NHS South East London Integrated Care Board

Engagement Assurance Committee

Minutes of meeting held on Tuesday 18 July 2023

Via MS Teams

Members present:

Anu Singh (AS) (Chair)	Non executive director, SEL ICB
Kolawole Abiola (KA)	Southwark borough member
Stephanie Correia (SC)	Lambeth borough member
Tal Rosenzweig (TR)	Director of VCSE Collaboration & Partnerships
Folake Segun (FS)	Director, South East London Healthwatch
Geraldine Richards (GR)	Lewisham member
Dr Toby Garrood (TG)	Joint Medical Director, SEL ICB
Muriel Simmons (MS)	Bexley member
Marc Goblot (MG)	Greenwich member
Helen Laker (HL)	Greenwich member

In attendance:

Rosemary Watts (RW)	Associate Director of Engagement, SEL ICB
Emma James (EJ)	MSK project manager, SEL ICB
Dr Kathy Payne (KP)	Consultant, GSTT
Iuliana Dinu (ID)	Head of Engagement, SEL ICB
Jennifer McFarlane (JM)	Engagement Manager, SEL ICB

Minute taker: Simon Beard

Apologies were received from: Tosca Fairchild, Orla Penruddocke, Chris Boccovi, Livia La Camera, Amanda O'Brien.

		Actioned by
1.	**Introduction and welcome**	
1.1	AS welcomed all and thanked them for their attendance. Meeting attendees introduced themselves.	
2.	**Opening Business**	
2.1	Minutes of last meeting The minutes of the last meeting were reviewed and agreed by members present with no objections.	
2.2	Matters arising RW highlighted two areas: • The ICB Joint Forward Plan had been updated following the engagement activities which were briefed to the committee members at the last meeting, including two online webinars and	

borough engagement activity. A final version had been published on the ICB website.
The south east London engagement focussed on four areas where it was felt that insight was lacking – being cancer, planned care, urgent and emergency care (UEC), and end of life care. A number of key themes had come up during the discussions and had been incorporated into a slide on engagement in the Joint Forward Plan; these were:

- more partnership working and collaboration across the system in all areas;
- better communications across all the areas of focus;
- a focus on early detection of cancer, with work on improving awareness in the signs of cancer and making people more comfortable to come forward with concerns;
- planned care – how to work differently to meet peoples' needs and a need to build and develop the workforce to support people in planned care;
- how to secure the right care at the right time to stop UEC services being used as the default;
- the need to simplify a complex system around end of life care, to recognise the needs of carers, and improve the availability of time accessible information.

- ICS strategy development – a paper outlining the issues the strategy was trying to address had been produced, looking at five key priority areas of prevention, early years, young peoples mental health, adults mental health, and access to primary care especially for long term conditions. The paper would be discussed at the Integrated Care Partnership (ICP) Board next week. The paper contained a description of the challenges and ambitions and proposed next steps to developing solutions, together with metrics and outcomes to measure delivery.

3. The engagement process in the Musculoskeletal (MSK) programme

3.1 RW introduced the item, noting that this agenda item was in response to a request from committee members to be able to better understand ongoing engagement work taking place in the system. This would enable members to determine how the committee could influence and provide advice, and understand other approaches being adopted to engagement.

3.2 EJ reminded the committee that MSK referred to conditions affecting joints, bones, muscles, tissues around nerves and auto immune conditions. The ICB recognised that MSK conditions impacted a lot of people in the population, but also that care across the six SEL boroughs was varied, and this was not always warranted. Consequently, the SEL MSK programme was created to understand what works well and to improve care across the whole pathway. There was a clear aim to involve people with lived experience from the start. The projects vision was to transform MSK services to secure high quality personalised care for people with MSK conditions.

3.3 The engagement process comprised:

- Webinars, which saw 36 people attending and resulted in 102 interactions.
- Roadshows at five MSK service waiting rooms in order to meet people who were actually using the MSK service. A lesson learned was that not everyone had time to enter into a discussion though.
- Creation of a community group to informally discuss issues. The group had met seven times so far.
- Quarterly meeting of a Programme Board of key stakeholders, including those with lived experience. Arrangements for this included a pre-meet with board members to ensure they understood the issues on the agenda in advance which had created more engagement in the meeting.
- Use of a survey to set the programmes priorities at the start. 205 responses had been received.
- Use of a dedicated online chat forum via the Let's Talk platform.

3.4 Key learning from the engagement exercise was that:

- Physio self referral was a national priority so the practice form was sent out to the lived experience group to check it served its purpose.
- There was good positive feedback on ensuring shared decision making takes place so this would be explored further.
- People did not necessarily see waiting as a bad thing if it meant they were seeing the right people to get the right advice.
- It is important to market services and engage with people on the work being done. Assumptions should not be made that people know what is available to them. Use of websites is not always the best tool for advertising.

3.5 Next steps for programme engagement were to:

- Gather insights from the group and invite people to a workshop on chronic MSK pain in September.
- Continue with the meetings of the community MSK lived experience group and encourage expansion of its membership.
- Continue to use the "Let's Talk" platform to engage and receive feedback.
- Co-design and develop physiotherapy self-referral.

3.6 KP introduced the clinical perspective to the programme, noting:

- The benefits of using those with lived experience to support clinical training and development of process.
- the need to think "beyond the evidence base" and respond to individual needs.
- The importance of listening to the patient voice early on in transformation and the clinical pathway.
- It would be helpful to think about how people can "actively wait" – what can they do to inform themselves whilst waiting to progress along the pathway.

3.7	As an example of good learning from the engagement the group talked about how feedback from patients could be used to amend the approach to patient letters. Noting the Royal Colleges had previously asked clinicians to ensure they "write to the patient not the GP", feedback from patients suggested they wanted their GP to understand the technical aspects of their consultant's advice. Patients often felt they did not understand what the letter meant. TG asked if this could be rolled out further than the MSK project to understand what a "good letter" to patients looks like. FS noted that there was a different power dynamic between patients and secondary care clinicians than with GPs, and therefore patients often questioned their GPs in a way they would not with other clinicians. There was also a need to ensure plain words were used in correspondence and presentations. EJ advised that a guidance document had been produced providing key recommendations on letter structure and content.	
3.8	TG asked how good we are at measuring systematically the outcomes across pathways we are designing. EJ advised it was a real challenge for this project due to the multiple physio providers involved but the project team was hoping to bring things together more cohesively.	
3.9	TR reflected that it would be good for the project team to link in with VCSE partners to engage locally. People were more likely to access VCSE organisations on a regular basis and would only see a consultant when something serious arose.	
3.10	GR felt this was a really complex landscape, and more information was needed on the key issues. AS proposed an information pack be pulled together to be shared to set context. EJ confirmed a lot of research had been carried out against national and regional recommendations for MSK pathways to support the priorities set.	
3.11	**The committee noted the update and thanked the presenters for their time.**	
4.	**Review of the Engagement Assurance Committee (EAC)**	
4.1	<u>1-2-1 review discussions</u> RW reminded the group that following the last meeting, the ICB engagement team had conducted 1-2-1 discussions with public members of the committee to review how EAC was operating. Outcomes were presented at the meeting for discussion: • People felt at different levels of understanding and expertise, affecting ability to take part in conversations. • There was a lack of awareness of individual members areas of expertise and how to use it to best effect. • People welcomed the induction meeting in December, but a number proposed revisiting induction now the EAC was six months in. • It was suggested the EAC members should meet in a workshop/ informal setting in alternate months to the formal meetings.	

	• Agendas should include presentations on ongoing engagement work to support influencing of engagement. • The role of the committee needed better definition – what does providing assurance mean, where does the committee report to and how is it reported up. The committee should expect to receive updates and reports on actions and suggestions. • There should be two-way questioning between presenters and the committee. • The committee should see engagement plans and monitor progress against these plans. • The committee should be assuring work they have been involved in developing the engagement plans for. It was noted that discussions had already taken place about setting up an engagement planning group – should this be revisited? • Agendas needed to be less full to enable more time for discussion. • Committee members should be able to submit questions before the meetings. Could the "Let's Talk" hub be used to support this? • It would be good to consider how to link committee members up. • It was noted that there are better links to some local Healthwatch organisations than others. • There was a need to move more to co-production and disability inclusion.	
4.2	Committee members were asked for their reflections. • SC felt the review was very useful and was something that should be done regularly as a committee healthcheck. • MG agreed with the review and the method in which it was conducted. It was good to see how members special interests could be leveraged to support the committee's work and it would be helpful to look at alternative ways of moving issues along outside formal meetings. • KA reflected on the need to ensure EAC's work was integrated with other project work and did not operate in a silo. • MS supported the proposal to open up informal discussion lines.	
4.3	RW responded that: • the team was progressing with the proposal for an informal MS Teams meeting to take place in August with a loose agenda to support free flowing conversation. **ACTION: JMcF to look at possible dates and times for a two hour initial meeting, across a mix of evening and daytime dates and times.** • Avoidance of silo working was absolutely right, but the committee's purpose was to assure the ICBs engagement processes not to talk about integration. • Learning from elsewhere would be really beneficial in terms of developing co-production. **ACTION: RW to discuss with the SEL Engagement Practitioners'' Network and the new coproduction Group**	**JMcF** **RW**

	hosted by Healthwatch Greenwich to further our understanding of production and how to use this approach • The committee needed to think as a group about how it can ask pertinent questions on insight and diversity. • There was a need to recognise limitations to the group's influence – if it could not be assured about an engagement activity it cannot stop a project but can write recommendations. • RW and TG would discuss how to ensure the EAC's work was reported back up to the Clinical and Care Professionals Committee (CCPC) and ensure the work is directly visible to the Board.	**RW/TG**
4.4	<u>Terms of reference for EAC</u> As a further piece of this work, the EAC terms of reference (ToR) had been reviewed. In particular, a review of membership had been considered necessary, specifically: • Remove from membership "The Clinical and Care Professional Lead for patient and public engagement" as the chair, given that no appointment had been made to this role. • Change the NED member from deputy chair to chair and appoint the Joint Chief Medical Officer as deputy chair. • Amend VCSE reference to emphasise membership of the VCSE Alliance. • Remove from the list of voting members representatives of the Local Authority and Trusts as these had not been identified. • Change quoracy from requiring the Healthwatch representative to be present to either the Healthwatch representative or VCSE Alliance representative being present.	
4.5	The committee raised two specific points: 1. How could EAC members obtain information from the Equalities Sub-Committee and Population Health and Equity Executive (PHEE) on how they were engaging to deliver their work, as referenced in the ToR. **ACTION: RW to take this away to look at the best way to inform the EAC.**	**RW**
4.6	2. The ToR referenced one ICB member to be present for quoracy – it was confirmed this could include the ICB member who was the chair. **The committee members:** • **NOTED the feedback from the review and the plans proposed by the engagement team to address some of the issues raised.** • **AGREED the Terms of Reference changes, which would be referred to the Clinical and Care Professional Committee for approval.**	

5.	**Update on the development of the Voluntary, Community and Social Enterprise (VCSE) Strategic Alliance and working with the VCSE**	
5.1	In the interests of time, TR agreed to send an update to the committee members in writing.	**TR**
5.2	RW noted that there was ongoing work on developing a VCSE sector charter and a paper on it was going to the next Integrated Care Partnership Board on 24 July 2023. A workshop had been held in June between the ICS executive and VCSE Alliance to develop this charter.	
5.3	**The committee noted the update and the provision of a written report.**	
6.	**Update from South East London Healthwatch**	
6.1	FS confirmed that all the SEL Healthwatch organisations have produced annual reports, which covered the intelligence Healthwatch had gathered over the year and how it was shared. FS was pulling together a summary from across all six SEL organisations which would be ready by the end of the month and shared with RW for onward transmission.	
6.2	During the year over 70 reports had been produced covering a range of issues. Examples of work completed included a discussion with young people about the use of long term contraceptives, work with the Latin American community on access to health and care, a big focus on cancer services, and a big piece of work that was carried out by the Bexley, Greenwich and Lewisham Healthwatch organisations collectively to look at outpatients at Lewisham & Greenwich NHS Trust. This specific piece of work identified a need to improve communication and administration of appointments to improve patient engagement.	
6.3	Going forward work was continuing at pace, with projects planned to look at: • Supported living units; noting that in law, Healthwatch can enter any publicly funded service to make an assessment; • Work with the Latin American community to look at their specific needs and bring communities and service providers together; • Work around reablement through carers interviews and focus groups • Work to look at the experience of Black, Asian and Minority Ethnic (BAME) and Lesbian, Gay, Bi- Sexual, Transgender and Questioning (LGBTQ+) carers and those using maternity services; • Ongoing service reviews.	
6.4	TG asked if the feedback loop was working to ensure the reports from Healthwatch were having the desired impact with the right people. Specific services who were assessed received a report and work was done with providers to address any issues raised but FS felt more could	

6.5	be done to ensure reports were seen by as wide a stakeholder group as possible to inform learning across the system. FS and RW were exploring linking to SEL Healthwatch reports from the insights page - the what we have heard from local people and communities page on the ICS website. **The committee members noted the report.**	**RW/FS**
7. 7.1	**Any other business** No further AOB was raised.	
8. 8.1	**Meeting close** AS closed the meeting at 19.58, thanking everyone for their time.	

Date of next meeting:
Tuesday 26 September 2023, at 1800 (on MS Teams)