NHS South East London Integrated Care Board

Engagement Assurance Committee

Minutes of meeting held on Tuesday 26 September 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
Dr Toby Garrood (TG)	Joint Medical Director, SEL ICB
Marc Goblot (MG)	Greenwich borough member
Helen Laker (HL)	Greenwich borough member
Shirley Hamilton (SH)	Lewisham borough member
Shalini Jagdeo (SJ)	Bromley borough member
Chris Boccovi (CB)	South East London member
Orla Penruddocke (OP)	Bromley borough member
Livia La Camera (LLC)	Lambeth borough member
Tosca Fairchild (TF)	Chief of Staff, SEL ICB

In attendance:

Rosemary Watts (RW)	Associate Director of Engagement, SEL ICB
Iuliana Dinu (ID)	Head of Engagement, SEL ICB
Ben Collins (BC)	Director of System Development, SEL ICB
Lelly Oboh (LO)	Lead Pharmacist, Overprescribing, SEL ICB

Minute taker: Simon Beard

Apologies were received from: Geraldine Richards, Muriel Simmons and Jenny McFarlane

		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	<u>Minutes of last meeting</u> The minutes of the last meeting were reviewed and agreed by members present with no objections.	
2.2	<u>Matters arising</u> RW raised two areas: i. The ICB has funded Healthwatch Greenwich to run a small co-production project, with a focus on personalisation, personal health	

	budgets and co-production. EAC members were asked to consider joining the group. RW had a one-page summary of its activities to share, with the group meeting monthly on a Monday. The next meeting was on 9 October. ii. EAC terms of reference – this was due to go to the September meeting of the Clinical and Care Professional Leadership Committee for approval but this meeting was cancelled so the changes to the ToR had yet to be approved. **The EAC members noted the updates.**	
3. 3.1	**ICS Strategy Development Update** Ben Collins, ICS Development Director was invited to the meeting to update members on the ICS strategy. BC reminded the group that five strategic priorities had been set in February 2023, being: • Prevention and wellbeing, • Early Years, • Children and Young People mental health, • Adult mental health, • Primary care and people with long term conditions The work carried out so far had been to: • Refine the challenges and ambitions to turn them into achievable and measurable targets • Develop solutions which were shared with the Integrated Care Partnership (ICP) in July. BC talked the group through the different approaches that were needed for each priority, noting that: • On prevention, there was a need to focus on people from deprived neighbourhoods, the fundamental issue being that they don't trust health services, we don't know them, and there was a need to develop long standing relationships. • For early years the ICS was working with national charities and was looking at how to develop a model of holistic generalist intensive support for mums and babies with high vulnerabilities, learning from work in Greenwich area. • On adult mental health – early intervention, social orientated solutions were needed. The approach was being voluntary, community and social enterprise (VCSE) led, focussing on people recovering agency and empowerment, connecting into friendship groups and achieving employment. • BC highlighted a scheme in Walworth, which had featured in the national press, to develop wrap around health, education and social care to support children in deprived neighbourhoods. BC described the current challenge as working out where action across south east London (SEL) could help, with key areas identified as	

increase of funding, harnessing resources in partners differently, achieving spread and scale, and delivering a systematic method for sharing of learning and improvement.

BC ended by highlighting to the group two online webinars for the public that were planned for Friday 29 September and Monday 2 October to test the work so far in detail. The ICP would look at the work in October to make clear decisions about SEL level action on these areas.

3.2 The Chair opened the floor to questions.

- SC asked how achievement of the ambitions would be measured. BC responded that work on this area was in progress – for example, on prevention, the team were measuring variation in screening uptake from marginalised communities. For some areas this was more complex – for example, on how to create partnerships and eco systems to support children's resilience. For these areas it had been found that getting a group of partners together to discuss solutions was successful.
- CB asked, in relation to support for prevention in deprived areas, how it was envisaged to support individuals to transition from a single trusted point of contact with health services to a wider engagement with the NHS as an institution to enable them to access statutory services. There was a need to do more work on how to integrate peer support and lived experience into services and how to align it to clinical work. BC acknowledged that models of peer support worked well but more work was needed on implementation and how to invest in VCSE models and most effectively. There was a need to bring specialist services into the broader range of services on offer to ensure partnership working and understand the connectivity between services that could be achieved.
- KA felt the issue of integration was important, quoting an example that data had proven that children from Black African and Black Carribbean heritage were more likely to need mental health support, and asking how this could be achieved. BC noted the complexity of the engagement needed for this area and felt the solution was direct investment in VCSE organisations who specifically look at mental health in particular communities, and to focus on wellbeing and resilience in children early on.
- SJ noted that some boroughs had really good partnership working which was aligned to the strategic aims, so asked how best practice was being shared across boroughs. BC commented that this was exactly what the strategy was seeking to do.

3.3 AS wrapped up the discussion by asking how EAC members could continue to engage in the development of the strategy. BC offered 1-2-1 or a group follow up with the ICS team and reminded the group about the public webinars taking place.

	ACTION: RW to link with BC/ Maria Higson to set a date for a more detailed engagement session with EAC members. **The EAC members noted the update.**	**RW**
4.	**The engagement process in the overprescribing project**	
4.1	LO introduced herself as the SEL Lead Pharmacist for the overprescribing project. She presented a series of slides on the engagement that had taken place as part of the project, noting that this was the first time in pharmacy that this level of engagement had taken place with patients. Consequently, a lot had been learned from the process as well as from the specific feedback.	
4.2	LO started with providing some context, defining overprescribing as the use of medicine when: • There is a better non medicine alternative – e,g. diet, social prescribing. • Where the use is not best suited to the individual patient's circumstances or wishes – e.g. the patient does want to take it, or the medicine is not appropriate the for condition or for the patient as an individual. LO noted that there were multiple systemic, cultural and individualistic causes of overprescribing. A national report had suggested that 1 in 10 medicines taken were not necessary so this was a complex problem. Key points from the work done on this area included: • It was clear there was an ongoing need to engage with patients throughout the lifecycle of their medicine taking to mitigate the negative effects of taking medicines. • There was a clear effect on NHS resources – including financial impact, cost of avoidable hospital admissions, use of staff resources to prescribe and dispense. • There was an environment impact of medicines • Health inequalities were evident in medicine usage – there was an increase in prescribing of medication based on age, deprivation and ethnicity. • In South East London, 2 million medicines were issued at a cost of £16.5m in 2022-23. The way to address this was to target as many causes as possible to maximise outcomes. This required strong patient and clinician engagement to create shared decision making.	
4.3	The discussion then moved onto the specific details of the engagement project itself. The process had started in July 2022 with two online webinars and has continued with a public survey and outreach to community groups with an aim to produce a final report by 31 March 2024. The defined aims of the engagement work were to: • raise public awareness,	

- understand attitudes towards overprescribing,
- promote behavioural changes,
- transform the way patients were cared for, emphasising patient voice and shared decision making,
- gain insight into the experience of local people and clinicians,
- understand the triggers and behaviours that led to overprescribing,
- look at access to patient records to ensure timely decisions could be made on ceasing medications,
- ensure clinicians were skilled and confident to engage patients in conversations to reach a shared decision.

The method of delivery had included:

- a dedicated project page on the Let's Talk Health and Care online platform, asking people to share personal experiences,
- two online webinars,
- outreach to community groups catering for a variety of demographic groups,
- a patient survey which was due to close in December 2023. This had attracted 76 responses to date.

Themes that had come out of the feedback so far were:

- People want control over their medication,
- People want to know who to ask about their medicines,
- Failure in communication and information about patient's medicines across the system causes concern and adverse outcomes,
- There is value in having a GP/clinician who knows you well,
- There was a desire from patients to see a reduction in the burden of having multiple appointments,
- The role of the carer was critical,
- Informal methods of feedback were seen as good,
- There was a need to think about how to support people to take medications – for example, being aware of patients who may not be able to open blister packs.

Outcomes from the various engagement methods would be published on the Let's Talk Health and Care platform in January 2024, with feedback provided to group in January and February. The full report would be published in March 2024. The outcomes would then be used to inform development of staff training and a future methodology to manage medication prescribing.

LO concluded by highlighting some additional engagement work that is either ongoing or planned in the sector, including:

- A waste amnesty project in conjunction with the Lambeth Public Health team
- A patient experience co-design project for chronic pain with the Health Innovation Network
- A public campaign to influence behavioural change with the Health Innovation Network

	• A mini-pilot patient shared decision-making survey in Bromley	
4.4	OP congratulated the team on an exciting project and asked what the target response had been for the survey. LO had set an initial target of 40 so to achieve double that already was considered a real achievement. LO noted that the local responses had confirmed the outcomes from patient feedback received nationally which was a good validation. Feedback from GPs was also being gathered over time but there was not a plan to specifically survey them as a cohort. PCNs were also engaged with supporting data collection from both patients and clinicians.	
4.5	KA commented on the need to recognise that GPs and clinicians were the pathway into managing prescriptions but challenged if there were any conflicts of interest with prescribing. LO emphasised that the aim of the project was to shape how people are having conversations with patients to ensure patients feel involved in decisions and that the patient voice was at the heart of everything. Through empowerment of the patient they would be able to raise challenges across all disciplines where they were concerned, which should mitigate in this area.	
4.6	SH noted that for the patient it is sometimes extremely difficult to challenge a decision due to challenges in accessing services and empowerment of the patient to debate the rights and wrongs of their prescription. Would this be made easier as a result of this work? What key conditions had been identified in the research where overprescribing was a problem?	
4.7	CB raised the issue of underprescribing, using chronic pain as an example, and asked if positive intentions in reducing overprescribing could lead to underprescribing elsewhere or difficulty in accessing services and medications.	
4.8	In response to both these questions, LO acknowledged the extent of the project, especially in respect of influencing behavioural change. Chronic pain specifically had been a focus, noting that withdrawal of opiods created a significant risk so provided assurance that this was acknowledged as a disproportionately large problem.	
4.9	**The EAC members noted the presentation and thanked LO for her time.**	
5.	**Feedback from the ICB Equalities Sub-Committee (ESC)**	
5.1	TF updated the EAC members on the current work of the Equalities Sub-Committee. At the September meeting of the ESC, the committee had received updates on:	

	• Health inequalities work from Dr Di Aitken (Lambeth GP) and Catherine Mbema (Director of Public Health, Lewisham). This included a lot of information on how to address health inequalities for ethnic minorities. • The work the ICB equalities team were carrying on in assessing the ICBs performance against targets within domains 1, 2 and 3 of the Equality Delivery System – TF would feed back the outcomes to the EAC at a later meeting. • The appointment of new colleagues to look at digital inclusion – which it was hoped would help address the disparities identified across population demographics and areas of deprivation. • The development of equalities objectives with the aim to meet the ICBs general duty to eliminate discrimination.	
5.2	In addition, TF highlighted the work the ICB were doing on meeting the requirements of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), with the ESC receiving regular reports on progress. New guidance had recently been issued on workplace adjustments which the ICB were currently working through.	
5.3	A wellbeing passport was also being developed for ICB staff.	
5.4	**EAC members noted the update report.**	
6.	**Update on the development of the Voluntary, Community and Social Enterprise (VCSE) Strategic Alliance and working with the VCSE**	
6.1	TR reminded the group that at the last EAC meeting she presented on the VCSE charter and commitments for south east London. This linked to the broader ICS strategy framework discussed earlier. Next steps were now to define what this looked like in reality for each borough. This involved engagement with all partners across the system to develop this vision and to consider how to implement the charter. The overall aim was to change the approach to collaboration and how the VCSE is viewed. On a practical level, an updated draft of the VCSE charter would be presented to the ICP meeting in October for sign off of the high-level commitments. In the meantime, some intensive engagement was taking place with key people in partner organisations to socialise the charter and agree next steps. Following this, an in-depth engagement process to bring the system together would commence.	
6.2	On the VCSE strategic alliance, TR advised that there was work ongoing to diversify the membership, with plans for a big recruitment drive in January across the VCSE sector.	
6.3	KA recognised the need to work at pace on diversification – the current representation of ethnic minorities was not good enough. So real thought needed to be given to how to enable small and new	

	organisations to collaborate and get support from the voluntary sector. TR agreed the focus of the charter was about grass roots equity led organisations being supported.	
6.4	**EAC members noted the update report.**	
7.	**Update from South East London Healthwatch**	
7.1	FS reminded the group that Healthwatch continued to listen to the voices that were hardest to hear or are not heard from, and to work with partners in local authorities, health and care providers, and the VCSE to not just hear but shift the dial.	
7.2	A review of Healthwatch achievements was available through the recently published annual reports. Over 13,000 people had shared their experiences with Healthwatch in the last year and the outcomes had been shared through 76 briefings and reports. Areas of focus included conversations with the Latin American community, work to understand maternity experiences by those underserved by health, and a strong focus on mental health and primary care. Conversations continued around exclusion and access to services.	
7.3	Healthwatch had carried out a piece of work in Lambeth regarding the refugee council – signposting people to services and supporting them to use the health and social care system. Ongoing work as part of the "enter and view" programme was continuing, whereby Healthwatch representatives could enter a provider's premises to ask questions, give a view on services and make recommendations. A focus in the last year had been on care facilities. Recommendations had included improvements to noticeboards and work on culture and attitudes. One organisation had unfortunately been reported to the CQC as a result.	
7.4	Going forward FS advised there was a plan to focus on inequalities and having conversations with people about how to enhance access and bring new outreach and engagement tools to communities. Engagement with harder to reach communities, such as the Gypsy and Roma community, was being developed. Healthwatch were also working with the ICB engagement team to develop patient experience questions and were involved in the conversations around strategic priorities.	
7.5	KA asked if Healthwatch had carried out any work with ambulance services regarding handover delays. FS responded that last year Healthwatch had carried out a pan-London piece of work with London Ambulance Service to look at waiting times and handovers. This had been fed back as a whole London piece. The report was available on the Healthwatch England website. **ACTION: FS to share link to ambulance handovers report.**	**FS**
7.6	**EAC members noted the update report.**	

8.	**Feedback from informal session with public members of the committee held on 5 September 2023**	
8.1	RW reflected on the informal session held with EAC members recently. People had fed back it was useful and they were able to ask questions they felt restricted in doing so at the formal Committee meetings.	
8.2	Going forward it was proposed that the informal meetings should take place in the months between the formal meetings. It was proposed that the next informal meeting be used to have a strategy discussion with the ICS team.	
8.3	**Committee members agreed the proposal.**	
9.	**Any other business**	
9.1	ID updated the committee on the progress of the Peoples Panel. Recruitment had now finished with 1,083 people signed up. Everyone had completed an initial survey around their health and what was important to them. A full report is published on the ICS website at What we've heard from local people and communities - South East London ICS (selondonics.org). The report also considered the approach to recruitment. Invited panel members had attended two focus groups around anchor programmes – these were very well received and people felt they were listened to. Next steps were to keep the panel engaged and ensure they continue to represent SEL population and that their views are heard and influence programmes. Two future surveys were planned – one on winter and access to services, and another on the 111 service.	
9.2	RW updated the Committee on the outcome of the ICB's assurance report by NHS England. This was an annual assurance process to assess the ICB's delivery against their statutory duties. The principal source of assurance this year was the annual report and other publicly available information. Feedback on engagement was threaded throughout the response but it specifically noted: - Good governance around engagement. - The attempts to address health inequalities by using trusted voice organisations. - It welcomed the engagement approach. The assurance letter is published at 2022/23 South East London Integrated Care Board Annual Assessment - South East London ICS (selondonics.org).	
9.3	KA noted that at the last meeting FS had discussed some intelligence on the work across the six boroughs and asked that it be shared. **ACTION: FS/RW to share the links to the report with EAC members.**	**FS/RW**

10.	**Meeting close**	
10.1	AS closed the meeting at 19.59, thanking everyone for their time.	

Date of next meeting:
Tuesday 28 November 2023, at 18.00 (on MS Teams)