NHS South East London Integrated Care Board

Engagement Assurance Committee

Minutes of meeting held on Wednesday 24 September 2025
Via MS Teams

Members Present		
Anu Singh (Chair)	Non-Executive director, SEL ICB	**AS**
Toby Garrood	Medical Director, SEL ICB	**TG**
Tosca Fairchild	Chief of Staff, SEL ICB	**TF**
Orla Penruddocke	Bromley borough member	**OP**
Neville Fernandes	Lewisham borough member	**NF**
Chris Boccovi	South East London member	**CB**
Stephanie Correia	Lambeth borough member	**SC**
Kolawole Abiola	Southwark borough member	**KA**
Tal Rosenzweig	Director of VCSE Collaboration and Partnerships	**TR**
Folake Segun	Chief Executive, Healthwatch Lambeth (representing SEL Healthwatch)	**FS**
In Attendance		
Rosemary Watts	Associate Director of Engagement, SEL ICB	**RW**
Iuliana Dinu	Head of Engagement, SEL ICB	**ID**
Simon Beard	Associate Director, Corporate Operations, SEL ICB	**SB**
Apologies		
Shalini Jagdeo	Bromley borough member	
Geraldine Richards	South East London member	
Marc Goblot	Greenwich borough member	

		Actioned by
1.	**Introduction and welcome**	
1.1	The Chair welcomed all to the meeting. Due to the number of apologies, the Chair noted the meeting was not quorate, however, no decisions were required and RW would share any items after the meeting if needed.	
1.2	Declarations of Interest Declarations were shared in 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 for last meeting • RW confirmed the slides from the May meeting on Sickle Cell had been shared with Geraldine Richards after the July meeting. • The Guide to Healthcare presented in the July meeting had been nominated for a Health Services Journal (HSJ) award and was currently being updated.	
2.3	Matters arising None were raised.	

3.	**Developing engagement**	
3.1	RW presented this item, reminding the meeting that this work was being conducted with reference to the three shifts in the 10-year plan and the changing role of ICBs to focus on strategic commissioning. The purpose of this piece of work was to think about engagement and what strategic commissioning and neighbourhood development might need.	
3.2	On strategic commissioning, RW discussed the use of data and insight from engagement activity to identify priorities, as well as inform strategy development and co-designing and co-producing pathways with people, as set out in the ICB Blueprint produced by NHS England She noted that the Strategic Commissioning Framework is due to be published in October which should provide further detail.	
3.3	The engagement team had been thinking about how to pull together the 10-year plan requirements in the context of engagement work already being done, and longer-term community co-production and organising activity, such as South London Listens, the partnership with Impact on Urban Health and the VCSE Alliance Trust and Health Creation Partnership.	
3.4	RW discussed the concept of "community organising" – listening, understanding what people think the long-term solutions are to issues, and over time understanding the deep-rooted concerns that were important to people in their lives. The role of the ICB was to consider how to build on hyper-local community organising and use the insight gained from it to inform strategic commissioning.	
3.5	To support community organising, a guide had been produced which would be published as part of the engagement toolkit, covering key considerations such as how to build trust, how to address power dynamics and consider trauma informed approaches, how to support communities, and providing some live examples from south east London. RW emphasised the long-term nature of using community organising approaches, which the five-year commissioning strategy lent itself to. It was hoped to publish the documents in late September/ early October.	
3.6	AS recognised this was a key time to build in how we shape the ICB going forward. There was a need to be clear on the constraints the ICB changes may bring and understand what is in our gift, noting it is having a significant impact on people.	
3.7	SC applauded the thinking that had gone into this, recognising that some of the thinking could be implemented now by people changing their approach.	
	KA highlighted the power dynamics aspect of engagement, asking how much tertiary sector engagement was taking place. This was in the context of tackling anti-social behaviour and understanding the issues in order to help address areas of specific work for agencies. RW acknowledged this was challenging, noting the community organising approach solution already existed within many communities we are working with. The challenge was that the neighbourhood work was health and care focussed (looking at	

3.8	children and young people, frailty and people with multiple long-term conditions) but community organising was aimed at considering issues much wider than health and social care. It would take time to look at how to develop into this – for example use of green spaces. KA suggested an area of focus should be impact on mental health planning and delivery, particularly for children and young people. ID reminded the group that Be Well champions were already in place and some of the school-based work with children and young people was focussing on mental health.	
3.9	OP asked if a member of the public know necessarily know if the service they are using was part of this process? RW noted "community organising" is not a widely recognised term and would not be an approach to use for all engagement, more so for longer term projects. Key movers in the community would understand they are part of doing something differently but may not term it community organising.	
3.10	CB asked how the co-production work would play out in practice and become embedded, warning that consultation can be biased if you are not careful, dependent on the people who respond. What next steps were planned to support the application of the principles and what should this look like? RW confirmed conversations were ongoing internally, recognising the ICB was in a state of flux awaiting guidance on neighbourhood working, guidance on the framework for strategic commissioning, and understanding how the ICB cost savings may impact resourcing. As a result, the current focus was on updating the engagement toolkit pending further guidance and frameworks. RW recognised there are some deep-rooted health inequalities and issues that are much wider than health and there was a need to do something different to address and internal work and discussions are taking place to bring this together.	
3.11	NF commented on the need to recognise links between symptoms and causes – for example, issues around school exclusions could create anti-social behaviour. For community organising, NF recommending using AI to identify if SEL had missed something that other ICBs are doing. **The members thanked RW for the comprehensive update and insight.**	
4.	**EAC effectiveness review**	
4.1	SB presented the outcomes of the committee effectiveness review, reminding the members they had received the invitation to submit their thoughts in May and noting that the assessment was based on six responses received. The review process was good governance practice, and had covered all of the ICB Board committees, EAC and the equalities sub-committee.	
4.2	SB advised that no serious areas of concern had been raised by committee members, but three key areas of consideration were highlighted, based on the lowest scores received: • What measures can members use to be more confident that effective engagement has taken place for a project or scheme?	

	• Is more time needed in the agenda for discussion and questions following presentations? • Could there be more discussion on patient experience of care in presentations?	
4.3	The members were invited to consider these questions in order to inform how the Engagement Assurance Committee agendas and meetings could be formulated and run in future.	
4.4	SC asked if this was the first time the process had taken place. SB advised this was being done now as it was a year since the last governance restructure for the ICB and there had been sufficient time for new committees to be established and processes embedded.	
4.5	FS felt the question on measures of assurance was key, suggesting an aide memoire or toolkit could help people understand how they are gaining assurance and to be sure they have asked the right questions. OP agreed that there did not feel like there was enough time for an interesting conversation to be carried out to its conclusion at meetings. There was an assumption people had read the papers – a summary should be provided.	
4.6	CB felt the first two bullet point questions worked hand in hand, suggesting a need to be more precise in what we mean with assurance. More time for presentations would be useful and it was good to hear specifics from people who are presenting as this gives context – but a summary would reduce presentation time and give more time for the committee to focus in on specific areas for scrutiny.	
4.7	RW highlighted that section 4.2 of the terms of reference provided details of the engagement aspects to consider and suggested a bespoke front sheet be developed for the committee to include those questions to be specifically answered. On the patient experience of care question, an annual report to the committee by the Head of Patient Experience was planned. **ACTION: RW/SB to discuss development of a bespoke front sheet and revisit how the agenda could be built.**	
5.	**Six month review of engagement workplan**	
5.1	RW provided an update on progress made against the workplan discussed with the committee earlier in the year. Key points to highlight were: • The Clinical and Care Professionals Committee had reviewed their terms of working and how to support the work of EAC. • There was strong governance in place around engagement, with three Board members on this committee, plus the Director of Comms and Engagement. • The working with people and communities strategic framework still needed to be refreshed, partly as further guidance was awaited on the toolkit addendum. • A monthly “get involved” newsletter is published and available on the ICB website.	

	• Insight on projects had been shared and was as part of the planning round had been summarised. • The ICB continued to facilitate and organise the SEL engagement practitioners' network and community champions co-ordinators.	
5.2	RW noted that fewer engagement projects had commenced this year compared to previous years but this was due to the current context; however, six new south east London projects had been published on let's talk since April and a number of outreach events had taken place over the summer to promote them. .	
6.	**Update from VCSE Alliance**	
6.1	TR provided an update on the work of the partnership between the ICB, King's Health Partners, South London VCSE Strategic Alliance and VCSE strategic leaders across the Vital 5 – the key health issues causing unwanted deaths across communities. Working together as an equitable partnership, the group was developing processes around how healthcare system delivers prevention, with the work led by community members. Two face-to-face days had taken place to start working towards a shared vision, together with an online meeting to start to form community led ideas to health creation. This work would inform neighbourhood health working. Building of trust between partnership members would help inform how to build trust in the wider communities.	
6.2	TR was pleased to also report good progress in an initiative to embed VCSE leadership in key places in NHS trusts across SEL. The first successful scheme was at King's College Hospital where a VCSE representative was in a post within the King's strategy team to develop a new strategy in partnership with local VCSE organisations. Recruiting for two similar roles was underway at South London and Maudsley Foundation Trust (SLaM) which would support the trust to look at how it is partnering with local grass roots organisations. Discussions were also underway with Guy's and St Thomas' NHS Foundation Trust (GSTT) to look at a role to support development of the neighbourhood health integrator function for Lambeth and Southwark and how VCSE leadership can be embedded within this.	
6.3	**The committee thanked TR for the positive update.** AS highlighted the progress SEL had made in this area compared to peer organisations.	
7.	**Update from South East London Healthwatch**	
7.1	FS updated the members on likely changes with Healthwatch. Disestablishment of Healthwatch had been announced in June/ July as part of the NHS 10-year plan and following the Dash review into patient safety, which proposed the functions of Healthwatch England should transfer to a new directorate of patient experience being set up between NHS England and the Department of Health and Social Care (DHSC). It was anticipated this would be up and running by April next year. What happened to local Healthwatch functions was less clear, with the 10-year plan suggesting transfer to ICBs and local authorities, but no timeline was provided. FS	

7.2 7.3 7.4 7.5	noted that Healthwatch is set up in statute, so primary legislation would be required for its disestablishment. Since June/ July a national petition had been set up and an open letter sent to the Secretary of State asking for clarification around how potential conflicts of interest and the impact on patient trust would be managed when commissioners and service providers were “marking their own homework”. Parliament had seen a couple of motions asking about change and equality impact of change. In preparation, Healthwatch Chief Officers were looking at what was successful and what was not, to identify what would help those taking on the Healthwatch functions to do this well. KA raised a concern about lack of proper scrutiny of services once Healthwatch was no longer in place. Guidance was still awaited around proposed safeguards to ensure scrutiny remains. The Directorate of Patient Experience was expected to have a strong say in how scrutiny works. FS noted that the National Quality Board was also being reviewed but highlighted the opportunity available to consider how we scrutinise and challenge. AS formally recorded empathy and sympathy to staff affected by the changes. **The committee members thanked FS for her update.**	
8. 8.1	**Equalities sub-committee** RW reminded the group the papers from the last committee had been shared, and any questions should be sent to RW who would co-ordinate responses.	
9. 9.1	**Any other business** KA referred back to the community organising approach and the reference to power dynamics and trauma informed approaches and asked why this was a basis for community organising. RW advised that it underpins the ability to build up trust and identifies the baseline communities that may require more trust to be developed due to poor experience. There was a need to acknowledge and proactively create safe spaces for those people to tell stories to enable us to do things differently. CB advised that any meaningful work would be relational; trauma informed care is not done that well so the focus needed to be on managing out underlying issues – e.g. power dynamics fears which may stop people from engaging with statutory services.	
10. 10.1 10.2	**Meeting closed** The Chair shared thanks to all that attended and for their contributions and closed the meeting at 19.29. **The next meeting is scheduled for 26 November 2025**	