SEL ICB Engagement Assurance Committee
Minutes of the meeting on 22 May 2024 18:00-20:00
Videoconference via Teams

Committee members

Anu Singh [Chair]	ICB non executive member
Folake Segun	Director South East London Healthwatch
Geraldine Richards	Bromley Member
Kolawole Abiola	Southwark Member
Marc Goblot	Greenwich Member
Orla Penruddocke	Bromley Member
Shalini Jagdeo	Bromley Member
Stephanie Correia	Lambeth Member
Chris Boccovi	Bromley Member
Neville Fernandes	Lewisham Member
Tal Rosenzweig	Director of VCSE Collaboration and Partnerships

Attendees

Iuliana Dinu	Head of Engagement SEL ICB
Michael Boyce	Deputy Chief of Staff
Rosemary Watts	AD of Engagement SEL ICB
Dr Rob Davidson	GP and Clinical and Care Professional Leader
Kerry Lipsitz [item 7]	Director for Integrated UEC
Claire Goodey [item 7]	999/IUC Commissioning Manager

No	Minutes
1	**Welcome and introduction**
1.01	Anu Singh welcomed members to the committee.
2	**Minutes of March 2024 meeting and any matters arising**
2.01	The minutes of the last meeting were approved as a record of the meeting.
	Matters arising
2.02	Rosemary Watts noted that the Clinical and Care Professional Group had considered and endorsed the EACs revised terms of reference.
2.03	Kola Abiola reflected that the over-prescribing work presented at the last committee on feedback about patients needing help or advocacy to navigate the system, not feeling listened too, and experiences communication breakdown between clinicians and carers deserved further development and evolution into a project. He suggested that medicine management and medication review to be a stand alone services embedded with clinical services and that medical officers are recruited that work between Pharmacies and GPs surgery as liaison for patients with long term illnesses, for a specific period across SE London geographical spread to support structured medicines review and also to link needs with social prescribing. Rosemary Watts pointed to medicines optimisations teams and GPs continuing work on medicines reviews and multiple

	medications including leaflets and information for patients. Iuliana Dinu added that follow up conversations were planned with groups initially engaged to feedback on how their engagement had helped with the design of patient videos and leaflets.
2.04	***Community engagement in maternity services*** Iuliana Dinu reminded the committee that maternity services had been working with different voluntary sector organisations to engage with communities whose voices may be less heard and at risk of poorer maternity outcomes. An event to celebrate the programme and feedback all the outcomes and results from this programme had been held and a video was available. Each of the five voluntary sector organisations had used different methods of engagement, going beyond the usual survey for example, using creative way to engage with specific groups such as women who were refugees or asylum seekers. The discussion had not focused only on insights and concerns, but also proposed solutions, some of which might already be feasible to deliver by maternity services working together with communities.
3	**Pilot approach to Recognising involvement**
3.01	Rosemary Watts introduced the paper pointing out that public members were conflicted because of their eligibility under the proposed approach. The paper had been developed through the engagement practitioners network of colleagues across health and local authority. The aim was to recognise the expertise and time given by people who were involved in engagement. During a financial crisis, it was hoped the approach would remove some of the barriers to reach people particularly those from more marginalised communities. The approach would be in addition to the existing expenses policy and based on three levels of engagement. There would be no financial recognition for attending public meeting or webinars. For Level 2 participation in one off discussions focus groups and workshops would entitle participants to claim expenses as per the existing policy. To Level 3 which would attract the fee for involvement. Principles had been set out to emphasise that engaging in health and care should be a positive experience for people, with non-financial recognition continuing to be important such as examples for CVs and references. A small budget had been agreed and a pilot approach agreed with the end goal of devolving the budget to programmes and Places, who would lead most of the engagement. Oversight of the process would be via a small panel, an open and transparent process and a simple form for managers to complete. It would be important for people to claim within three months of the activity taking place which allow the budget to managed. If supported the proposal would be taken to the appropriate governance forum with the ICB.
3.02	Stephanie thanked Rosemary for the presentation of paper which was often difficult subject and supported the content.
3.03	Folake Segun asked if the approach referred to work directly undertaken by the ICB or engagement work commissioned from other organisations. Rosemary Watts noted that organisations would be encouraged to follow the ICBs, approach, but would need to fund any fees paid to people they engaged through the budget quoted for the contract.
3.04	Mark Goblot emphasised the importance of encouraging participation with non-financial elements such as certificates or acknowledgement of the impact of

	contributions. There was also a consideration of how the fees may impact on benefits and tax. He asked for a process which was as easy as possible, and avoid accounting for every separate task. Rosemary Watts noted that the Engagement Practitioners Network had discussed ideas such as a time banks. There had been work done by Oxleas on the impact on those receiving benefits which could be utilised.
3.05	Chris Boccovi welcomed the approach which could be effective in building trust promoting engagement and help people who suffered more from socioeconomic inequalities who were often the most important to engage with. Work by Oxleas had shown a positive benefit of similar schemes in encouraging those who were involved in co-production and engagement.
3.06	Geraldine Richards welcomed the policy as a way of progressing development and suggested that the form should clarify agreed timescales and roles depending on the nature of the engagement activity.
4	**Feedback from the ICS Equalities sub-committee (2 May 2024)**
4.1	Michael Boyce reported on the Equalities Subcommittee • terms of reference had been reviewed and the subcommittees performance performance against the aims assessed. The sub-committee had agreed to include all staff network chairs at meetings and discussed ways of facilitating better working together of the ICB directorates, LCPs and equalities groups. • Discussing inclusive leadership, the sub-committee commented frameworks available and discussed how the EDS22 had helped assess the ICB and ICS buy working with providers and including the patient, clinical and staff voices. • The public sector quality duty report for the ICB had been recently published and it was noted that the European Human Rights Commission had been looking at ICB compliance with public sector equality duties and had met with all ICBs. The EHRC had praised some of the examples shown in the SEL ICB PSED report including the equality sub-committee and the work of the eangagement team. • A equality impact assessment for the ICB management cost reduction had not found that the process had disadvantaged any particular group, although there were some recommendations in general about the organisation could improve representativeness. • The sub-committee had conducted a deep dive into population health and population health inequalities The population health and inequalities team had presented their new approach and focus on doing a limited number of projects to a high quality.
4.2	Anu Singh emphasised the need to keep a grip on work such as health inequalities and to ensure the EAC complemented the work the work of the equality subcommittee
5	**Update from South East London Healthwatch**
5.1	Folake Segun reported on the work of Healthwatch. • Bromley Healthwatch was focusing on community mental health services. • Lambeth Healthwatch would soon report on an examination of the whole mental health inpatient and community services pathway from primary care referrals to discharge and beyond in relation to Black men.

	• Both Lambeth and Greenwich were continuing work on maternity care. • In Lewisham some difficulties in access to services for people with learning disabilities and autism relating to inflexibility on reasonable adjustments had been noted. There was also a finding of a lack of initial access for certain demographic groups, particularly black, African and minoritized communities, but then an over representation in inpatient secondary care, • In Southwark work on health equity in communities had focused on the Latin American community last year and would now broaden to other communities in Southwark • The Q3 Insight report was available and the Q4 report being produced. • General communication issues with patients and between services and providers, leading to a lack of knowledge to make choices and a feeling of disempowerment. • Timescale issues were fed back on as well as people feeling rushed In 10min appointments after waiting hours particularly for outpatient reporting, and the reasons for appointments did not seem to match time allocated. Patients might have to process information quickly in an emotional state with written follow up not available for some weeks. • Barriers to accessing care continued, sometimes cultural and sometimes physical. • Work on Trans health had identified stigma and lack of understanding or willingness to understand.
5.2	Neville Fernandes asked about the focus on Black men in the Lambeth work. Folake Segun noted the focus had been informed by research showing an over-representation of Black men in mental health services.
5.3	Neville Fernandes asked about any work with the people with severe sensory disabilities. Folake Segun noted no current work but concerns often referenced in Greenwich on the issue and some work in previous years as Lewisham.
5.4	Kolawole Abiola expressed some concerns that Healthwatch work tended to re-identify existing problems and issues, with little feedback on how the NHS had addressed them. For example challenges had been raised in the previous meetings about accessibility via phone for patients, parking, unexpected cancellations, lack of understanding of services available through pharmacists, barriers to access for minoritised groups. It would be useful to understand what authorities were doing about these issues. Folake Segun recognised that the pace of change appeared slow but pointed out actions were being taken that would take some time to have an effect.
6	**Update on the Voluntary, Community and Social Enterprise (VCSE) Strategic Alliance and the VCSE charter implementation**
6.1	Tal Rosensweig presented work with specialist VCSE and the communities they were embedded in on a project funded by Health education England on groups under-represented in the health and care • Deaf and hard of hearing people. • People with caring responsibilities and in particular young carers • People of Black, Caribbean and African heritage, • Migrants, refugees and asylum seekers noting that permits to work were a key issue for some but others had the right to work but found difficulty in securing employment

	• Neurodivergent people particularly those with autism and people with learning difficulties. The VCSE groups identified as best able to engage with each group had been commissioned to do collaborative work within communities. An executive summary of the insights developed was being finalised, and organisations had committed to start work on some of the solutions working with the communities themselves.
6.2	Tal Rosensweig updated on progress on the implementation of the VCSE charter. An infrastructure, capacity and skill building grant had been developed for six boroughs focused on grassroots organisations, developed working with them to strengthen their work with communities experiencing the highest levels of inequalities. Improving VCSE strategic leadership focused on the ICB and developing an offer for remunerated roles which would make sure there was consistency and learning. Peer support for these roles was also being developed.
6.3	Neville Fernandes advised that migrants refugees and asylum seekers also needed to obtain right to rent as well as the right to work. Tal Rosenzweig noted that this had been highlighted during the work with the local VCSE specialising in working in this area.
7	**Engagement in South East London 111 Service Redesign**
7.1	Claire Goodey updated on the engagement in support of the redesign of the South East London 111 service. The current contract for the provision of 111 finishes in March 2026 and identified as an opportunity to reflect on what's working well and what's not working well before we enter into a new contract in 2026. Over 400 people had completed a survey including members of the Peoples Panel. Themes in the responses included barriers to accessing the 111 service for people who were not proficient in English, those who were socially deprived, those with dementia, people with physical and sensory difficulties, people with complex needs, people not registered with a GP or without legal status to be in the UK, those living alone experiencing mental health difficulties, neurodivergent people and people with learning disabilities. It was planned to reach out to the groups highlighted by the survey results and work with comms and engagement leads on suitable community groups to help with this work had started.
7.2	Stephanie Correia asked whether users of the 111 service were asked to evaluate the service at the point they used it. Claire Goodey noted that they were asked to complete a survey immediately and also followed up after a day or so. This information was included as part of the review.
7.3	Dr Toby Garrood asked if there was baseline data available for the service, or by index of deprivation. Claire Goodey noted that the data received form the provider was anonymous – the registered GP practice was known but not the postcode of the patient.
7.4	Neville Fernandes asked whether applications to provide instant translations had been considered. Claire Goodey noted that once the patient reached the call handler there was an opportunity to ask for a translator however there were a few English questions to navigate the menu to reach this point.
7.5	Orla Penruddocke pointed out that there were a large number of recommendations, and asked if there was an approach to prioritise them.

7.6	Claire Goodey agreed that some of the recommendations might be easier to achieve than others it was hoped to increase the ability to respond to demand and reduce callback times by splitting the call handling function from the clinical assessment service and delivering the clinical assessment service on a smaller borough scale. The triage tool was nationally commissioned and although had some disadvantages was also useful. Patient education was also a recommendation which needed to be pursued as the promotion had been quite limited in the past.
7.7	Shalini Jagdeo asked about young people and particularly young carers, and whether they would be tailored to meet the needs of this group. Claire Goodey noted that in general the call handler would seek to pass a child straight through to clinical support with a high priority rather than try to triage.
7.8	Dr Rob Davison commented that 400 responses was a good result for the survey. It was important to examine not just the kinds of people that use the service but not the reasons they were calling the service. Over the years it had evolved to be mainly focused on primary care from very high acuity emergencies that may require an ambulance, to requests for repeat medication on reassurance about a long-term condition.
7.9	Dr Toby Garrood asked if there was a method for people as the phoned the service to be informed about a better way of accessing services, and whether there was currently access in near-realtime to feedback given by patients using the services from LAS. Claire Goodey noted that responses had improved in this area with easier ways for people to contribute. The feedback tended to report happiness with the service and advice given but complaints about time for the call back.
8	**Any other business**
8.1	Iuliana Dinu reported on some workshops to get views on how to help people to know where to go for information guidance and advice about health care. A survey of the peoples panel and general public had highlighted issues and small focus groups were invited to ensure that messages, and particularly visual aids were easily accessible. Three workshops had been held so far and the work would continue.
8.2	Kolawole Abiola asked about work around primary care services. Rosemary Watts noted that deliberative work on primary care had started with frontline staff, and would continue with a process of deliberation with a representative group of 100 Londoners. Work would continue on the issues with marginalised groups with the help of VCSE organisations. The Focus would be on digitalisation of primary care, triage and access and the development of integrated neighbourhood teams.
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