Lancashire and South Cumbria Integrated Care Board

Approved 28 February 2024

Minutes of the meeting of the
ICB Public Involvement and Engagement Advisory Committee (PIEAC)
held on Wednesday, 12 December 2023 at 10:00am to 12:30pm in the Lancashire and South Cumbria Integrated Care Board (LSCICB) Offices, Windermere Meeting Room,
County Hall, Preston

Position on Committee	Name	Title/Role
Members	Debbie Corcoran	Non-Executive Member of the ICB (Committee Chair)
	Roy Fisher	Non-Executive Member of the ICB (Committee Vice Chair)
	Neil Greaves	Director of Communications and Engagement
	David Rogers	Head of Communication and Engagement (Insight)
	Amanda Bate	Head of Communications and Engagement
	Tricia Whiteside	Non-Executive Director, Lancashire Teaching Hospitals NHS Fo Trust
	Tracey Ingham (representing Steph Cordon)	Assistant Director of Safe and Strong Communities – Westmorland and Furness Council
	Michaela Goodridge (representing Pauline Wigglesworth)	Co-Production Delivery Lead, Blackpool Council
Participants	Katie Eagan	Representative of Voluntary, Community, Faith and Social Enterprise (VCFSE)
	Andrew Bennett (from item 9)	Director of Population Health
	Jodie Carney (representing Lindsay Graham)	Healthwatch Representative
	David Brewin	Head of Patient Experience
	Dan Clough	Communications and Engagement Manager
	Trina Robson	Engagement Co-Ordinator, South Cumbria Place
	Nick Barkworth	Clinical Network Manager
	Sarah Mattocks	Head of Governance
	Rachel Melton	Deputy Associate Director All Age Continuing Care and Individual Patient Activity
	Sandra Lishman (Minutes)	Committee and Governance Officer

No	Item	Action
1.	**Welcome and Introductions** The Chair opened the meeting and welcomed everybody, announcing that Steph Cordon had joined the committee as the Local Authority representative, represented today by Tracey Ingham.	
2.	**Apologies for Absence** Apologies had been received from Sarah O'Brien, Philippa Cross, Naz Zaman, Steph Cordon, Debra Atkinson, Vicki Ellarby and Heather Woodhouse. The Chair highlighted that the meeting was not quorate and any approvals required would be looked at during the agenda item.	
3.	**Declarations of Interest** (a) Public Involvement and Engagement Advisory Committee Register of Interests – Noted. Roy Fisher declared an interest that he was now the Interim Chair of Blackpool Place Based Partnership. **RESOLVED: There were no other declarations of interest relating to items on the agenda. Members were asked that if at any point during the meeting a conflict arose, to declare at that time.**	
4.	**(a) Minutes from the previous meeting held on 25 October 2023 and Matters Arising** Outside of the meeting, Naz Zaman had commented that page 7, item 7, should reworded to read "…it appeared to meet a certain target audience, for example, this leaflet (provided by NHSE) would not land well with groups that are termed as hard to reach or disengaged". **RESOLVED: Subject to the update as highlighted above, the minutes of the meeting held on 25 October 2023 were approved as a correct record.** **(b) Action Log** **(23/24)25Oct2023-01 Complaints –** Item on agenda. Closed. **(23/24)25Oct2023-02 Winter Communications and Strategy Plan –** N Greaves confirmed that work was underway and updates received to date had been useful. Linked to discussion at the last meeting, N Zaman had feedback; N Greaves would discuss further with K Eagan outside of this meeting. Ongoing progress was noted. **(23/24)25Oct2023-03 VCFSE –** On workplan to be on February meeting agenda. Item closed. **(23/24)25 Oct2023 – 04 – ICB Audit of Engagement with Public, Patients and Carers, MIAA -** A formal action plan had been created for focus, to enable people to contribute in terms of recommendations and to ensure actions completed. **(23/24)25Oct2023 – 01 – Dying well engagement update –** To be received and picked up by the Finance and Performance Committee. Item closed as responsibility discharged to the ICB Finance and Performance Committee.	

5.	**Standing Assurance and Insight Reports** **a) Public Engagement and Involvement Assurance Report: October to November 2023 -** D Rogers presented a report providing assurance for the delivery against the strategy for working in partnership with people and communities across the ICB and embedding the principles of public involvement and engagement. The report also summarised engagement, involvement and co-production activity supporting priority system transformation programmes, other ICB programmes of work and a summary of activity to support partnership working in place. It was highlighted that much work had taken place around fragile services including urology, head and neck cancer and vascular. A Citizen's Health Reference Group had been established and there was a lot of interest at the first meeting. An NHS England funding bid had been secured to work with Lancashire BME to understand experiences and the needs of unpaid carers from the ethnic minority community. Following recommendations from the Mersey Internal Audit Agency (MIAA) review regarding setting targets for engagement and to assist with tracking, a pie chart would be created showing engagement work undertaken and established benchmarking on all reports on the action plan over the next few months. Healthwatch were undertaking a project, called 'Our Voice in Health and Social Care', around British Sign Language (BSL) to learn about the barriers faced by the deaf community and formulate key recommendations, to help influence and improve services. A Lancashire County Council meeting had recently been held to listen to parents' and carers' experience of Special Educational Needs and Disability (SEND) for young people and a SEND review in Lancashire was being looked at for 2024. Carers praised the Council and partners at the meeting. T Whiteside reflected that a lot of progress had been made on embracing terms of engagement since the inception of the committee and raised awareness to ensure that no groups had been missed. D Rogers commented that the February meeting report would include engagement with all groups of people, including work around the new hospitals programme and response to more marginalised disadvantaged communities. Capacity was placed around where the priority programmes were. Engagement outreach had taken place in key areas and providers were looking to change the service model, including gastroenterology and orthodontics. Engagement had taken place with around 5% of relevant service users and providers were starting to embed some principles. Targeted engagement work had taken place in areas of Place where there were known higher hospital admissions, including priority ward work. N Greaves confirmed that the February insight report would reflect on the system model, connections on how work was being made systematic, including detail to ensure all group/individual voices were feeding back into the network, both detail project by project and also holistically as a system. The Chair expressed that progress had been seen in meeting reports since the committee first met, including a richness and understanding on how the work was making a difference in terms of deciding what the ICB does and how engagement was captured to ensure others were aware to make the difference required. N Greaves responded that work in Place included priority wards looking at deprivation and partners were included as insight was partnerships working in place, e.g., hubs in Blackpool. **RESOLVED: That the Public Involvement and Engagement Advisory Committee:-** - **Note the content and summary of insights contained within the report.**	**NG/DR**

	- **Recognise and endorse the engagement and involvement activity undertaken across the ICB and learning being embedded.** - **Note the forward view of upcoming engagement, involvement and co-production activities for the next period.** - **System model has been developed.** **a(i) Public Involvement and Engagement Policy –** T Whiteside welcomed the policy and in particular the governance and control structure detailed within. N Greaves confirmed that the policy was required to be in place across the ICB as an organisation as the ICB were unable to govern the way this type of work could be used by other organisations. It was explained that the work undertaken around strategy, people and principles was around what we would do for leverage to work. The ICB's annual report included detail on how the system performed against statutory guidance. The policy had internal focus with purpose to ensure it was clear why there was priority and how responsibility was discharged across internal teams. N Greaves would test the policy with the Citizen's Reference Panel, asking if they understood why this was being done and that everything shared was important. **RESOLVED: That members of the committee within the meeting room supported the Public Involvement and Engagement Policy. Due to the meeting not being quorate, support would be sought from committee members not at the meeting by email.** ***POST MEETING NOTE – Full support was received for the Public Involvement and Engagement Policy. The ICB Board would be asked to endorse the Committee's recommendation to approve the policy at its meeting on 10 January 2024.*** **b) Public and Community Insights Report: October to November 2023 -** D Rogers spoke to the report which highlighted the headline trends and key themes including primary care, urgent and emergency care, continuing healthcare and dentistry, all of which continued to be a focus of interest and concern in relation to patient complaints. Key highlights included the response rate of 45% for the Withnell engagement study and registered patients felt there was a need for involvement. The ICB had been working and engaging with Patient Participant Groups, being a vital resource and another part of the cohort of professional engagement. The Chair acknowledged a richness within the report in terms of activity being delivered and insights. D Brewin clarified that the Freedom of Information data within the report focused on October and November, rather than September as the report stated. Concern was raised regarding the number of cases closed as opposed to the number of cases open. R Fisher highlighted that some Freedom of Information requests could not be dealt with within the ICB's financial envelope and some would be dealt with by the Commissioner's Office, which could contribute to the high numbers reported – D Brewin would clarify numbers and more in-depth information to members outside of this meeting. It was confirmed that the process for Freedom of Information activity was being reviewed and insights and themes would be welcomed around the process. Discussion was held around people's frustration of voices and whether they were being listened to/heard. This was referenced in the engagement report and the importance of having a good understanding of patient stories and next steps would be highlighted at the next meeting as it was felt there was a need to describe what the ICB has done as a follow up from the patient stories. D Rogers reported that the next Quality Committee meeting would focus on the review of patient stories and it was anticipated that a report around actions taken and the impact would be reported to the	**NG** **DB**

	Public Involvement and Engagement Committee at its February meeting. Discussions had been held with people from BSL to influence their ability to be able to be involved in patients and their discussions with GPs and hospitals; this was being picked up as part of patient stories, ensuring reflection of different committees. Information on how success was being measured and key messages of insight on what people were thinking to permeate across the Lancashire and South Cumbria system, would be included in future reports. It was highlighted that ChatBox, a website for the needs and scope of people on waiting lists, was no longer in use. A lot of work had taken place around elective care and there was now a more refinement of people on waiting lists. There was a dissatisfaction of people being contacted through ChatBox. A further update would be provided at the next meeting. **RESOLVED: That the Committee:-** - **Note the content and summary of insights contained within the report.** - **Recognise and endorse the engagement and involvement activity undertaken across the ICB and the resulting insights shared in the report.** - **Note the forward view of upcoming engagement, involvement and co-production activities for the next period.**	
6.	**Continuing Health Care (CHC): Process for Involvement and Capturing Patient Experience** R Melton spoke to a presentation describing the new service model for All Age Continuing Care (AACC) and Individual Patient Activity (IPA) that had been implemented from 1 October 2023 and highlighting that a new quality hub was being put in place, incorporating public involvement and patient engagement into AACC and continuing healthcare. 150 staff had been TUPE'd over to Lancashire and South Cumbria ICB on 1 October 2023, joining the existing ICB AACC and IPA team. Every incomplete referral (ICR) must now be completed within 28 days. To ensure more usage of the voluntary sector, a representative had been invited to meetings. The learning and development lead would be working with the audit and patient experience lead, looking at how to become a proactive, rather than a reactive service. A new model of personal health budgets was being rolled out in Lancashire and South Cumbria in January/February 2024 and these were under the remit of the CHC Head of Quality. In order to ensure that the new model continued to improve, a learning and development lead role had been created. All new posts had been recruited to, with staff starting in roles soon. The Chair expressed that it was helpful to see how the model of care was changing, supported by increased investment. It was evident that feedback had shaped the investment decision and service delivery, with commitment as a team. Continuing healthcare was also used for end of life. Careful consideration was required in relation to engagement with the committee. It was thought that discovery interviews may be meaningful with this cohort and D Rogers would discuss further with R Melton outside of this meeting. There was uncertainty whether learning had been captured correctly as there was currently no check as to whether the outcome happened or made a difference. D Brewin expressed that when complaints were looked at in detail, much was around care delivered, which would not be seen in data. Mapping had been undertaken a couple of years ago and it was suggested that this model be looked at as included methodology	

	based around friends and family type snapshot. Compliments would also need to be captured. T Whiteside welcomed this work and raised whether given the medical understanding and needs of the condition, how many people were accessing the support they were entitled to, suggesting that data was used to support people, rather than waiting for people to ask. It was felt this to be an opportunity to educate health care workers and to be able to signpost people to the right channels of the service. R Melton reported that training with acute trusts was being looked at. Relationships were also being built with local authority colleagues and in future, a social worker would be expected to be at assessments. K Eagan expressed that a group of strategic health leads had recently been formed to ensure the VCFSE sector was informed and included in an organised and considered way. K Eagan would contact R Melton outside of this meeting to understand a broader perspective of the sector, for reporting into this group. The Chair confirmed that appropriate assurance of public and patient engagement within the new model and service had been received, with feedback captured. The Committee asked for an update in 6 months on how things had progressed, including a comparison of the previous and current service, the number of people touched by the service to get an understanding of scale, and the engagement approach to support individuals. It was clarified that the Quality Committee were monitoring the service from an assurance point of view. The Public Involvement and Engagement Committee would require assurance from patient experience. The Committee thanked the Continuing Healthcare team for this update and congratulated the team on the staff awards held last week. **RESOLVED: That the committee note the update and provide a further update in 6 months.**	
7.	**Complaints and Patient Experience Review** D Brewin presented a report providing a 'deep dive' into the complaints and patient experience activity plans, focusing on the delegation of both primary care and complaints. It was highlighted that the number of complaints had dropped significantly since September 2023. The handling of primary care complaints and enquiries were being dealt with locally since 1 July 2023, increasing the overall volume received. A higher number of dental complaints had been received than other systems and ICBs. A collaborative piece of work was required to be undertaken with Trusts looking at handling complaints across the system. 11.7% complaints had been upheld against the England average of 27.6%, it was thought this might be due to how complaints were categorised. Members noted that the Patient Advice and Liaison Service (PALS) had recently been restricted with a limited offer of more signposting and more self-help, with less liaison and intervention. More use of 'pass to provider', with discretionary power would be used in future to manage the flow of incoming work across primary and secondary care. The patient experience service had now been deferred. In total, it was forecast to have 3732 experiences captured this year, including complaints, MP letters and via PALS. The Chair reflected an interest in learning more about PALS and changes to the service, including how the service was responding to the changes and how people were being supported to ensure they were receiving a quality experience. She also felt that it would	

	be helpful to be aware of compliments received. The Committee were content with the assurance provided and there was clear evidence and judgements around changes to the service. D Brewin responded that there was risk with PALS providing a limited service as the demand remained, however, the restricted service had been put into process as there was virtually no resource. Compliments were not promoted but recorded and a piece of work was planned to be undertaken with continuing health care, around compliments. It was sometimes unclear where governance would be reported and work was in progress around how quality was being monitored, being part with the provider, and around how this would feed and see outcomes. Training on complaints would be offered to various teams, including continuing healthcare, where the distinction between everyday problems and people's 'tipping point' would be discussed. R Fisher expressed that the interrelationship with committees was vital and highlighted that the Patient Safety Incident Response Framework panels included ICB representatives, looking at serious incidents in acute trusts. It was important that patient experiences were fed back into the relevant committees to work together to understand the information. D Brewin commented that links and learning should strengthen as the Patient Safety Incident Response Framework evolved and that clinician concern was not necessarily what concerned the patient. The Chair asked for an infogram of the oversight of this committee and Quality Committee, in relation to complaints, which could be shared. J Carney reported that youth huddles were being held in Lancashire; a summary of what people were sharing would be sent to D Brewin capturing how many people were signposted, etc., and would be included in a future insight report. In summary, the Committee confirmed they were assured on activity and plans of the complaints and patient experience team, noting that the function was under significant pressure. Risks had been identified and mitigated and continued to be managed. **RESOLVED: That the Committee:-** - **Note the contents of the report.** - **Recognise the activity already undertaken.** - **Agree to receive further reports as the patient experience and complaints work develops in the coming months.**	**DB**
8.	**Dental Access and Oral Health Improvement Programme** A Bate introduced the report outlining the background to dental access and oral health in Lancashire and South Cumbria and the need for a robust communications and engagement plan. N Barkworth highlighted key points within the report and explained that the plan would contribute to a reduction in poor oral health, improve patient access and support the work of health and social care professionals in their oral health conversations with patients. The ICB was given the delegation of dental as a contractual responsibility earlier in 2023, alongside TUPE of several NHS England staff. The NHS receives funding for 60% of population funding for support, however, with oral health decline since the pandemic, this translated to around 50%. The main area of focus was for people to receive access to dental care. Evidence showed that there was a big oral health decline or poor oral health in areas of deprivation. A recent report showed alarming numbers of children requiring teeth removal and showing poor oral health in the North West. The plan showed an intention for extension of stakeholder and patient involvement to shape the service going forward. The plan was iterative and would be reviewed as an ongoing process with metrics for evaluation.	

	D Clough reported that the oral health improvement programme was the outcome of discussions held at a conference held earlier this year, hosted by the primary care dental team. To understand how to improve services based on people's thoughts, the ICB was tasked to communicate with members of the public around access to services and self-care. Positive feedback had been received from the development of key messages around access, oral health and self-care, which was the first step of an action plan created to take this work forward. It was highlighted that since the meeting paper had been written, there had been a development around funding to support communication and engagement activity, which would result in reflection of evaluation with limitations in work that could be conducted, most work would be undertaken in-house. A primary care intranet page was in development and engagement with staff and members of the public would be looked at in the New Year. It was explained that local authorities held the statutory duties for oral health, and the ICB was working in tandem with wider stakeholders. The local authority was currently funding some good campaign work for children and young people. If people were more informed, it was hoped that a decrease in people asking questions on accessing oral health care would be seen, however, there were also more elements that need to be achieved in the metrics. The Chair commented that the report was helpful and demonstrated the issues that need to be looked at in this challenging position. M Goodridge reported that messages had been co-produced with local authority colleagues from a Blackpool perspective, which she would share with N Barkworth. A lot of work had taken place around the language used to help encourage people to do things differently. T Whiteside highlighted a potential risk that this work could make more of a demand to an already stressed service. In relation to inequalities, oral health was a much broader issue including affordability of toothpaste, good quality food and nutrition and consideration should be made to balance messages to members of the public. It was noted that local authorities do toothbrush and toothpaste schemes for children and consideration would be made to the suggestion of the distribution of toothpaste to families due to affordability. T Whiteside continued that school nursing would be working with the population health messages, therefore connecting a variety of workers which would prove important. An example was provided of where a friend had struggled to get access to an emergency dentist for her son – A Bate would contact Tricia outside of this meeting to investigate this in order to strengthen communications. There was good provision for emergency care across Lancashire and South Cumbria, providing 5000 appointments monthly, usually accessed via 111 and within 24 hours and a pathway had been commissioned for follow up care following emergency treatment. 40% of the ICB population did not have access to NHS dentistry, and it was highlighted that this included those who had decided not to take up NHS services and those who would rather contact a dentist as and when required rather than on a regular basis. D Brewin reported that consideration should be made to communications ensuring clarity and honesty as the public were suspicious and confused when their NHS dentist ceases their NHS contract and the patient is presented with a suite of payment options for what they perceive to be the same dentist, dental practice and treatment. This was recently discussed at a local dental committee meeting. A Bate raised that there was risk around an increasing demand to services when an awareness was raised; the plan was iterative	**AB/TW**

	due to the difficulty to anticipate what those issues may be and A Bate would work with D Brewin as things emerged in terms of complaints. ***Andrew Bennett joined the meeting.*** The Chair confirmed that this was a national problem and the committee had received assurance that a plan was in place, connected to population health, place and other parts of the system. Members recognised that resource would be challenging and that there may be a need to reframe this when timings were looked at in terms of capacity. It had been demonstrated that patient feedback had been listened to and groups and place based partnerships were connected. It was noted that Healthwatch would be a useful signpost. **RESOLVED: That the Committee note the contents of the communications and engagement plan to support dental access and oral hygiene.**	
9.	**Priority Wards** A Bennett introduced the item to advise the Committee on the approaches to engagement being utilised as part of a developmental piece of work in each of the 4 Places relating to priority wards. The team had drawn on data produced nationally around disadvantaged wards that create significant demand for services, some wards with very high rates and a small number below average. The approach had been to work with community partners and residents, to identify the main factors impacting on the health of communities. Members acknowledged that the work was resource intensive but would reveal significant issues which the ICB would need to consider in its approach to improving health, tackling inequality, improving service performance and implementing changes to health and care systems. Initial findings from member of the community feedback included barriers to accessing primary care and awareness of availability of supporting services. Previous work had been built on, with a triangle of civic, community and service-based interventions. Connecting this work to ICB strategies was being looked at. Members discussion included that this piece of work aligned with the insight report to this meeting around outreach and speaking to people. It was felt this was an important methodological and phenomenological approach, with a strong ethical framework to stay alongside communities. Members asked if any feedback would be given to members of the communities as to the outcomes of the work. K Eagan expressed that as part of VCFSE work, there was lived experience and examples of stories of people that had changed their lives because of things working, highlighting that the VCFSE sector may have specialist experience aligned to these areas. Following recent work undertaken in Fleetwood around deprivation, reductions in A&E attendances had been seen. T Whiteside felt that focus should be on what the barriers were stopping people living a thriving. Conversations need to be centrally led to see a shift in self-care and self-reliance. A Bennett commented that the work in Fleetwood showed the community having balanced control in health, supported by leaders in organisations. The challenge was to bring capabilities into other areas. The Chair expressed that this work should be looked at when framing other work.	

	RESOLVED: The Committee noted the slides presented and issues raised in the context of ICBs approaches to working with communities.	
10.	**Citizen's Health Reference Group** N Greaves updated members on the development of the Citizen's Health Reference Group, with 15 residents submitting an expression of interest form. The first meeting had taken place as an introductory session and an iterative programme had been planned for January to March 2024. The intention was to bring a public perspective via this group, which was expected to evolve and develop. **RESOLVED: That the Public Involvement and Engagement Advisory Committee:-** - **Note the content of the report.** - **Recognise and endorse the approach to develop the Citizens Health Reference Group.** - **Agree that in principle, individuals from this group will be identified as participants to provide public perspective to future PIEAC meetings.**	
11.	**Committee Escalation and Assurance Report to the Board** To be agreed outside of the meeting.	
12.	**Items Referred to Other Committees** No items were referred to other committees.	
13.	**Any Other Business** There was no other business.	
14.	**Items for the Risk Register** There were no items.	
15.	**Reflections from the meeting** T Whiteside expressed that the committee had come on an amazing journey and conversations were starting to drive communications and engagement. Concern was raised due to the absence of ICB Executives at today's meeting due to the change of meeting date, and it was noted that D Brewin was S O'Brien's deputy at this meeting. The Chair thanked everyone for their committee participation, support and input.	
16.	**Date, Time and Venue of Next Meeting** Wednesday 28 February 2023 (10 am – 12.30 pm, Meeting Room 1, ICB offices, County Hall, Preston, PR1 8XJ)	