purely local authority housing issue and wanted the matter regarded also as a public health issue that needed to be looked at by the Joint Committee.

There was a general consensus amongst Joint Committee members that there was a strong link between poor housing conditions and poor physical and mental health. A member expressed the view that Health and Wellbeing Boards would be better placed to look at this particular issue. He felt that at the moment, the Joint Committee should be focusing on Covid recovery plans.

Mr Bland felt that it was important that a distinction be made between what matters should come before the Committee on a six borough basis and what matters should be looked at individually within each borough. He felt that it was important that the six borough CCG did not duplicate work undertaken individually in each local borough. With respect to a future meeting he suggested that a December meeting may be appropriate. The Chairman proposed a meeting in early December, and suggested that at the meeting, the main area of focus should be on the pilot scheme requiring appointments at emergency departments and how

this had worked out in practice. A member suggested that the main area of focus should be access to primary care like GP services and walk in centres.

Dr Bhan stated that she would be able to provide an update on the trialling of appointments at emergency departments at a meeting in December if required, however this would be limited to a verbal update as there would not be enough data existing at that time for a formal report.

The Chairman proposed that preparations be made for a meeting in early December. This would commence at 4:30pm and should not last longer than two hours.

The clerk drew the Chairman's attention to an email that had been received from the Guys and St Thomas's NHS Foundation Trust, concerning their proposed merger with the Brompton Hospital. They had asked the Joint Committee whether or not they would like to receive a presentation concerning the merger, or if the Joint Committee would be content in receiving appropriate documentation. The suggested date for a possible presentation was given as early October. The Chairman felt that in this case, the submission of documentation from Guys and St Thomas's was sufficient. If subsequently any members of the Joint Committee wanted to comment on the documentation, the comments should be directed to Mr Walton (Joint Committee Clerk,) who would draft a collective response on behalf of the Committee.

Finally, the Chairman thanked everyone for their hard work and for attending and congratulated Councillors Mark James and Marianna Masters on their appointment as Vice Chairs of the Committee.

52 WORK PROGRAMME

The Chairman suggested that the matter of the recommendations of Professor Kevin Fenton's report, and the effect of Covid-19 on the BAME population may be something that could be added to the Work Programme.

The Chairman felt that there should be a re-focus on mental health issues and that this should also be factored into the work programme. The Chairman asked who was going to lead on the mental health side and was extra money going to be made available for mental health. Andrew Ayers responded that CCGs took investment in mental health services seriously, and they had been directed (for a variety of reasons) to allocate a higher percentage of their funding pro-rata to mental health service provision.

Chairman