NHS
South East London
Clinical Commissioning Group

Engagement Assurance Committee

Minutes of the meeting held on Monday 17 January 2022

Via MS Teams

Members:	Joy Ellery (JE)	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) *(until 1900)*	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
	Stephanie Correia (SC)	Committee member
Present:	Rosemary Watts (RW)	Assistant Director for 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
	Gemma Oliver (GO)	
Apologies:	Shirley Hamilton	
	Samantha Ross-Harding	

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. JE advised her declared interests can now be removed.
3.	**Minutes of the 15 November 2021 meeting, actions and matters arising** <u>i. Minutes</u> The minutes were reviewed and agreed by the committee.

	HL raised that on page 6, under "SEL Co-Produces", her point was that patients do not want to take the role of the subject matter expert when it comes to their health, they want clarity and expertise from a qualified expert; in this instance they may prefer to be told what they need to do. . **ACTION: HL to send a proposal for the amendment required to the text.** *Post meeting note: HL sent through the following sentence: Some people would like, even need, to be told what to do to resolve their health conditions. This can be more helpful when they aren't managing their illness properly.* <u>ii. Action log</u> • The "Development of engagement strategic framework" item on the log is a live issue for the ICS programme and should remain <u>open</u>. • Astra Zeneca issue (15 November 2021 action) - early batches of AZ not being accepted in the EU - RW had checked and there is nothing on the Government website on this and no action required by the CCG. This action is proposed to be <u>closed</u>. <u>iii. Other updates</u> *Let's Talk Health and Care South East London* Bang the Table have now signed an NHS contract so can get started fully on the platform. The Data Protection Impact Assessment has also been completed so all governance around this is complete. It was proposed that a shared space by created for the EAC on the platform to be used for committee discussion outside of the meeting. *Citizens' panel* £20k of funding had recently been received from NHS England to set this up, recruiting a demographically representative sample of the south east London population. The platform would be used to ask for views, ask questions to inform policy. KB raised the use of the term "citizens" as an exclusive term. LH/RW confirmed this was a temporary reference and were aiming to land on a different name longer term. The updates were noted by the committee.
4.	**Engagement report: teledermatology focus group for assurance** Gemma Oliver (GO), project manager, presented this item to the group to provide assurance that appropriate engagement had taken place. GO explained that the SEL dermatology network had been sent up in 2018, comprising Guy's and St Thomas' NHS Foundation Trust, Lewisham & Greenwich NHS Trust, and King's College NHS Foundation Trust, overseen by the CCG. One of the areas where the group had collaborated was on teledermatology. There had been some engagement with patients, and patients were keen to look at solutions. A team of clinicians had devised a model and pathway, comprising secondary care providing medical photography followed by a remote review by clinician. An

	outcome letter was generated from the consultation with outcomes either to refer back to the individual's GP or into secondary care. This approach was successful for the 16 - 50 age group as lesions are usually benign so can be managed with advice and guidance from the GP. Patient engagement took place on the pathway and included review of a proposed information leaflet. Two focus groups had met to provide feedback on a mock up letter, the leaflet, and proposed pathway. Despite a disappointing attendance, useful views and good feedback from people who had recently been on the dermatology pathway was obtained on wanting to see a condensed summary at the beginning of the leaflet and the addition of the pathway diagram. The information also needed to be patient friendly, in clear English, and avoiding medical terminology. The data gathered was presented back to the project working group who meet monthly. The next stage was to procure a platform to gather information together, with the desire to start the pilot at the beginning of March. WB reflected on her own experiences where doctors had found it difficult to identify what is happening with her son's eczema. WB asked if there was A range of different ethnicities considered in the project to enable comparison of skin types by photograph. GO assured the group that the photographers are used to looking at photos of different skin types, and had been advised that there is limited difference in identifying lesions for different skin colours. SC queried the term "A and G" used in the paper received - this stood for "Advice and Guidance". Clarity was sought on whether the patient would always see a GP before being referred into the service? GO advised that the request is that the GP sees the patient first but this is outside the service's control. Generally this is happening in south east London. LLA asked about the pathway age range of 16-50 - was there still a requirement for a parent or carer to be linked into a 16 year olds care pathway? GO confirmed that photos would only be taken primarily wrist to waist, and legs down. GPs are advised that informed consent is required for this service. For vulnerable 16 year olds, a face-to-face consultation is recommended. JE suggested that the low uptake for the focus groups could indicate that people felt there was no need for major changes to the pathway or to provide feedback. GO was thanked for providing the assurance feedback to the committee. GO left the meeting.
5.	**Presentation and discussion on developing the working with people and communities strategy of the South East London ICS for discussion** AS opened this item with a reminder that the underlying question of this strategy was - "what does great look like?". The focus this time was on the emerging messaging and vision. RW advised that discussions on the wording for the vision had taken place since the EAC last met, at the steering group, the Healthwatch South East London

	Patient Group, and the first meeting of the ICS engagement practitioners network. The result was a draft mission statement, vision statement and the operating principles. The document presented today addressed the feedback items raised by those groups, including issues around clarifying the language used and the addition of more content. The team was particularly keen to get feedback on the draft narrative. Engagement with communities across south east London will take place over the next few months and we need to tell a story about what an ICS is and explain what this will mean to the public.
	
	Feedback from the group was rich and detailed, and is summarised below:
	
	General
	• written in plain English
	• good to see it speaks to people - less clinical and corporate.
	
	Mission and vision
	• MG wanted to see something about integration - things coming together to create a better future - otherwise the reader was still left with the question "so what?".
	• Need to understand what can be expected from the ICS - justify its purpose.
	• Need to make wording tighter, for example:
	  ○ does vision need "together" in the line?.
	  ○ for working in partnership with local communities and people - does this also need "in everything we do"?
	
	On engagement principles
	• Make wording more concise and to the point.
	• On first line "(1) - we work in equal partnership with local people with lived experience" - do we need "lived experience" so people don't feel excluded if they haven't got it?
	• Should this include line include "equal" as it is not? JE noted that equity is what we are striving for and it was important to stress that.
	• Need to more clearly define how this is going to be delivered not just what will happen. RW advised this will also be addressed in the strategy document.
	
	On emerging narrative
	• RW suggested use of the Let's Talk Health and Care SEL platform as an EAC chat forum for discussion on narrative - this would reduce email traffic and also enable trialling of the platform.
	• Narrative is quite wordy, some sentences are too long.
	• OP liked the highlighting of staff also as residents.
	• In the second paragraph, second sentence, some people have conditions that they cannot control the circumstances for which they arose - it is not linked to lifestyle associated health.
	• Need to clarify want the term "High quality care, closer to home" relates to.

	• Concern the sentence referring to the Pandemic is trying to deal with a difficult concept in one sentence - not sure it works. • Lots of talking about working in partnership across many sentences. • Good references to combined resources as this is an important point. Working together reinforces that. There is a need for people to understand that health and care are two different facets that are being brought together in a seamless way. • We are now at a point where we need to stop saying that the pandemic has highlighted the known differences between outcomes and experience. We know there is a difference - this is a fact - we need to deal with it and work together to make the change. • Suggest delete "most" in third paragraph. • The last sentence references local organisations but it needs to clearly reference local residents as well. *On engagement to inform strategy development slide* • Bullet points make the point clear and concise. • Need to think about how the first line implies there is an opportunity from having a negative experience. • On first line there is a word missing after "concerns and comments…" • Need to consider the use of the phrase "health inequalities" and if it is understood or an appropriate reference - acknowledging there is a desire to hear from people in particular who suffer from inequalities. JE asked to confirm the timescales for completion. It was acknowledged that there needed to be sufficient time allocated and it was suggested that the next meeting be used to consider methods of delivery. However, in the meantime the new digital platform could be used as a tool to share thoughts and comments. **ACTION: RW to consider with AS how this could be achieved.**
6.	**Internal audit report - stakeholder management for information** JE introduced this item, outlining the internal audit process, and explaining there were four possible outcomes to an audit ranging from poor (minimal assurance) to excellent (substantial assurance). The outcome of this report was that **substantial assurance** had been provided to the auditors, which is the best outcome possible. This really reflected the high quality of work that is carried out by the team and JE expressly thanked the team and recognised the effort put in by RW to provide evidence to the auditors. RW advised that one management recommendation had been made, which was to complete a stakeholder mapping exercise. The team already knew the stakeholders but for each specific engagement piece there would be a different stakeholder map so it was not considered useful to have one consolidated map. JE reiterated that she had never seen a report with only one recommendation, which demonstrated how good the result was by the team, excellently led by RW,

	who should all be highly praised. JE noted that page 10 of the report referenced the PCCC arrangements which appeared to be an error in the report. SC felt the report was good to read in terms of whole engagement process. On page 6 there was a reference to the annual stakeholder survey which hasn't been held. SC asked if this would happen? RW advised that the comment referenced a requirement from NHSEI for a 360 stakeholder survey, but this had not been required for the last two years due to the pandemic. The outcome was noted by the committee and the engagement team congratulated.
7.	**Review of out-of-pocket expenses policy** LH advised the group that two amendments had been made to the policy, as listed on the cover sheet, to make the relevant areas more explicit and reduce scope for interpretation. The amendments made were: a) To confirm the policy did not apply for public events b) To confirm that a standard rate for childcare was applied across south east London, removing the individual borough listings. No comments were raised by committee members.
8.	**Update from Healthwatch** FS updated the group on Healthwatch activity since the last meetings. Healthwatch had received lots of comments about vaccinations and vaccination centres. A lot of comments were positive, with people reporting good experiences. There had been one blip where people had long waits but that was now resolved. A number of comments had been received about challenges around accessing dental care. One of the outcomes of delay in treatment in lock downs was that people were now finding it harder to find NHS dentists in a couple of boroughs. The team were working with Healthwatch England to determine if this was a localised or national issue. Healthwatch were looking at workplans for next year, with a potential shift from undertaking deep dives on particular services to looking at pathways and considering how to make the data gathered more accessible to the ICS in a more structured way. Face-to-face engagement was not taking place at the moment, particularly to respect the pressures on the system. JE enquired how online surveys were carried out? FS advised there was a preference for Zoom but Teams was also used, along with telephony. It was acknowledged that using online virtual options meant hardware was also needed.

	OP asked if an online only approach impacted the work Healthwatch was doing. FS acknowledged it made a big difference as the focus was on people who don't follow traditional methods of engagement, so Healthwatch like to get into communities and pursue outreach opportunities through GPs, job centres etc. All those opportunities were lost at the moment but they were working with voluntary sector groups who support communities. The committee noted the report.
9.	**Feedback from the Equalities Committee** JE provided feedback on the last meeting that took place on 6 January 2022. The committee had discussed the vaccination programme and the national mandate for NHS staff to be vaccinated. There was consideration about why some people had received the vaccine but not boosters and how to engage with them. The group also considered training for managers to support staff who did not want to be vaccinated, and the messaging that needed to go to people about the booster. The committee also discussed how to reduce inequalities in staffing, with feedback received from various staff networks including Beyond BAME, LGBTQ+ group and the parenting network. The staff survey was considered, noting an 84.9% response rate. It was considered positive that people felt able to give their responses. Finally, recognising the strong cross-over with the Engagement Assurance Committee, the Equalities Committee received feedback from RW and FS on this committees activities. The committee noted the report.
10.	**Engagement risk** RW presented to the committee the latest version of an engagement risk on the Board Assurance Framework. It was noted that the original risk concerned the CCG not outreaching/ engaging with diverse communities. The Engagement Assurance Committee was cited as a risk control, as was the excellent audit outcome. The risk update was presented to this committee to provide assurance that risk controls are in place and there is substantial assurance. No comments were received from the committee.
11.	**Any Other Business** SC highlighted that she had been involved in the London Care Record and asked if consideration could be given to including an update as a future agenda.

	LLC commented on how full the agenda was and that it was sometimes difficult to embrace everything discussed. Clarity was requested on the committee's role with all the items on the agenda. Could the agenda be more condensed to enable higher quality discussion? It was suggested whether the committee's role be best placed to advise on how to get a reach into our communities and feedback on the general community sense of feeling, and input to discussion about what health inequality means. JE commented that the committee was about obtaining assurance on engagement, not a forum for engagement itself, but that sometimes the group was used to help develop and discuss thinking on engagement and receive papers for information on engagement and that was what added to the agenda items. JE advised the committee that she had been working on a research project with Kingston University and St George's to look at how the public and patients are embedded in health and social care commissioning. The project was asking for people's views on how people's experience and knowledge in engagement is used by providers and organisations to influence health commissioning and decision making. Anyone interested in taking part should contact JE. RW reminded the committee that Integrated Care Boards would not now be in place until 1 July 2022, so CCG governance was extended for another three months. Therefore, the Engagement Assurance Committee would have a May 2022 meeting scheduled. There was no requirement to review the committee Terms of Reference as this extension was a national directive.
12.	**Date of next meeting** Monday 21 March 2022, 18:00 to 20:00.
13.	**Meeting Close** The chair thanked everyone for attending and their valuable input. The meeting closed at 20:00.