NHS South East London Integrated Care Board

Engagement Assurance Committee

Minutes of meeting held on Wednesday 8 July 2026

Via MS Teams

Members Present		
Anu Singh (Chair)	Non-Executive director, SEL ICB	**AS**
Orla Penruddocke	Bromley borough member	**OP**
Marc Goblot	Greenwich borough member	**MG**
Stephanie Correia	Lambeth borough member	**SC**
Kolawole Abiola	Southwark borough member	**KA**
Geraldine Richards	South East London member	**GR**
Muriel Simmons	Bexley borough member	**MS**
Shalini Jagdeo	Bromley borough member	**SJ**
Folake Segun	Chief Executive, Healthwatch Lambeth representing south east London Healthwatch organisations	**FS**
Tal Rosenzweig	Director of VCSE Collaboration and Partnerships	**TR**
In Attendance		
Rosemary Watts	Assistant Director of Engagement, SEL ICB	**RW**
Ian Sutton	Project Lead, LDA Partnership Programme, SEL ICB	**IS**
Simon Beard	Associate Director, Corporate Operations, SEL ICB	**SB**
Apologies		
Toby Garrood	Medical Director, SEL ICB	**TG**
Tosca Fairchild	Chief of Staff, SEL ICB	**TF**
Neville Fernandes	Lewisham borough member	**NF**

		Actioned by
1.	**Introduction and welcome**	
1.1	AS welcomed all to the meeting and thanked them for their time.	
1.2	Declarations of Interest Declarations were shared in the papers and no additional conflicts or declarations were raised in the meeting.	
2.	**Minutes of last meeting**	
2.1	Members agreed the minutes as a correct record of the previous meeting.	
2.2	Actions RW noted the draft charter for hospitals and doctors working better together was discussed last time. The wording had been changed but these changes were limited due to the level of engagement already undertaken. The document would be published shortly once all hospitals had signed up.	

3.	**Engagement in the development of the community autism service**	
3.1	Ian Sutton (IS) attended to present. After setting the context for the creation of the project team, he described the focus of direction for the Learning Disabilities and Autism (LDA) programme on admission avoidance and appropriate support for those remaining at home. A key aspect of this project was to understand the experience of those with autism, with a focus on adults as there was little to no infrastructure in place to provide support compared to children with access to school teams etc.	
3.2	The engagement programme involved an online survey, focus groups, and the recruitment of two people with lived experience (from eight expressions of interest) to inform planning for future service provision.	
3.3	IS presented key findings: From the online survey: • 89% of those who took part in the online survey had accessed support services • Services that supported mental health needs was the biggest gap • Poor transition from child to adult services, availability of information on the services available, and support for carers of autistic people were also identified gaps. In particular there was a dramatic change noted in how people with autism were treated when they became 18. From the focus groups: • There was a need for improved training and awareness for frontline health professionals • Autistic people needed to be better involved in improving services as the felt misunderstood and unappreciated as the fixed way systems recorded information prevented the richness of their stories from being captured • There was a need for improved communication and information sharing • Services needed better integration at a local level Other areas of improvement identified included: • Long waiting times • More accessible, tailored services • Gaps in service provision across physical health, mental health, communication support and social/ recreational activities.	
3.4	Recommendations and actions from the engagement were: • Investment in autism-specific training • Expansion in the availability of specialised services for autistic adults • Development of broader community projects to provide a wider network of support, with an aim to improve public awareness and availability of community-based projects. • £480k of funding (£80k per borough) was being provided to support development of local strategies on a borough basis. The bulk of the investment would be in community autism services for adults who cannot get help through existing services.	

- A new community autism service was co-designed with members of the community with lived experience to develop specifications and fundamentals of the service. There was a particular requirement to ensure support was available to autistic adults from marginalised, seldom heard and under-represented communities including those known to be experiencing health inequalities.
- There was a recognised need for a focus on mental health – particularly to address concerns around burnout or overwhelm. It was felt current services were not sufficiently neuro aware.

3.5 Delivery of the community autism service would be provided by Oxleas NHS Foundation Trust for Bexley, Bromley and Greenwich, and South London and Maudsley NHS Foundation Trust (SLaM) for Lewisham, Southwark and Lambeth. A 12-month pilot would operate to test proof of concept. Design had started in October last year but there had been a challenge to find the right qualified people to fill the team. Most posts were out for advert at the moment. The intention for Oxleas and SLaM was a soft launch in September. This was intentional to avoid inundating the service immediately. It was expected the first referrals would be through GPs and other mental health services.

3.6 Questions were invited from members.

3.7 SC asked how the pilots would be evaluated. IS responded that because established NHS providers had been contracted to provide the service it would be expected that they would have systems in place to do this. IS provided assurance it was incumbent on those writing the specification to ensure the engagement with the autistic community continued to ensure the project team hears from those who have accessed the service. This part had not yet been designed.

3.8 MG shared his personal experiences of trying to access services and stated the main problems were around obtaining information and lack of integration between services. It was good to have a central resource which has case management abilities. A complex needs hub was being developed in Greenwich which was good as it avoided people having to travel out of borough. In terms of older adults, studies suggested 90-95% of autistic people who were undiagnosed were over 50 years of age so emphasis on adults was encouraging. MG pointed out that housing was a difficult area but this was not covered by the project. MG offered his own input to the project. IS noted the change in diagnostic parameters has identified additional adults who hadn't been identified as autistic before – so this had created a capacity challenge. A lot of support was available outside of health – so collaboration was key. MG highlighted a lack of intersectional data which needed looking into.
ACTION: IS to make contact with MG separately for his project input.

3.9 KO noted the reference to autistic adults living with parents and observed how parents struggle to know how to deal with those scenarios. KO asked who was involved in the engagement, and if key parts of the community be identified for a focus. IS confirmed the online survey had covered autistic people and their carers, noting the carers group was generally parents with

	autistic teenagers. There was a need for some education with partners to tell them to look out for the people who could be diagnosed as autistic.	
3.10	OP recognised this was an ambitious programme and asked what age range was covered, how many people formed the focus groups, and if the project team was working with local organisations as well? How would GPs know to refer to the new system – was there a communications plan for the programme? IS stated the age profile of respondents was highest for the 35-50 year-old age bracket at 44%, with 20% aged 51-64, and 34% aged 25-34. The age of carers aged 35-50 was the biggest group, with 38% aged 51-64. On local organisation engagement – SLaM and Oxleas were using community learning disability teams to use existing links into GPs to drive internal communications for awareness, with a focus on people with complex and enduring issues which are about to tip into crisis. The service being launched was for those aged 18+.	
3.11	KO reiterated the need to understand people's journeys and history which underlined how there should not be a boundary to step over when people transition from Children and Young People (CYP) services to adults. People needed passports etc to ensure information is shared across health providers.	
3.12	**The members thanked IS for his presentation.**	
4.	**Healthwatch**	
4.1	FS delivered a summary of insights from the south east London Healthwatch (HW) organisations for the period January to March 2026.	
4.2	HW organisations had heard from a wide range of people. Positive comments cited the high quality and compassionate nature of staff even under pressure, the excellent staff at Evelina and Chartwell Unit at Princess Royal University Hospital (PRUH), how people liked informal engagement with an opportunity to discuss their health needs with NHS professionals in non-clinical environments (for example, in post-natal support clinics in non-clinical settings). Challenges included access to services, GP appointments, inequality in using digital access for GP appointments across boroughs, a feeling of people being overwhelmed by multiple apps, and hospital access challenges based on parking, travel, and waiting times. Wider determinants were also discussed - housing, financial pressures, daily stress impacting how people received care.	
4.3	On the work done around the NHS App – 1 in 5 people felt they didn't know how to use the app to contact their GP. This was a particular issue for older residents, who were less confident with technology. It was felt the digital first approach needed more steps and clearer guidance.	
4.4	The value of person-centred care came through the feedback, recognising how people value being listened to. There remained a challenge around trust, cultural understanding, and the need to address stigma. Accessible information was an issue with the requirements of the Accessible Information Standard not trickling down as it should.	

4.5	Communications still felt fragmented between services, with unclear ownership of care particularly around referrals, which meant some people were co-ordinating care themselves. Alongside this, it was reported that updates to appointments and results were not coming in on time. Professionals reported challenges around information sharing between services.	
4.6	Challenges were also reported around accessible support for deaf residents and practical barriers around mobility.	
4.7	In summary the key takeaways were; staff are valued, access was still a challenge, digital systems created opportunities but still some barriers, and good care relied on better communication and trust.	
4.8	FS also provided a brief general update on the status of Healthwatch – the Health Reform Bill which was proposing the abolition of HW was in Parliament at Committee stage, meaning MPs were looking at proposals in more detail and receiving evidence. This would then move to report stage in the next few weeks and be considered by the House of Lords in September.	
4.9	**Members noted the update with thanks.**	
5.	**VCSE**	
5.1	TR provided two brief updates: • VCSE strategic leads were now fully embedded in NHS trusts locally. As a result there was already a determinable shift in how trusts view the voluntary sector and how they can partner together better. This meant more opportunity for the voluntary sector to shape and influence developments. • Work at a London level was being undertaken to bring together health data and voluntary sector health data and insight under the OneLondon platform. The project was looking to bring in diverse views of voluntary sector organisations across London to understand how best to use data - what is most accessible in a proportionate way.	
6.	**Strategic commissioning**	
6.1	RW delivered a precis of the policy changes currently taking place in the health system, particularly in respect of the ICB, leading to a shift to the ICB being a “strategic commissioner” and how the policy announcements had underlined the need for engagement to be a core element of future work.	
6.2	RW reminded members of the timeline for policy announcements, starting with the announcement in March 2025 that ICBs would be required to reduce their running costs by 50% through the publication of the Model ICB Blueprint, 10 Year Health Plan, the Dash review and the Strategic Commissioning Framework. The three strategic shifts were centred on hospital to community, analogue to digital, and treatment to prevention.	

6.3	The ICB Model Blueprint highlighted the need for user involvement and co-design to be essential in any future strategic commissioning models. This supported: • Gathering data and intelligence to understand the local context, and convening local communities to challenge and critique • Using user input to identify priorities, develop pathways and co-produce strategies to inform the development of a long-term population health strategy • Defining outcomes and prioritising interventions to address health inequalities through effective delivery of services and resource allocation • Embedding feedback from people and communities, staff and partners to evaluate impact.	
6.4	RW highlighted the conclusion in the Dash review that there is a need to streamline and consolidate how user voices are heard and acted upon. A proposal in the report was for Healthwatch functions to be split across a new directorate of patient experience in the Department of Health and Social Care, for adult social care to go to local authorities and health to ICBs.	
6.5	The Strategic Commissioning Framework identified three key requirements of ICB success in relation to engagement: • "Capability in…working with… service users to co-design services" • "Sustained and meaningful engagement with people" • "An ability to involve people and diverse communities and understand their experiences through asset-based approaches that facilitate co-production and empower community driven solutions"	
6.6	SC – asked what was the end date for the workforce changes. RW anticipated people would be confirmed in new roles for 1 October, but notice would be worked through the autumn period.	
6.7	The members thanked RW for the informative presentation.	
7.	**Any other business (AOB)**	
7.1	No AOB was raised.	
8.	**Meeting closure**	
8.1	The Chair thanked those who attended and closed the meeting at 19.15.	
8.2	The next meeting is scheduled for 30 September 2026, at 18.00 via Teams.	