NHS South East London Integrated Care Board

Engagement Assurance Committee

Minutes of meeting held on Wednesday 25 September 2024

Via MS Teams

Chair: Anu Singh (AS)	Non-executive director, SEL ICB
Members present:	
Tosca Fairchild (TF)	Chief of Staff, SEL ICB
Toby Garrood (TG)	Medical Director, SEL ICB
Kolawole Abiola (KA)	Southwark borough member
Folake Segun (FS)	Director, South East London Healthwatch
Orla Penruddocke (OP)	Bromley borough member
Shalini Jagdeo (SJ)	Bromley borough member
Neville Fernandes (NF)	Lewisham borough member
Marc Goblet (MG)	Greenwich borough member
Stephanie Correia (SC)	Lambeth borough member
In attendance:	
Rosemary Watts (RW)	Assistant Director of Engagement, SEL ICB
Iuliana Dinu (ID)	Senior Engagement Lead, SEL ICB
Graham Tanner (GT)	Associate Director for Primary and Community Based Care - Bexley, SEL ICB

Minute taker: Simon Beard

Apologies were received from: Tal Rosenzweig, Geraldine Richards, Livia La Camera and Chris Boccovi.

		Actioned by
1.	**Introduction and welcome**	
1.1	AS welcomed all and thanked them for their attendance.	
2.	**Opening Business**	
2.1	Declarations of Interest No new interests or conflicts with agenda items were declared. AS reminded the members about the need to complete a declaration of interest and the two stage process in Disclose to confirm the record.	
2.2	Minutes of last meeting The minutes of the last meeting were agreed with one exception raised by ID – on point 7.1 – the reference to “key insights from 360 sessions” should say “360° feedback sessions”.	

2.3	Matters arising a) Outreach on NHS 111 – ID ID updated the members on the outreach work on the NHS 111 reprocurement following the substantial agenda item at the May meeting. Outreach activity had continued with a variety of groups across SEL, including a session online with a SEL-wide learning disabilities group. Following collection of the insight data the team was developing the service specification for the new NHS 111 contract. It was intended to have members of the public as part of the procurement panel through an open and transparent recruitment process which EAC members could apply for if they wished to. In response to a question from FS, ID confirmed the procurement panel would be opened up to members of the communities who were engaged in the insight gathering, and that they would receive feedback on the impact of their engagement and progress on the procurement. b) Approach to recognising involvement - RW RW advised that the approach to recognising involvement has been approved for a six month pilot period as outline in the May meeting. This discussion paper was now being turned into a guide for managers. Members of EAC would be eligible to apply for support noting the rate was £14 per hour plus an hour for preparation and reading. The aim was to provide a real incentive to encourage people from underserved and marginalised communities to become more involved and increase diversity of voices involved in engagement activity. Engagement activity had been tightly defined in the guidance.	
3.	**Primary Care access and recovery plans**	
3.1	GT presented this item, opening by reminding the group that primary care was a function delegated to the boroughs in south east London, which meant that whilst all teams were working to nationally agreed priorities there were some nuances to delivery at place.	
3.2	GT introduced the delivery plan for recovering access to primary care, introduced in May 2023 as a suite of recovery plans within healthcare alongside elective and urgent and emergency care recovery plans. The primary care plan had four key domains: • Empower and support patients – with emphasis on the NHS app and promotion and support of self-referral pathways and expansion of pharmacy pathways • Work on Modern General Practice, looking at enablers like digital telephony and tackling the 8am appointment rush • Building of workforce capacity • Cutting of bureaucracy	
3.3		

On the Modern General Practice model, this comprised components on:

1) Access – via phone, online and walk in
2) Care navigation and alignment of demand and capacity – considering triaging and filtering and developing the receptionist role in directing to care pathways to get people to the right place at the right time and manage resources appropriately.
3) Improvement through a cyclical review process to sustain and embed good practice.

To support this process, funding was made available centrally, with some paid upfront and some held back by ICBs dependent on performance delivery. One of the criteria of assessment was patient experience of contact. As the national GP Patient Survey was only published after the ICB assessment date other measures were used such as the Friends and Family Test (FFT), local surveys and information from Patient Participation Groups (PPGs).

GT highlighted that the requirements for this year were lighter touch, looking at availability of digital telephony and self-assessment approach to care navigation process.

3.4

In terms of local Bexley work to evaluate the progress made, this included:

- Review of the outcomes of the Friends and Family Test (FFT), of which there were over 50,000 responses to consider for 2023/24. Generally positive responses ranged from 87% to 95% for PCNs.
- Comparison of National GP Patient Survey results year on year.
- Local survey work, for example:
  - The 2022 enhanced access patient and public engagement programme which looked at ability to book appointments outside of “normal” hours, particularly weekday evenings. This was done by sending text messages to residents with a link to a survey. Outcomes included recognising that weekday evening appointments were more valued than weekend appointments, with Sunday appointments considered the least useful, and a preference for face-to-face appointments and for residents to see their own GP. This enabled some local additional criteria to be applied to how the Bexley enhanced access capacity was structured.
  - A local GP patient survey was carried out between November 2023 and March 2024, targeting patients within appointments in the last four weeks, to inform PCN activity

Modern General Practice digital enablers included focus on Accurx to support patients to make appointments and communicate with their GP practice, use of cloud-based telephony to add features such as call queuing, average wait times, and callback functionality, and use of Healthtech1 automation work, piloted in Bexley, to make GP registration easier.

3.5

	GT acknowledged this made quite an ask on patients to evolve how they access primary care and created a need to support communities to access digital tools. As a result, the team used the expansive community champions network in Bexley to act as a conduit to promulgate information on the work being done, and support people to use the new enablers. Take up had been good via the VCSE organisations working in the community champions arena. The team was also benefitting from the support provided by Bexley local elected representatives. A scrutiny project group was set up to engage with practices and patient groups to enable understanding of what has happened and to understand patient and public experience. This work came up with six key recommendations which broadly aligned with the NHSE Delivery plan, including initiatives like making devices available in GP reception areas and how to better utilise primary care estate. In response, the team are looking to use options such as profiling of a PPG in the Bexley Newsletter and encourage public involvement. Communications work was also underway with the Better Access Bexley campaign which would run throughout winter, covering different aspects of the Modern GP work at six weekly intervals.	
3.6	SC raised three points • Would an evaluation of the impact of the different communication models be conducted? GT advised this was the expectation, using assessment to evaluate the changes to key indicators such as overall experience and experience in making an appointment on the phone. • how were the views of a diverse population gathered? This was done through the community champions network. • What level of influence over GP practices did the ICB hold? GT recognised they were private organisations but there was influence through the commissioning and contracting process.	
3.7	MG reflected it would be interesting to note the success of this project against those in other areas, noting the impact of digital literacy on this approach. Use of new Accurx in MG's area had not helped in improving communication. The benefit of a new service was limited by the capacity given to it by a practice – e.g. if all appointments were filled through 8am telephone bookings the online service had no capacity left available. MG asked if any barriers had been identified from digital roll out and if these were affected by population factors. GT felt the main advantage of digital tools enabled a spreading of capacity throughout the day, with a variety of approaches from practices to support this, recognising there was a need to balance this with access to other modes of communication. MG felt a levelling up was needed between practices to smooth the access and approach by practices.	
3.8	NF noted there was some Covid fatigue in the system and commented that weekend appointments were less popular. GT advised directions on enhanced access stated that weekend access should be provided between 0900 and 1700 but there was no obligation to provide	

3.9	appointments on Sundays. Bexley ran a virtual assessment service on Sundays but feedback generally indicated it was not a popular day for appointments. In Lewisham there were extended services from GPs at hospital but Bexley did not have an acute site in-borough. Video consultations was still a developing area but increasingly people were valuing face-to-face appointments post Covid.	
3.10	OP referred to the FFT data, noting trends were based on overall experience and suggested some more demographic information behind it may be helpful. OP reflected that PPGs could be front and centre of the improvements that could happen, but that PPGs sometimes felt they were not involved enough. This could offer an opportunity and should be a future planning consideration. GT acknowledged there was a wide range in the level of involvement of PPGs across practices, but as the GP contract was limited in the detail of expectations from PPGs the team was limited in their influence in this area and therefore a focus was placed on those that were operating to best practice.	
3.11	KA suggested the recovery work should include some analysis of a hierarchy of patient needs to ensure the new GP service procurement focused on population needs. This should be the first premise of the evaluation process – to solve local problems. KA had not seen this in the recovery plan. On improving the primary and secondary care interface, KA felt the plan should include a wellbeing plan and asked if the work on expanding community pharmacies that was presented to EAC previously could be considered to encourage collaboration with GP services, especially around medicine reviews and management. GT acknowledged there was a lot of activity already going on in expanding community pharmacy services; the work being done through the model was being assessed in terms of general impact on the system including acute services. On procurement of primary care, there was a lot of work to look at how to collaborate across providers, recognising the benefits of local care networks, and how primary care providers can work together with other providers. KA felt the learning should be shared across all the boroughs. **The Committee thanked GT for this comprehensive presentation and noted the update.**	
4.	**Feedback for the ICS Equalities sub-committee**	
4.1	TF directed members to the paper provided, noting the amount of work that had been invested into the committee and the areas discussed. TF highlighted that FS had attended the last meeting to discuss the work of Healthwatch which was well received.	
4.2	No questions were raised.	
4.3	**The Committee members noted the report with thanks.**	

5.	**Update from South East London Healthwatch**	
5.1	FS delivered a summary of the views gathered by Healthwatch organisations in south east London between April and June 2024. Key insights were gathered from over 1,800 people across all six boroughs, and identified: • Challenges with access to all primary care services, including dentistry and access to prescriptions, particularly for older people and those with limited access to digital services/ devices. • Poor communication between both patients and providers, and between providers themselves which resulted in delays in getting responses, meaning patients felt their voices were not heard and their concerns dismissed too quickly. • Overly difficult responses provided to people with mental health or learning disabilities which impacted their ongoing care. • Lack of responsiveness to cultural or linguistic needs creating a sense of exclusion. • Poor responses to questions on discharge and access challenges. • Trust remained a big issue for many communities, in some areas linked to the increase in use of digital tools.	
5.2	At the last meeting of the EAC, FS had promised to bring back some examples of where change was happening to emphasise some of the positive work taking place. These included: • Oliver McGowan training for GPs on supporting people with autism and learning disabilities • Good communication, particularly from staff at Queen Elizabeth Hospital Woolwich.	
5.3	FS also highlighted a couple of projects where actions were underway to respond to Healthwatch reports previously reported to EAC: • Healthwatch Southwark had worked with the Latin American community on engagement with health services. All providers who had recommendations in that report had now responded and actions plans were in place to listen to the issues raised. • Outcomes from the review of maternity services had been looked at and there were action plans and analysis underway to identify scope for improvements. • Issues identified in Healthwatch Lewisham's work with LGBTQ+ people on access to care had been escalated to NHS England for a regional response as it was relevant across multiple sectors.	
5.4	In response to a request from KA, FS referred members to the latest Healthwatch insight report which would be shared. **ACTION: FS to share a link to the latest insight report.**	
5.5	KA asked if an update on Covid and impact on primary care services could be provided to members. This was not something currently being looked at by Healthwatch. TF proposed public health or primary care colleagues would be best placed to do this.	**FS**

5.6	**ACTION: Angela Bhan or Catherine Mbema to be invited to a future EAC meeting to discuss.** MG expressed interest that staff had found the Oliver McGowan training useful as it was felt there was a noticeable uneven knowledge in health about these issues.	**RW/ID**
6. 6.1 6.2	**Voluntary, Community and Social Enterprise (VCSE) sector update** Tal Rosenzweig had submitted apologies for absence from this meeting, but had asked RW to deliver the following two updates: • TR was working on widening participation in the health workforce and working with VCSE organisations and more underrepresented communities to achieve this. A face-to-face workshop was taking place tomorrow to bring together key stakeholders to jointly plan implementation of the co-developed solutions presented to EAC last time. • The VCSE Strategic Alliance in conjunction with the ICB were developing voluntary and community sector professional lead roles across the system, where they will have most strategic impact, based on the ICBs Clinical and Care Professional leads model. Once the scope and key requirements of the roles had been determined they would go out to the VCSE community for recruitment. **The members noted the update.**	
7. 7.1 7.2	**Draft Engagement workplan and objective** RW opened by reminding the members that the workplan had been last reviewed in November 2023. The purpose of the paper was to update members on the engagement teams objectives in the year and progress to date. In the previous year, five objectives were considered against the five strategic aims which had caused some repetition, so RW had grouped some aims together for this year into three key areas: • **Establish good governance for engagement and support open and transparent governance across ICB.** EAC was a key part of this deliverable. • **Develop, embed and improve ICB processes for working with local people and communities, including those with lived experience and communities experiencing health inequalities.** The aim here was to build trust through promoting the importance of engagement internally within the ICB. A list was provided of the programme support currently being delivered, with RW noting the use of the engagement toolkit as a key instrument for supporting programmes, and the work to enhance diversity and quantity of membership of the Peoples' Panel, and promote the Let's Talk Health and Care SEL platform.	

7.3	• **Working across the ICS, with support from Healthwatch and VCSE, to develop collaborative approaches to engage local communities, align engagement and reduce engagement fatigue through a shift to dialogue and co-production**. The team were looking at how to work more deeply with VCSE organisations and Healthwatch to reach into communities and build engagement based on the South London Listens community organising model they used with Citizens UK and wider VCSE models. In addition, the team facilitated networks including an ICS engagement practitioners' network of over 50 people working on engagement across partner organisations, and a community champions co-ordinators network to share best practice and join up projects and programmes. RW highlighted the insight reports the team were using to inform their work, including: • Healthwatch insights reports. • a new report from Mabadiliko, whose work was predominantly aimed at understanding the view of people from Black, African, Black Caribbean and South Asian communities, and those living in socio-economically deprived neighbourhoods, which sought to combine a summary of various commissioned reports into one aggregated piece of work to share key themes.	
7.4	No questions were received from the members.	
7.5	**AS thanked RW for the update on behalf of the members, emphasising the importance of the work the team were doing.**	
8.	**Any other business**	
8.1	<u>Engagement in women's and girls' health</u> ID described the work that had been started in this area, which may be followed up with a more detailed presentation at a later meeting. This was a project looking to change the way women's and girls' health was delivered, using insight already existing together with outcomes from a survey currently out for responses. This had been promoted through a social media campaign and had so far received over 1,100 responses from diverse communities and age ranges. The survey would remain open until the end of the month. The team also going out to meet various groups, attending the South Asian heritage month festival in Bexley, freshers' fairs in local colleges, Ageing Well project in Lambeth, and planning more in depth focus groups open to those who have expressed interest in being more involved through three online focus groups plus specific focus groups with Southwark College. Following these engagement activities, the team would be discussing output with partners at two workshops in October, followed by further engagement on the proposed model developed. KA observed information from this group was useful and looked forward to more information and insight being shared with the committee.	
8.2	<u>Creative Health</u>	

	ID reminded people the latest engagement newsletter included information on creative health. The team was recruiting ten members of the public to co-produce a clear development plan on creative health. Applications were encouraged.	
9. 9.1	**Meeting close** AS closed the meeting at 19:58, thanking everyone for their time.	

Date of next meeting: 27 November 2024