NHS
South East London
Clinical Commissioning Group

Engagement Assurance Committee

Minutes of the meeting held on Monday 15 November 2021

Via MS Teams

Members:	Joy Ellery (JE) (chair)	Lay member for Public and Patient Involvement
	Folake Segun (FS)	Director, Healthwatch, South East London
	Dr Faruk Majid (FM)	Governing Body Clinical lead
	Orla Penruddocke (OP)	Committee member
	Claire Mayes (CM)	Committee member
	Neville Fernandes (NF)	Committee member
	Helen Laker (HL)	Committee member
	Kike Biye (KB)	Committee member
	Winnie Baffoe (WB)	Committee member
	Marc Goblot (MG)	Committee member
	Livia La Camera (LLC)	Committee member
	Shirley Hamilton (SH)	Committee member
Present:	Rosemary Watts (RW)	Assistant Director of Engagement
	Lotta Hackett (LH)	SEL CCG Head of Engagement
	Jenny MacFarlane (JM)	SEL CCG Engagement Manager
	Anuradha Singh (AS)	Patient and public engagement sponsor
	Jessica Levoir (JL)	Head of Partnerships, Governance and Programmes
	Fiona Gaylor (FG)	Consultant Patient and Public Engagement
Apologies:	Stephanie Correia (SC)	

In attendance: Simon Beard (minute taker)

1.	**Welcome and introductions** The Chair welcomed everyone and thanked them for attending.
2.	**Declarations of interest** No additional declarations of interest were raised.
3.	**Minutes of the 20 September 2021 meeting, actions and matters arising** <u>Minutes</u> The minutes were reviewed and agreed by the committee. <u>Action log</u> • The “Development of engagement strategic framework” item on the log is a live issue for the ICS programme and should remain open.

	• Both other items had been closed quickly after the last meeting.
4.	**Developing the working with people and communities strategy of the South East London Integrated Care System** JL opened the discussion on this agenda item, reminding the group that at the last meeting there was discussion about setting up a steering group for this piece of work, with two EAC members invited to join. OP and SC and volunteered. JE, FS, RW and members from trusts, local authorities, the voluntary sector, and London South Bank University were also involved. The steering group had now met twice and had seen the paper, which had also been to ICS executive. Feedback from the executive team was that the organisation should be ambitious in this area and think about accountability to local people. A focus on tackling inequalities in south-east London was key. It was emphasised that this is still a work in progress so any further thoughts would be welcomed. Areas of focus for the committee's attention were vision and operating principles. Key points raised by the members were: <u>Vision</u> • JE asked could we use of "commit" instead of "aspire" to better reflect our ambition? FS commented that "aspire" has no accountability for lack of action and better underlines the sharing of power. • Vision should provide a projection of what things will look like in the future for the beneficiaries, rather than just detail of how we will operate. Need to make a commitment to it. The strategy needs to describe how we are going to achieve the vision. • Need to include something that is actionable to enable measurement of progress against it. • Need to explain concepts that many people are not familiar with such as coproduction • Vision needs an outcome – what is the reason for doing this? What is the end rather than just the means. <u>Operating principles considerations</u> • How to benchmark with other organisations. • Need to simplify language to make it understandable for everyone – could use simple illustrations to demonstrate what is being done and how this will affect end users. Where "NHS speak" was necessary a glossary of terms could be considered for inclusion on any papers. • Could a simplified version of the contents of the Constitution be produced that could be shared. AS summarised the purpose of the document as trying to tell a story but also set a new tone for the future. Vision and principles should ideally be aligned across all

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	organisations in south east London; if the concepts can be got right the language can be looked at separately. The group considered the operating principles individually with the following comments: 1: SEL ICS Listens • Need to listen to our diverse communities to predict health and care needs. • Emphasis has been given to listening but there needs to be two way communication – speaking clearly as well as listening. Should this be included explicitly? What comes from ICS has to be clear and accessible to all. • Need to define what listening "looks like" • First sentence does not sound accessible at all – this needs reviewing. • Need to consider various engagement methods – not just a reliance on people reading and interpreting documents. Conversations with grass root organisations were being planned as a phase of engagement next year. 2: SEL ICS Shares • Is about public accountability and sharing decisions with panels and representative groups. • Words seem to focus on being responsive and adaptable, learning and adjusting, measuring progress towards our goals. • Need to define what "investments" means? AS clarified this means how money will be spent – in a similar way, local authorities have annual engagement events to enable public to have input into this area. • Feedback loop needs to be constant, unending. Is that implicit in this section? 3: SEL ICS Learns • Links to "listens" but is about the organisation changing because of what it has heard. 4: SEL ICS Co-produces • About working with local people on shared experiences. Need to move away from paternalism. • All other principles feed into this - is so important it should be the first principle not the last. • "Co-production" is jargon – what is wrong with "working together". Include words like "influence" and "agency" to explain how this gives power to the community. • Need to be clear why this is different this time for the NHS – explain why this is going to work. • Need to think about what happens with communities who are unable to have a voice for whatever reason – e.g. those at the margins, those that don't want to be in public forums.

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	• This needs to be about empowering patients to be part of the solution rather than being passively told this is what is happening – about being transparent about health conditions and making people aware of their choices, supporting them with the knowledge and skills to enable them to make a decisions about their own healthcare. • Co-production needs to include organisations outside of the NHS to pick up other social issues (e.g. housing) that have health consequences. FG advised the group that work was already underway on considering how we engage with local people to inform the development of the ICS and the ways the ICS works with people and communities, asking what is already working, what has already been done, being upfront about what is open for debate, asking questions on things people can influence rather than those they cannot. RW proposed that the online engagement platform could be used to test out ideas with the members before the next meeting. The members noted the work being undertaken, and that a further iteration of the document would be worked on to encompass the comments received.
5.	**Feedback from the joint seminar of the Engagement Assurance Committee, the Equalities Committee, and the Quality and Safety sub-committee** JE provided some feedback on this meeting, which had come about as JE had observed through sitting on all three committees that there was cross over on topics and learning, particularly in terms of people issues. There were legal requirements for each group but initiatives such as deep dives could be carried out together to benefit from input from all three areas of expertise and perspectives. Collectively, the online engagement system would be useful to gather intelligence for all three committees, the quality team had good mechanisms for setting up deep dives and the equalities committee were looking at equalities for staff and health inequalities. Members were offered the opportunity to participate in the discussions. KB commented that this was a good initiative but there was a need to bring the whole system together to look at health inequalities, this needed to be fully integrated into the whole organisation, not just with some departments. The committee noted the update.
6.	**Development of online engagement platform for discussion** JM introduced this update item, reminding the committee that the pilot phase closed on 24 September. Feedback received was included in enclosure Di of the meeting papers which captured the tools used to test the platform. Following feedback and internal discussions the name for the platform was “Lets Talk Health and Care South East London”. As a consequence changes had been made to the URL and email notifications address. Technical issues had now been resolved. Thanks were extended to everyone for participating.

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	LH advised the committee that borough leads had now been trained on the platform to enable support to local activities, with plans underway to formally launch the platform. Members were reminded about activating their account and that it was recommended to use an alias name to remain anonymous. The group discussed the benefits of having a space on the platform that was restricted to EAC members only to support interaction between meetings. OP asked how input to the platform would be overseen to pick up on comments added. LH/JM would be spending a significant amount of time on this but where borough based activities were set up on the platform the local borough leads would be expected to manage this. RW added that project managers could also be set up to enable people to run individual projects. MG asked if there was going to be a soft launch to a limited number of people to ensure any issues are ironed out before going to the wider public? LH advised that this had been the purpose of the pilot and initially only one project at a time would be launched. LLC asked if the website was intended only for engagement with the general public. RW advised there would be space for boroughs to interact "internally", including setting up community partnership meetings at, for example, local care partnership level, with each borough having in place a communications and engagement network. Some information governance issues just needed to be resolved to confirm who could set up projects as it has to be a statutory organisation for information governance compliance. The committee noted the update.
7.	**Joint Programme Patient, Carer and Public Involvement in Covid Recovery: attitudes and behaviours in relation to accessing care and services during the pandemic** RW provided an update on this agenda item, which had been fully briefed to committee members earlier in the year. The related to the joint Guy's and St Thomas' / King's College Hospital (GSTT/KCH) charitable-funded project to look at patient attitudes and behaviours around attendance at face-to-face vs online appointments during Covid-19, by commissioning Ipsos Mori to run a telephone survey of 1,500 patients. An infographic showing high level points, an executive summary, and a link to the full report, had been circulated. In summary, people were largely comfortable with face-to-face appointments in hospitals, with more concern expressed by carers and people form Black, Asian and Minority Ethnic communities around appointments. Work was ongoing with three workstreams to dive into findings and check back with patients to co-design and improve services, focussing on Long Covid, self-care and waiting for treatment, and self treatment. London South Bank University had been commissioned to take the work forward and consider if attitudes have changed since the survey.

	CM highlighted alignment to work being undertaken by the King's transplant patient team, which may be useful to link in. The committee noted the update.
8.	**Update from Healthwatch** FS gave the group an update on current Healthwatch activities. Currently enquiries received by Healthwatch were about the booster programme challenges – where and how to get the booster, together with concerns about variation to GP access. Healthwatch were working with Lewisham and Greenwich NHS Trust to look at their outpatients transformation programme, and looking to support the CCG/ ICB with messaging about access to services in winter and where best to get support. Engagement with Primary Care Networks (PCNs) was under review, with legislation likely to create change – Healthwatch responsibilities may be replicated at PCN level not just borough. Healthwatch was challenging itself internally about how it reflected the communities it worked with. Looking at the 2022 programme, engaging with communities was a priority and the feedback on this could be triangulated with ICS priorities. System and place conversations about relationships, data sharing, and working better together were all underway. CM noted that there was a confusion about the Covid booster jab – particularly for the clinically extremely vulnerable community where this was a third primary dose not a booster. It was noted that this needed to be urgently addressed and the right information shared with those providing vaccines as well as those receiving it. The committee members thanked FS for the update and noted its contents.
9.	**Feedback from the Equalities Committee** FM provided a reflection on Equalities Committee (EC) activity this year, noting it was good to see how EAC has worked with EC. Over the year, EC had been responsible for developing statutory duties around protected characteristics and outcomes. Deep dives on maternity and mental health had been priority areas, together with a focus on workforce related issues. This had yielded some really good results. Good data had been collected on workforce disability issues, which needed to be approached in a similar way to the Workforce Race Equality Standard (WRES). Some of Workforce Disability Equality Standard (WDES) reporting was not statutory but was so well presented that it would be going to Governing Body as a report. Some EC absences had meant a few meetings were cancelled. A Report by Dr Amena Verity on inclusion in South Lewisham was planned to be considered and was presented at the Lewisham equalities group recently.

	Reflecting on the earlier agenda item, the joint committees meeting was particularly important, with the principles being developed guiding the way the groups worked in the future, with the absolute need for a partnership approach lead by the public. JE thanked FM for the report on behalf of the committee.
10.	**Engagement risk** RW presented the engagement risk which formed part of the CCG's strategic Board Assurance Framework. RW would be updating the risk to reflect the engagement with communities and people work. No comments were received from the committee.
11.	**Any Other Business** Two AOB items were raised. • NF asked about an Astra Zeneca batch issue, where certain batches were deemed invalid to permit travelling abroad, and if the CCG was planning any specific action on this issue. **ACTION: RW to check internally**. • KB highlighted a report issued on the day of the meeting about NHS failures in sickle cell care. This was an example of health inequalities. FM advised that he attended some of LGT's equalities meetings and at the last meeting they had selected a range of clinical priorities to address equality issues – one of those was sickle cell. In winter sickle cell admissions outnumber combined diabetes and asthma admissions so this highlighted the need for more attention. This highlighted as a general principle the need for this committee to maintain awareness of matters that other groups are prioritising to ensure alignment across the ICS.
12.	**Date of next meeting** Monday 17 January 2022, 6pm to 8pm. Monday 21 March 2022 would be the following meeting date.
13.	**Meeting Close** The chair thanked everyone for attending and reminded all members that they could contact her at any time via email to raise an issue or comment. The meeting closed at 19:58.

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