NHS South West London
Integrated Care Board

SWL Integrated Care Board Meeting in public

15 July 2026 - Agenda

Time: 10.30 – 13.00

Venue: Trafalgar Suite, Hotel Antoinette, Wimbledon, SW19 1SD

Date of next meeting: Wednesday 21 October 2026

Introduction

10.30: Item 1: Welcome - verbal update

Chair

1.1 Apologies for absence
1.2 Declarations of Interest
1.3 To approve minutes of the Board Meeting held on 29 April 2026
1.4 Action Log

Standing Items

10.35: Item 2: Decisions Made in Other Meetings

Ben Luscombe

In Focus

10.40: Item 3: Merton Place

Mark Creelman

Decision

11.10: Item 4: Approval of the revised SWL ICB Governance Framework

Ben Luscombe

NHS South West London
Integrated Care Board

Information

11.30: Item 5: Annual Report and Accounts 2025/26

Dinah McLannahan/Ben Luscombe

11.50: Item 6: Board Committee Updates and Reports

Item 6.1: Finance and Planning Committee Update – Dinah McLannahan
Item 6.2: Month 2 Finance Report – Dinah McLannahan
Item 6.3: Quality & Performance Oversight Committee Update – Masood Ahmed
Item 6.4: Quality Report – Elaine Clancy
Item 6.5: Performance Report – Jonathan Bates
Item 6.6: Audit & Risk Committee Update – Dinah McLannahan
Item 6.7: Remuneration Committee Update – Masood Ahmed

12.15: Item 7: Organisation Report

Andrew Bland

12.20: Item 8: Any Other Business/Meeting Close

12.25: Item 9: Public Questions

Chair

Members of the public are invited to ask questions. Priority will be given to those questions received in writing in advance of the meeting.

SWL ICB Board Declarations of Interest as at 8 July 2026

Employee	Role	Interest Type	Interest Category	Interest Description (Abbreviated)	Provider	Date Arose	Date Ended	Date Updated
Andreas Kirsch	Partner Member - Local Authorises	To follow						
Andrew Bland	SWL ICB Chief Executive Officer	Declaration of Interest - Other	Indirect	Partner is a Programme Director at an NHS Provider Trust	Guy's & St Thomas' NHS FT	16/01/2026		28/04/2026
Andrew Bland	SWL ICB Chief Executive Officer	Declaration of Interest - Other	Financial	Chief Executive of another ICB (within a Cluster arrangement)	NHS South East London ICB	09/02/2026		28/04/2026
Anne Rainsberry	SWLNEN01 Independent Non Executive Chair	Declarations of Interest – Other	Non-Financial Professional	I am an Non-Executive Director of the LAS	London Ambulance Service	01/01/2025		26/05/2025
Ben Luscombe	SWLCA01 Director of Corporate Affairs	Nil Declaration				21/05/2025		
Dinah McLannahan	Chief Finance Officer	Declarations of Interest – Other	Financial	Treasurer - Minis and Juniors section	Old Halesonians Rugby Football Club	01/04/2025		
Dinah McLannahan	Chief Finance Officer	Declarations of Interest – Other	Non-Financial Professional	Independent Trustee	Your Trust Charity, West Midlands	01/04/2025		
Dinah McLannahan	Chief Finance Officer	Declarations of Interest – Other	Financial	Joint Chief Finance and Compliance Officer, South East London ICB	NHS South East London ICB	26/06/2026		
Elaine Clancy	SWLEMT05 Chief Nursing Officer	Declarations of Interest – Other	Non-Financial Personal	School Governor- Langley Park School for Girls	Langley Park School for Girls	01/04/2023		02/04/2025
Elaine Clancy	SWLEMT05 Chief Nursing Officer	Declarations of Interest – Other	Non-Financial Personal	Trustee for the 1930 Fund for District Nurses	1930 Fund for District Nurses	01/04/2023		02/04/2025
Elaine Clancy	SWLEMT05 Chief Nursing Officer	Declarations of Interest – Other	Non-Financial Professional	on secondment to GESH NHS Heathcare Trust	GESH NHS Trust	15/09/2025		
Jamal Butt	SWLNEN04 Non- Executive Member	Outside Employment		Cambridge University - Entrepreneur In Residence Life sciences.	Cambridge University	01/11/2024		07/04/2025
Jamal Butt	SWLNEN04 Non- Executive Member	Outside Employment		Venture Partner	Plutus Investment Group	01/11/2024		07/04/2025
Jamal Butt	SWLNEN04 Non- Executive Member	Outside Employment		Non Executive Director -Out Patient Dispensary NHS Hospitals Sussex.	Pharm@Sea Ltd	01/11/2024		07/04/2025
Jamal Butt	SWLNEN04 Non- Executive Member	Outside Employment		Non executive Director -Start up Health Tech	William Oak Diagnostics Ltd	01/11/2024		07/04/2025
Jamal Butt	SWLNEN04 Non- Executive Member	Outside Employment		Non Executive Director -Wellness Company	Well02 Ltd	01/11/2024		07/04/2025

Nicola Jones	SWLWSCL01 Clinical Director Primary Care	Declarations of Interest – Other	Financial	Clinical Director Primary Care, SWL ICS	SWL ICS	01/06/2022		25/04/2025
Nicola Jones	SWLWSCL01 Clinical Director Primary Care	Declaration of Interest - Other	Financial	The Partnership is the leaseholder of the new Brocklebank Health Centre and other organisations are sub-tenants on a non-profit basis - currently CLCH, King's Dental Service and Cora Podiatry.	Brocklebank Partners	07/07/2026		
Nicola Jones	SWLWSCL01 Clinical Director Primary Care	Declarations of Interest – Other	Financial	I am a partner in a partnership which holds 3 PMS/GMS contracts (Brocklebank Group Practice, St Paul's Cottage Surgery and The Haider Practice).	Brocklebank Partners	01/04/2026		
Omar Daniel	SWLNEN06 Associate Non-Executive Member	Shareholdings and other ownership interests		24 ordinary	My Personal Therapeutics (Trading as Vivan Therapeutics)	01/04/2024		22/04/2025
Omar Daniel	SWLNEN06 Associate Non-Executive Member	Declarations of Interest – Other	Non-Financial Professional	Advise and mentor Cambridge spin outs	Founders at University of Cambridge	01/04/2024		22/04/2025
Omar Daniel	SWLNEN06 Associate Non-Executive Member	Outside Employment		Early stage startup advisory and investment	Harbr	01/04/2024		22/04/2025
Omar Daniel	SWLNEN06 Associate Non-Executive Member	Shareholdings and other ownership interests		9 preferred	Anathem ltd	01/04/2024		22/04/2025
Omar Daniel	SWLNEN06 Associate Non-Executive Member	Declarations of Interest – Other	Financial	Advisor	Lutra Health	01/04/2024		22/04/2025
Omar Daniel	SWLNEN06 Associate Non-Executive Member	Outside Employment		The medical travel company	TMTC	01/04/2024		22/04/2025
Robert Alexander	SWLNEN05 Non- Executive Member	Outside Employment		Interim Chair NWL Acute Provider Group	North West London Acute Provider Group	01/04/2026		
Robert Alexander	SWLNEN05 Non- Executive Member	Outside Employment		Non Executive Director	London Ambulance Service NHS Trust	01/11/2024		
Robert Alexander	SWLNEN05 Non- Executive Member	Outside Employment		Trust representative Trustee	Imperial Health Chariity	01/11/2024		
Robert Alexander	SWLNEN05 Non- Executive Member	Outside Employment		Trustee	London Ambulance Charity	01/11/2024		
Robert Alexander	SWLNEN05 Non- Executive Member	Outside Employment		Advisory role	CHKS Ltd	01/04/2025		
Robert Alexander	SWLNEN05 Non- Executive Member	Outside Employment		Strategic advice on health sector matters and infrastructure/capital developments particularly	Health Spaces Ltd	01/04/2025		
Sir Richard Douglas CB	SWL ICB Chair	Outside Employment	Financial	Senior Counsel for Evoke Incisive, a healthcare policy and communications consultancy	Evoke Incisive	01/04/2016		10/02/2026

Sir Richard Douglas CB	SWL ICB Chair	Trustee	Non-financial professional interest	Trustee, Place2Be, an organisation providing mental health support in schools	Place2Be	01/07/2022		10/02/2026
Sir Richard Douglas CB	SWL ICB Chair	Declaration of Interest - Other	Non-financial professional interest	Trustee Demelza Hospice Care for Children, non-remunerated	Demelza Hospice	01/09/2022		10/02/2026
Sir Richard Douglas CB	SWL ICB Chair	Outside Employment	Financial	Non-executive member, Department of Health and Social Care Board	Department of Health and Social Care	01/04/2024		10/02/2026
Vanessa Ford	Chief Executive, SWL and St George's Mental Health NHS Trust	Declarations of Interest – Other	Financial	Chief Executive SWL & St Georges Mental Health NHS Trust and a CEO member of the South London Mental Health and Community Partnership (SLP) since August 2019.	SWL & St Georges Mental Health NHS Trust	03/04/2023		29/09/2025
Vanessa Ford	Chief Executive, SWL and St George's Mental Health NHS Trust	Declarations of Interest – Other	Non-Financial Professional	Chief place officer -Merton Lead CEO for MH strategy London region	Merton Place	03/04/2023		29/09/2025
Vanessa Ford	Chief Executive, SWL and St George's Mental Health NHS Trust	Declarations of Interest – Other	Non-Financial Professional	Mental Health Representative on the ICB	SWL ICB	03/04/2023		29/09/2025

NHS South West London
Integrated Care Board

Minutes – NHS SWL Integrated Care Board

Minutes of a meeting of the NHS SWL Integrated Care Board held in public on Wednesday 29 April 2026 at 11.30 in 120 The Broadway, Wimbledon, SW19 1RH

Members

Chair
Richard Douglas

Non-Executive Members
Dr Masood Ahmed, Non Executive Member, SWL ICB
Bob Alexander, Non Executive Member, SWL ICB
Anne Rainsberry, Non Executive Member, SWL ICB
Jamal Butt, Non Executive Member, SWL ICB

Executive Members
Andrew Bland, Chief Executive Officer, SWL ICB
Dinah McLannahan, Chief Finance Officer, SWL ICB
Elaine Clancy, Chief Nursing Officer
Jonathan Bates, Chief Operating Officer, SWL ICB

Partner Members
Dr Nicola Jones, Partner Member, Primary Medical Services
Jo Farrar, Partner Member, Community Services
Vanessa Ford, Partner Member, Mental Health Services

Non Voting Attendees
Omar Daniel, Associate Non Executive Member

In attendance

Ben Luscombe, Director of Corporate Affairs
Maureen Glover, Corporate Governance Manager

Apologies
Cllr Andreas Kirsch, Partner Member, Local Authorities

1 Welcome and Apologies

1.1 Richard Douglas (RD) welcomed everyone to the meeting. Apologies were noted as above and the meeting was quorate. RD introduced himself as the new Chair of the ICB and Andrew Bland (AB) the new Chief Executive and noted this was their first SWL ICB Board meeting in public. RD said the nature of the meeting moving forward might change to reflect the new role of the ICB.

1.1 Declaration of Interests

1.1.1 A register of declared interests was included in the meeting pack. The following additional declarations were noted:

Andrew Band was also the CEO of South East London (SEL) ICB and his partner is a Programme Director, employed by Guys and St Thomas NHSFT.

Bob Alexander (BA) has been made Interim Chair of the NWL Acute Group and this replaces his Vice Chair role at Imperial College Healthcare.

Masood Ahmed (MA) noted that he had updated the online system.

1.2 **Minutes, Action Log and Matters Arising**

Minutes

1.2.1 The Board **approved** the minutes of the meeting held on 28 January 2026.

1.3 Action Log

1.3.1 The action log was reviewed, and it was noted that all actions were closed.

2 Decisions Made in Other Meetings

2.1 Ben Luscombe (BL) presented the report.

The Board **noted** the decisions made in its SWL ICB Part 2 meetings on 28 January and 18 March 2026

3 Publication of the SWL NHS Capital Resource Use Plans 2026/27

3.1 Dinah McLannahan (DML) presented the report.

3.2 The Board received and discussed the report. Assurance was sought regarding potential revenue implications arising from the capital plan, noting that while prioritisation of capital schemes had been undertaken, detailed business cases and revenue impacts had not yet been fully assessed. It was noted that the current assumption was revenue cost-neutral, subject to affordability and approval of business cases, which would be reflected in submissions to NHS England.

3.3 The Board discussed the emerging approvals process for schemes subject to further approval and noted that the detailed timetable had not yet been confirmed. A reasonable level of confidence had been expressed in the prioritised schemes, which focused on estates safety, emergency care, digital investment and delivery of constitutional standards, while recognising the risk associated with external approval timelines and process capacity.

3.4 The Board highlighted concerns regarding potential delays arising from national decision-making processes and noted this as a key risk. The Board also discussed the extent of system visibility across wider public sector infrastructure plans and acknowledged this as an area for future development.

3.5 It was confirmed that, notwithstanding the absence of formal control totals, the ICB retained a system oversight role in relation to infrastructure and estates to ensure financial sustainability and service effectiveness, consistent with responsibilities set out within the Board Assurance Framework.

The Board considered and **approved** the draft 2026/27 NHS Capital Plan publication.

4 Green Plan

4.1 DML presented the report.

4.2 The Board discussed the Green Plan, noting questions regarding the scale of carbon savings across the system and the relative contribution from individual programmes. It was agreed that further clarification on carbon savings would be provided outside the meeting.

4.3 Members highlighted the need for greater emphasis on quantifying the economic and cash-releasing benefits alongside carbon reduction, noting that the estimated £2.3m cost saving appeared modest and lacked sufficient ambition given the current financial context. It was agreed that future iterations of the Green Plan should place greater focus on measurable financial benefits.

4.4 The Board identified areas for further consideration in setting priorities for the coming year, in particular climate adaptation and travel and transport, recognising their potential alignment with cost savings and wider system benefits.

The Board **noted** the report.

5. Board Assurance Framework

5.1 The Board received the report, which was presented by BL, and noted plans to undertake a deeper dive of transition risks arising from the Change Programme. It was noted that further consideration of these risks was scheduled for the Audit and Risk Committee in July, in the context of delivery of the ICB Blueprint and the 10-Year Plan.

5.2 The Board discussed the scale and pace of organisational change, including clustering and the associated risks around organisational churn, loss of corporate knowledge and financial exposure. It was confirmed that programme-level risks were being reviewed and aligned to the corporate risk register and Board Assurance Framework, with further work to ensure these were appropriately reflected as the ICB's role evolved.

5.3 Members considered the adequacy and maturity of transition risk reporting, noting the relative stability of current scores and the need for clearer visibility of trends over time. The Board discussed the distinction between residual and target risk scores, emphasising the importance of alignment with risk appetite and assurance that actions would demonstrably reduce risk. Further work was agreed to test whether target risk scores were realistic and achievable in the current operating context.

5.4 The Board also discussed the maturity of the risk framework, including use of comparative analysis across providers and systems, and agreed that this remained an area of ongoing development as the ICB transitioned towards a more strategic commissioning focus.

The Board **noted** the contents of the report.

6 Board Committee Updates and Reports

Finance & Planning Committee Update

6.1 Jamal Butt (JBu) presented the Finance & Planning Committee update and gave an overview of the key issues discussed at its meeting on 25 February 2026.

Month 11 Finance Report

6.2 DML presented the M11 Finance Report noting the forecast on plan for the ICB and the system.

Quality & Performance Oversight Committee Update

6.3 Dr Masood Ahmed (MA) presented the report and gave an overview of the key issues discussed at the Quality & Performance Oversight Committee meetings on 11 February and 8 April 2026.

Quality Report

6.4 Elaine Clancy (EC) presented the report, noting continued system pressures, including urgent and emergency care performance, corridor care, workforce challenges, sickness absence and vacancies.

6.5 Members highlighted the need for greater visibility of mental health performance, including long waiting times, quality concerns and recent CQC activity, and requested stronger reflection of these issues in future reports. The Board discussed the impact of revised infection prevention and control thresholds, noting system-wide deterioration against the new standards. Assurance was provided that providers were responding to the revised requirements, and it was agreed that further detail on provider actions would be discussed at the Quality Committee.

6.6 The Board considered the data on Never Events. Emphasis was placed on understanding trends, learning and shared improvement across the system. It was confirmed that learning was disseminated locally and nationally and that no consistent themes had been identified.

6.7 Members welcomed planned further focus on children's waiting times and asked that neurodevelopmental waiting times be considered separately from wider mental health access issues.

Performance Report

6.8 Jonathan Bates (JBa) presented the report.

6.9 The Board noted a significant gap between expected and actual performance in relation to physical health checks for people with serious mental illness. It was noted that while improvement was anticipated, the gap was unlikely to fully close within the year.

6.10 The Board considered data on GP appointments and noted limitations in understanding unmet demand, as current reporting captured booked and planned appointments rather than attempts to access care that did not result in an appointment. It was noted that improvements in data collection, including telephony and online systems, were beginning to provide better visibility of demand, and that South West London continued to perform well nationally in terms of primary care activity.

6.11 Members discussed the balance between face-to-face and virtual consultations and noted that there was no single optimal model, with local population need being a key determinant. Opportunities to further understand patient flow between primary and acute care, including potentially avoidable hospital attendances, were noted as an area for future system learning.

Audit & Risk Committee Update

6.12 Bob Alexander (BA) presented the report and gave an overview of the key issues discussed at the Audit & Risk Committee on 27 January and 24 March 2026.

Remuneration Committee Update

6.13 Jamal Butt (JBu) presented the report which provided an overview of the decisions made by the Committee at its meeting on19 March 2026 and the decisions that were made out of Committee on 10 February and 30 March 2026.

The Board **noted** the report.

7 Organisation Report

7.1 AB presented the report and highlighted key points as: consultation arrangements and the decision to extend by one week in response to staff and union feedback; the scale and nature of staff feedback and commitment to provide a management response by the end of May; staff wellbeing and morale impacts as the change programme progressed and became more individualised; and operational continuity risks during transition, including gaps created by voluntary redundancy before new structures were in place.

7.2 AB also highlighted engagement on a national planning request with limited time for Board engagement prior to submission, and the intention to provide more substantive follow-up beyond the immediate return.

The Board **noted** the report.

8 Any Other Business

8.1 There was no other business and the meeting was closed.

9 Public Questions

9.1 A member of the public raised a concern about demographic trends and future demand pressures. The Chair and members responded by emphasising the strategic commissioner role, population health analysis, prevention focus, and the intention to explore these themes further in future meetings.

Next meeting in public: Wednesday 15 July 2026

ICB Board - Part 1 Action Log - 15 July 2026

NHS South West London
Integrated Care Board

Date of Meeting	Reference	Agenda Item	Action	Responsible Officer	Target Completion Date	Update	Status
ALL ACTIONS ARE CLOSED							

NHS South West London
Integrated Care Board

Decisions made in other meetings

Agenda item: 2

Report by: Ben Luscombe, Director of Corporate Affairs

Paper type: Information

Date of meeting: Wednesday, 15 July 2026

Date published: Wednesday, 8 July 2026

Purpose

To ensure that all Board members are aware of decisions that have been made, by the Board, in other meetings.

Executive summary

Part 2 meetings are used to allow the Board to meet in private to discuss items that may be business or commercially sensitive and matters that are confidential in nature.

The following items were discussed during Part 2 Board meetings on the following dates:

29 April 2026

- How the Board would be appropriately assured and sighted on the Special Educational Needs and Disability (SEND) Reforms, including immediate and short-term actions and the expected progress against the approved reform plans.

20 May 2026

- Approval of the delegation of authority to the Audit and Risk Committee to sign off the Annual Report and Accounts.
- Endorsement of the Representation Panel's recommendation to uphold the original procurement outcome for the provision of an Ophthalmology Service for Community Eyecare Services and to proceed to contract award.
- Approval of new awards and contract modifications for NHS Acute and Mental Health Services under the Provider Selection Regime Direct Award A contracts.

26 May 2026

- Approval of the SWL ICB Management response to consultation and the final organisational structure.
- Determination of a substantial service change relating to the permanent relocation of GSTT specialist children's cardiac, respiratory and critical care (CRIC) inpatient services and agreement that Chair's action be taken to approve the ICB response to NHSE.

17 June 2026

- Approval to proceed with the procurement of the Mental Health Support Team Programme through a 3-year +1+1+1 contract, subject to agreed financial mitigations and the supporting business case.

- Approval of the Community Dental Services procurement via a Provider Selection Regime Direct Award, with the award of 5+5 year Personal Dental Service (PDS) agreement for both contracts.

The Board discussed and **approved** the above items.

Recommendation

The Board is asked to:

- Note the decisions made at the Part 2 meetings of the Board.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
N/A

Corporate objectives
This document will impact on the following Board objectives:

- Overall delivery of the ICB's objectives.

Risks
N/A

Mitigations
N/A

Financial/resource implications
N/A

Green/Sustainability Implications
N/A

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
N/A

Patient and public engagement and communication
N/A

Previous committees/groups
N/A

Committee name	Date	Outcome

Final date for approval
N/A

Supporting documents
N/A

Lead director
Ben Luscombe, Director of Corporate Affairs

Author
Maureen Glover, Corporate Governance Manager

NHS South West London
Integrated Care Board

ICB Governance Framework

Agenda item: 3

Report by: Ben Luscombe, Director of Corporate Affairs

Paper type: Decision

Date of meeting: Wednesday, 15 July 2026

Date published: Wednesday, 8 July 2026

Purpose

To present the proposed South West London (SWL) Integrated Care Board (ICB) Governance Framework and supporting governance documents for approval.

The paper sets out the rationale for the revised governance model, describes the key components of the framework and seeks approval of the governance arrangements required to support the ICB's future operating model and strategic commissioning role.

Executive summary

The proposed Governance Framework provides an integrated set of governance arrangements through which the ICB will exercise its statutory functions, delegate authority, provide assurance and maintain accountability.

Developed alongside South East London ICB, the framework seeks to create a more strategic, streamlined and aligned approach to governance, supporting effective decision-making, clearer accountability, proportionate assurance and stronger delegation.

The framework comprises amendments to the ICB Constitution, a revised Scheme of Reservation and Delegation and Schedule of Matters Delegated, updated Standing Financial Instructions, revised Committee structures and Terms of Reference, and a Board Ways of Working statement.

Subject to Board approval, the framework will be implemented from 1 October 2026, with constitutional amendments progressing through the required NHS England approval process.

Key Issues for the Board to be aware of:

- The framework has been co-designed through Board engagement, joint workshops and governance reviews. It is underpinned by principles to strengthen strategic Board focus, clarify accountability, reduce duplication, empower delegation, and integrate oversight across quality, performance, finance, workforce, transformation and risk.

- During the transition from Clinical Commissioning Groups to Integrated Care Boards (ICBs), a range of statutory functions were formally transferred to ICBs. While the ICB Model Blueprint

sets the strategic direction for ICBs as system leaders and commissioners, these statutory duties remain unchanged and will require legislative reform to be amended.

Recommendation

The Board is asked to:

- Approve the proposed ICB Governance Framework and supporting governance documents.
- Approve the constitutional and governance amendments set out within the accompanying papers.
- Note that the constitutional amendments require subsequent approval by NHS England and agree that the necessary approval process should be initiated following Board approval.
- Agree that the ICB Governance Framework will take effect 1 October 2026 following Board approval and become the governance framework through which the ICB operates, subject to the constitutional approval requirements described above.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
N/A.

Corporate objectives
This document will impact on the following Board objectives:

- Overall delivery of the ICB's objectives.

Risks
N/A.

Mitigations
N/A

Financial/resource implications
None

Green/Sustainability Implications
N/A

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
Not applicable at this stage

Patient and public engagement and communication
N/A

Previous committees/groups
N/A

Committee name	Date	Outcome
ICB Board Seminar	18 February 2026	
ICB Board Seminar	18 March 2026	

Final date for approval
N/A

Supporting documents
ICB Constitution
Scheme of Reservation and Delegation and Schedule of Matters delegated
Updated Standing Financial Instructions
Terms of Reference
Board Ways of Working Statement

NHS South West London
Integrated Care Board

Lead director

Ben Luscombe, Director of Corporate Affairs

Author

Steve Crocker, Deputy Director of Corporate Affairs

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board Governance Framework

ICB Board
15 July 2026

Contents

1. Purpose

1.1. This paper provides an overview of the proposed ICB Governance Framework for South West London Integrated Care Board (ICB) and the suite of governance documents that support its implementation.

1.2. The framework has been developed to support the ICB's continuing evolution as a strategic commissioning organisation, ensuring governance arrangements remain effective, proportionate and aligned to both statutory responsibilities and the organisation's future operating model.

1.3. The framework has been developed in the context of emerging South East London ICB and South West London ICB cluster arrangements, which are now operating in practice through a jointly appointed Chair and executive leadership and increasingly aligned ways of working. It provides the governance arrangements needed to support this operating model whilst maintaining the statutory responsibilities and accountabilities of each individual ICB.

1.4. The paper explains the rationale for the proposed framework, describes its principal components and seeks approval of the supporting governance documents.

2. The Governance Framework

2.1. The ICB Governance Framework provides the arrangements through which the organisation exercises its statutory functions, takes decisions, delegates authority, manages its activities and maintains accountability.

2.2. The framework is built as a hierarchy of interdependent governance documents. At its foundation are the legislative and regulatory requirements that establish the statutory responsibilities, powers and duties of Integrated Care Boards. These requirements are translated into the ICB Constitution, which establishes the formal governance arrangements of the organisation and the authority of the Board.

2.3. Supporting the Constitution are a set of additional documents that define how authority is exercised in practice. These include the Scheme of Reservation and Delegation and the Schedule of Matters Delegated, which sets out those matters reserved to the Board and those delegated to committees, members of the executive and other officers of the ICB. This document defines operational decision-making authority and financial delegations to postholders within the ICB. Related to this, the Standing Financial Instructions establish the organisation's financial control framework.

2.4. The Board's committees operate within this framework through formally approved Terms of Reference, which define their purpose, responsibilities, delegated authority and reporting arrangements.

2.5. The framework is further supported by a Board Ways of Working statement, which articulates the principles, behaviours and expectations that underpin effective

governance and support the practical operation of the formal governance arrangements.

2.6. The purpose of this framework is not simply to define governance arrangements, but to support better decision-making, clearer accountability, effective delegation and stronger assurance across the organisation.

3. Alignment with South East London

3.1. The future governance framework has been developed collaboratively with South East London ICB as part of the wider development of a clustered governance function and aligned arrangements across the two organisations.

3.2. A key design principle has been to achieve alignment between South East London and South West London wherever reasonably practicable, creating a 'mirrored' governance architecture with consistent committee structures and delegation arrangements. This is intended to support the jointly appointed Chair and executive leadership team, reduce unnecessary variation, adopt best practice and to provide a stronger foundation for ongoing collaboration.

3.3. Whilst the intention has been to maximise alignment, limited areas of divergence remain where these are required to reflect local organisational arrangements or specific operational requirements. Any such differences have been introduced only where considered necessary and proportionate.

3.4. Additionally, SWL and SEL ICBs will establish a joint time-limited Transition Committee to provide assurance and oversight of the ICB SEL and SWL ICB organisational change programmes, reporting to SEL and SWL ICB Boards. The Committee's role is to ensure a safe and coherent transition, managing local risks, tracking progress and overseeing the development of organisational design and implementation of the change process, including the transfer of functions to providers over time.

4. Background and design approach

4.1. Over recent months, the ICB Board has considered how governance arrangements should evolve as the ICB increasingly focuses on its role as a strategic commissioning organisation with a remit to improve population health outcomes, reduce inequalities, deliver the strategic shifts towards prevention, community-based care and digital transformation, and exercising its wider system leadership and convening role.

4.2. At the same time, the organisation is operating with significantly reduced management capacity in response to national expectations regarding running costs, and a new leadership model with a jointly appointed Chair, CEO and executive team. This requires governance arrangements that are efficient and capable of supporting effective decision-making in this context, and as new management structures are recruited to and postholders in place between July and December 2026.

4.3. Board discussions identified a number of consistent themes that have shaped the development of this framework. The framework is designed to support the ICB's evolving role as a strategic commissioner by:

- creating greater clarity regarding decision-making and accountability.
- strengthening delegation to committees, the Executive and officers.
- reducing duplication across governance arrangements.
- focusing Board and committee attention on strategic priorities, outcomes, risks and major trade-offs; and establishing committee structures and information flows that better integrate quality, performance, finance, workforce, transformation and risk oversight.

4.4. Together, these changes are intended to enable the Board to focus on strategic leadership and stewardship of the organisation whilst ensuring that appropriate scrutiny, assurance and decision-making arrangements remain in place throughout the ICB.

5. System and partnership governance

5.1. The formal governance arrangements described within this paper represent one component of the wider governance model through which the South West London system will operate.

5.2. The effectiveness of the proposed governance framework is dependent upon the effective functioning of partnership governance arrangements across the broader South East London health and care system. The ICB is only able to deliver on its statutory responsibilities and strategic ambitions through collaboration with NHS providers, local authorities, primary care, the voluntary, community and social enterprise sector and wider partners. As such, effective partnership governance is an essential enabler of the overall ICB governance model rather than a parallel or separate set of arrangements.

5.3. At a South West London level, the governance framework assumes the continued operation of system partnership arrangements that support the development and delivery of shared priorities and provide the collaborative leadership necessary to deliver system objectives. This includes the System Sustainability Group and wider partnership governance arrangements supporting key strategic enablers including workforce, digital and estates. These forums play a critical role in developing shared strategies, coordinating delivery, resolving cross-organisational issues and providing collective leadership across the system.

5.4. The ICB will continue to convene and support these and will be represented across them by the Chief Executive Officer and designated members of the ICB executive team.

5.5. The framework also recognises the critical role of place-based partnership arrangements in improving outcomes for local populations. Whilst place no longer forms part of the formal committee structure of the ICB, it remains a fundamental organising principle for delivery of integrated care, neighbourhood development and joint commissioning.

5.6. The ICB governance model therefore relies upon effective place-based partnership leadership across all six boroughs, bringing together NHS organisations, local authorities, primary care, voluntary sector partners and local communities to shape and deliver local priorities.

5.7. Health and Wellbeing Boards continue to play a particularly important role within this model. As statutory partnerships bringing together local government, the NHS and wider partners, Health and Wellbeing Boards provide an important forum for understanding local population need, shaping strategic priorities at place level, promoting integration and supporting delivery of improved outcomes for local residents. The ICB's governance framework assumes continued alignment between ICB governance arrangements and the strategic leadership exercised through Health and Wellbeing Boards at place level. This will include ICB support at place level for convening H&WBB chairs and Directors of Public Health and the ICB to coordinate the development of neighbourhood health plans.

5.8. Future place-based responsibilities for neighbourhood development and joint commissioning will continue to be exercised through Place Leads and working closely with borough partners and place-based governance arrangements. This approach supports subsidiarity, strengthens local leadership and ensures that decisions are taken as close as possible to the populations and communities they affect whilst maintaining appropriate accountability to the ICB Board.

6. Components of the Governance Framework

Constitutional changes

6.1. The ICB Constitution establishes the formal governance architecture through which the Board discharges its responsibilities, delegates authority and exercises oversight. They provide the foundation upon which all other governance arrangements are based.

6.2. The framework includes a small number of proposed amendments to the Constitution to reflect the revised governance model and committee structure. These are included as appendix 1.

Scheme of Reservation and Delegation (SoRD) and Schedule of Matters Delegated (SoM)

6.3. The revised SoRD and SoM provides clarity regarding those decisions reserved to the Board and those delegated to committees, the Executive and officers of the ICB. It

establishes clear accountability and decision-making routes and authorities, ensuring decisions are taken at the most appropriate level.

6.4. The ICB SoRD and SoM is included as appendix 2.

Standing Financial Instructions (SFIs)

6.5. The SFIs establish the organisation's financial governance framework, setting out financial responsibilities, controls and approval arrangements to ensure the proper stewardship of public resources and compliance with statutory and NHS requirements.

6.6. The SFIs have been reviewed and updated to align with the future governance model and revised committee structure and are included as appendix 3.

Committee Terms of Reference

6.7. The Terms of Reference translate the governance framework into the practical operation of Board committees. Whilst the Constitution establishes the governance architecture, the SoRD and SoM define decision-making authority and the SFIs establish financial controls, the Terms of Reference define the specific purpose, responsibilities, membership, delegated authority and reporting arrangements for each committee. They provide clarity regarding the role each committee plays within the wider governance framework and how committees support the Board.

6.8. The proposed Committee structure comprises:

- Strategic Commissioning Committee
- Neighbourhood Strategic Delivery Committee
- Patient Safety Committee
- Audit, Risk and Assurance Committee
- Remuneration Committee
- ICB Transition Committee

6.9. Collectively, the committee structure is intended to provide a clear route through which strategy is translated into delivery, assurance is provided to the Board and delegated decision-making can be exercised at the appropriate level.

6.10. Committee terms of reference are included as appendices 4-8.

7. Board ways of working

7.1. The governance framework is underpinned by a Board Ways of Working statement which complements the formal governance documents by setting out the behaviours, expectations and operating principles that will support effective governance in practice.

7.2. Whilst the Constitution, delegations and Committee Terms of Reference establish formal accountabilities and decision-making arrangements, the effectiveness of the governance framework will ultimately depend on how Board members, committee members, Executive leaders and officers work together to discharge their responsibilities.

7.3. The Ways of Working statement therefore reflects a collective commitment by Board members, committee members, Executive leaders and ICB officers to support effective governance.

7.4. In practice, this will be characterised by:

- A stronger focus on population outcomes, strategic priorities, major risks, delivery and significant trade-offs.
- Decisions being taken at the appropriate level, supported by clear accountability and effective delegation.
- Committees focusing on assurance, scrutiny, development of proposals and delegated decision-making, rather than duplicating Board or Executive responsibilities.
- Concise, evidence-based reporting that supports decision-making and assurance, with greater emphasis on insight, risks, opportunities and action.
- Constructive challenge and collective accountability, with Board members, committee members, Executive leaders and officers contributing actively to effective decision-making.
- Effective partnership working across South West London, recognising that delivery of the ICB's objectives depends upon collaboration with providers, local authorities, Health and Wellbeing Boards, primary care, the voluntary sector and wider partners.
- A culture that is strategic, outcome-focused, accountable and delivery-oriented, whilst maintaining appropriate assurance and oversight.

7.5. Together, these commitments are intended to support a governance culture that enables the organisation to make better decisions, provide stronger assurance and deliver improved outcomes for people in South West London.

7.6. The ICB Board ways of working statement is included as appendix 9.

8. Operationalising the ICB Governance Framework

8.1. Approval of the governance framework represents the beginning rather than the completion of the transition to the new governance model. Realising the intended benefits of the framework will require a coordinated programme of implementation across the ICB.

8.2. Following Board approval, work will be undertaken across the ICB's team to embed the new arrangements and support consistent operation of the framework.

Key implementation priorities will include:

8.3. Supporting Board members, committee members, Executive leaders and officers to understand their roles within the new governance framework and ways of working.

8.4. Establishing annual cycles of business and forward plans for the Board and committees, aligned to statutory requirements, strategic priorities and planning cycles.

8.5. Completing a set of approved guidance and related templates or agreed common formats to support the production of consistent information and reporting to committees and the Boards of both ICBs. This will be designed to align with the principles included in the ways of working document appended to this paper.

8.6. Designing and embedding a refreshed suite of integrated governance information products and assurance reports across both ICBs, reducing duplication and supporting a more strategic view of quality, performance, finance, workforce, transformation, delivery and risk across the organisation.

8.7. Alignment and mirroring of key ICB policies and procedures relating to corporate governance for SEL and SWL ICBs.

8.8. Utilising a part of initial meetings of committees to discuss and propose amendments to ToRs, which may include adjustments to both scope and membership, with proposed amendments being proposed to the ICB Board for review and approval. This will be supplemented by a six-month stocktake report to the Board on the implementation to date of this governance framework, with an opportunity to adjust and improve based on initial learnings.

8.9. Establishing mechanisms to monitor the effectiveness of the framework and identify opportunities for continuous improvement as the arrangements mature. This will be completed as an annual review of the governance framework, over and above the reviews of committee effectiveness.

9. Implementation of the framework

9.1. Subject to Board approval, the ICB Governance Framework and supporting governance documents will come into effect on 1 October 2026 following approval by the Board of both SEL and SWL ICBs. Elements of the implementation programme described in section 8 will continue during the initial period of operation.

9.2. The revised Committee structure, delegations, SFIs, and ways of working will collectively form the live governance framework through which the ICB operates from that point onwards.

9.3. The proposed constitutional amendments are subject to approval by NHS England in accordance with statutory requirements. Following Board approval, the necessary process for NHS England approval will be initiated. Pending formal approval by NHS England, the ICB will operate in accordance with the approved governance framework to the fullest extent permissible within the existing Constitution and applicable statutory requirements.

9.4. Any consequential updates to ICB corporate policies, governance handbook materials and supporting documentation will be completed following Board approval.

10. Documents presented for approval

10.1. The governance framework is supported by the following documents presented alongside this paper:

a. Proposed ICB constitutional amendments (appendix 1).

b. Scheme of Reservation and Delegation and Schedule of Matters Delegated (appendix 2).

c. Standing Financial Instructions (appendix 3).

d. Strategic Commissioning Committee Terms of Reference (appendix 4).

e. Neighbourhood Strategic Delivery Committee Terms of Reference (appendix 5).

f. Patient Safety Committee Terms of Reference (appendix 6).

g. Audit, Risk and Assurance Committee Terms of Reference (appendix 7).

h. Remuneration Committee Terms of Reference (appendix 8).

i. ICB Board Ways of Working Statement (appendix 9).

11. Recommendation

11.1. The proposed ICB Governance Framework represents an integrated package of governance arrangements designed to support the ICB's future operating model and strategic commissioning role.

11.2. The Board is asked to:

a. Approve the proposed ICB Governance Framework and supporting governance documents.

b. Approve the constitutional and governance amendments set out within the accompanying papers.

c. Note that the constitutional amendments require subsequent approval by NHS England and agree that the necessary approval process should be initiated following Board approval.

d. Agree that the ICB Governance Framework will take effect 1 October 2026 following Board approval and become the governance framework through which the ICB operates, subject to the constitutional approval requirements described above.

NHS South West London
Integrated Care Board

Proposed changes to SWL ICB Constitution

NHS South West London ICB will retain its own Constitution to recognise its status as a statutory body. The Constitution will require amendment to reflect the changes in Executive role titles and addition of Chief Commissioning Officer as an ordinary member.

The Board is asked to consider an updated version of the Constitution, for submission to NHS England for approval, which has the following changes:

1.1. General changes throughout

- To update role name references for Chief Finance and Compliance Officer and Chief Nurse and Quality Officer.

1.2. Changes to section 2.2 Board membership

- Add a Chief Commissioning Officer as Ordinary member.

1.3. Changes to Section 3 Appointments

- Update descriptions for role eligibility and appointment process to reflect the changes to Board membership detailed above.

1.4. Changes to Section 4.7 Quorum

- No proposed changes to SWL quoracy which is:

  a. The Chair or Deputy Chair.
  b. Either the Chief Executive or the Chief Finance Officer.
  c. Either the Executive Medical Director or the Chief Nursing Office.
  d. At least one other Non-Executive Member.
  e. At least one Partner Member.

- The addition of Chief Commissioning Officer to the requirement would present a situation where there is no alternative option, with all other members alternatives exist e.g. Chair or Deputy Chair.

NHS South West London Integrated Care Board

CONSTITUTION

Document Management

Revision history

Version	Date	Summary of changes/Approvals
1.0	1 July 2022	Approved by NHS England
2.0	16 November 2022	Updated to reflect changes to the model ICB constitution requested by NHS England
2.0	23 November 2022	Approved by NHS England
2.1	19 July 2023	Updated to include reviewed Standing Orders Appendix 2
3.0	15 November 2024	Updated to reflect changes to the model ICB constitution requested by NHS England
4.0	28 May 2025	Updated to reflect changes in membership, and other miscellaneous amendments
4.1	11 June 2026	Draft amendments to executive role titles and board membership

CONTENTS

1. Introduction

1.1 Background / Foreword

1.1.1 NHSE has set out the following as the four core purposes of ICSs:

a) Improve outcomes in population health and healthcare;
b) Tackle inequalities in outcomes, experience and access;
c) Enhance productivity and value for money;
d) Help the NHS support broader social and economic development.

1.1.2 The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

a) Improving the health of children and young people;
b) Supporting people to stay well and independent;
c) Acting sooner to help those with preventable conditions;
d) Supporting those with long-term conditions or mental health issues;
e) Caring for those with multiple needs as populations age;
f) Getting the best from collective resources so people get care as quickly as possible.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS South West London Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is coterminous with the London Boroughs of Croydon, Kingston upon Thames, Merton, Richmond, Sutton and Wandsworth.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This Constitution is published at www.southwestlondon.icb.nhs.uk

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions.

These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);
d) Adult safeguarding and carers (the Care Act 2014);
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000); and
g) Provisions of the Civil Contingencies Act 2004.

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

a) section 14Z34 (improvement in quality of services);
b) section 14Z35 (reducing inequalities);
c) section 14Z38 (obtaining appropriate advice);
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions);
f) section 14Z45 (public involvement and consultation);
g) sections 223GB to 223N (financial duties); and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

1.5.2 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The Constitution will be reviewed as necessary by the CEO of the ICB. Following this review, the CEO will recommend necessary amendments to the Chair of the ICB, for agreement.
b) Proposed amendments will be put to the ICB Board for ratification.
c) Urgent amendments will be agreed by the ICB CEO and Chair.
d) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) **Standing orders** – which set out the arrangements and procedures to be used for meetings and the process to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published.

a) **The Scheme of Reservation and Delegation (SoRD)** – sets out those decisions that are reserved to the Board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated.

b) **Functions and Decision map** - a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook** – This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:
   a) The above documents a) – c).
   b) Terms of reference for all committees and sub-committees of the Board that exercise ICB functions.
   c) Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body, or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
   d) Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
   e) The up-to-date list of eligible providers of primary medical services under clause 3.7.2.

e) **Key policy documents** - which should also be included in the Governance Handbook or linked to it - including:
   a) Standards of Business Conduct Policy;
   b) Conflicts of interest policy and procedures;
   c) Policy for public involvement and engagement.

2. Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section three.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website (www.southwestlondon.icb.nhs.uk).

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the Board" and members of the ICB are referred to as "Board Members") consists of:

a) a Chair;
b) a Chief Executive;
c) at least three Ordinary members.

2.1.4 The membership of the ICB (the Board) shall meet as a unitary Board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England policy, requires the ICB to appoint the following additional Ordinary Members:

a) three executive members, namely:
- Chief Financial Officer;
- Executive Medical Director;
- Chief Nursing Officer;

b) At least two non-executive members;

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description;
- Primary medical services (general practice) providers within the area of the ICB and are of a prescribed description;
- Local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

2.1.7 While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the Board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has four Partner Members:

a) Two Partner Members – NHS Trusts and Foundation Trusts;
b) One Partner Member – Primary Medical Services; and
c) One Partner Member - Local Authorities.

2.2.2 The Board is therefore composed of the following members:

a) Chair;
b) Chief Executive;
c) Two Partner Members - NHS and Foundation Trusts;
d) One Partner Member - Primary Medical Services;
e) One Partner Member - Local Authorities;
f) Four Non-Executive Members (one of which, but not the Audit and Risk Committee Chair, will be appointed Deputy Chair and one of which, who may be the Deputy Chair or the Audit and Risk Committee Chair, will be appointed the Senior Non-executive Member)
g) Chief Finance & Compliance Officer;
h) Executive Medical Director; and
i) Chief Nurse~~ing~~ & Quality Officer.
~~i)~~j) Chief Commissioning Officer

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2.2.3 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.4 The Board will keep under review the skills, knowledge, and experience that it considers necessary for members of the Board to possess (when taken together) in order for the Board to effectively carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at Board Meetings

2.3.1 The Board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for Board meetings. They will be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Participants will be able to address the meeting and ask questions but may not vote. This may include:

a) All Executive Directors of the ICB who are not appointed members of the Board.

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.3.4 Observers may be asked to leave the meeting by the Chair in the event that the Board passes a resolution to exclude the public as per the Standing Orders.

3. Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test";
b) Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles); and
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a Board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

a) In the United Kingdom of any offence, or
b) Outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office;

b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings;
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest; or
d) of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A Health and Care Professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated;
b) the person's erasure from such a register, where the person has not been restored to the register;
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded; or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002; or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities); or
b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area; or
b) Any of the disqualification criteria set out in 3.2 apply.

3.3.4 The term of office for the Chair will be a maximum of three years and the total number of terms a Chair may serve is three terms.

3.4 Deputy Chair and Senior Non-executive Member

3.4.1 The Deputy Chair is to be appointed from amongst the Non-executive members by the board, subject to the approval of the Chair.

3.4.2 No individual shall hold the position of Chair of the Audit and Risk Committee and Deputy Chair at the same time.

3.4.3 The Senior Non-Executive Member is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.

3.5 Chief Executive

3.5.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.5.3 The Chief Executive must fulfil the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.5.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; or
b) Subject to clause 3.5.3(a), they hold any other employment or executive role.

3.6 Two Partner Members - NHS Trusts and Foundation Trusts

3.6.1 These two Partner Members are jointly nominated by the NHS Trusts and/or Foundation Trusts which provide services for the purposes of the health service within the ICB's area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition:

a) Croydon Health Services NHS Trust;
b) Central London Community Healthcare NHS Trust;
c) Epsom and St Helier University Hospital NHS Trust;
d) Kingston and Richmond I NHS Foundation Trust;
e) London Ambulance Service NHS Trust
f) St George's University Hospitals NHS Foundation Trust;
g) South London and Maudsley NHS Foundation Trust
h) South West London and St George's Mental Health NHS Trust; and
i) The Royal Marsden NHS Foundation Trust.

3.6.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be the CEO of one of the NHS Trusts or Foundation Trusts within the ICB's area.

3.6.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.6.4 These members will be appointed by a panel constituted by the Chief Executive and will be subject to the approval of the ICB Chair.

3.6.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.6.1. will be invited to make one nomination for each of the vacant roles outlined in 3.6.2.
- Eligible organisations may nominate individuals from their own organisation or another organisation and will, at the same time, confirm that nominations have been jointly agreed.
- All eligible organisations will confirm that they approve the full list of nominees proposed.

b) Assessment, selection, and appointment, will be subject to approval of the Chair under c):
- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.2 and 3.6.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.6 The term of office for these Partner Members will be three years with no limit on the number of terms that can be served. At the end of each term, the eligible nominators will be asked if they jointly agree to the current members being re-nominated. If they agree and subject to members remaining eligible, the Chair will be asked to re-approve these members. If they do not agree, the nominations, selection and appointment process will be re-run.

3.6.7 In exceptional circumstances, the Chair may reappoint a Partner Member for a period of 12 months without the need to re-run the nominations process. The extension cannot be for a period longer than 12 months. The Chair must inform the Board of any decision to make such an extension at the earliest opportunity.

3.7 One Partner Member - Providers of Primary Medical Services.

3.7.1 This Partner Member is jointly nominated by providers of Primary Medical Services for the purposes of the health service within the ICB's area, and that are Primary Medical Services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

3.7.2 The list of relevant providers of Primary Medical Services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

3.7.3 This member must fulfil the eligibility criteria set out at 3.1 and also be a practising GP in the South West London ICB's geography.

3.7.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.7.5 This member will be appointed by a panel constituted by the Chief Executive and be subject to the approval of the ICB Chair.

3.7.6 The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each eligible organisation described at 3.7.1 will be invited to make one nomination.
   - The nomination of an individual must be seconded by five other eligible organisations.
   - Eligible organisations may nominate individuals from their own organisation or another organisation.
   - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals with a failure to confirm within five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment will be subject to approval of the Chair under c):
   - The full list of nominees will be considered by a panel convened by the Chief Executive;
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.3 and 3.7.4;
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.7 The term of office for this Partner Member will be for three years. The total number of terms they may serve is three terms. At the end of each term, the eligible nominators will be asked if they jointly agree to the current member being re-nominated. If they agree and subject to the member remaining eligible, the Chair will be asked to re-approve this member. If they do not agree, the nominations, selection and appointment process will be re-run.

3.7.8 In exceptional circumstances, the Chair may reappoint a Partner Member for a period of 12 months without the need to re-run the nominations process. The extension cannot be for a period longer than 12 months. The Chair must inform the Board of any decision to make such an extension at the earliest opportunity.

3.8 One Partner Member - Local Authorities

3.8.1 This Partner Member is jointly nominated by the Local Authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) London Borough of Croydon;
b) The Royal Borough of Kingston upon Thames;
c) London Borough of Merton;
d) London Borough of Richmond upon Thames;
e) London Borough of Sutton; and
f) London Borough of Wandsworth.

3.8.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive or hold a relevant Executive level role, or be an elected member of one of the bodies listed at 3.8.1.

3.8.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.8.4 This member will be appointed by a panel constituted by the Chief Executive and be subject to the approval of the ICB Chair.

3.8.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.8.1. will be invited to make one nomination.
- Eligible organisations may nominate individuals from their own organisation or another organisation and will, at the same time, confirm that nominations have been jointly agreed.
- All eligible organisations will confirm that they approve the full list of nominees proposed.

b) Assessment, selection, and appointment will be subject to approval of the Chair under c):
- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.8.2 and 3.8.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.8.6 The term of office for this Partner Member will be three years with no limit on the number of terms that can be served. At the end of each term, the eligible nominators will be asked if they jointly agree to the current member being re-nominated. If they agree and subject to the member remaining eligible, the Chair will be asked to re-approve this member. If they do not agree, the nominations, selection and appointment process will be re-run.

3.8.7 In exceptional circumstances, the Chair may reappoint a Partner Member for a period of 12 months without the need to re-run the nominations process. The extension cannot be for a period longer than 12 months. The Chair must inform the Board of any decision to make such an extension at the earliest opportunity.

3.9 Executive Medical Director

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act; and
b) Be a registered Medical Practitioner.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.9.3 This member will be appointed by the Chief Executive Officer of the ICB subject to the approval of the ICB Chair.

3.10 Chief Nurs~~e~~ing & Quality Officer

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act; and
b) Be a registered Nurse.

3.10.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply.

3.10.3 This member will be appointed by the Chief Executive Officer of the ICB subject to the approval of the ICB Chair.

3.11 Chief Finance & Compliance Officer

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.11.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply.

3.11.3 This member will be appointed by the Chief Executive Officer of the ICB subject to the approval of the ICB Chair.

3.12 Chief Commissioning Officer

3.12.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.12.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply.

~~3.11.3~~3.12.3 This member will be appointed by the Chief Executive Officer of the ICB subject to the approval of the ICB Chair.

~~1.1~~3.13 Non-Executive Members

~~1.1.1~~3.13.1 The ICB will appoint four Non-Executive Members.

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~~1.1.2~~3.13.2 These members will be appointed by a panel constituted by the Chair and be subject to the approval of the Chair.

~~1.1.3~~3.13.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be an employee of the ICB or a person seconded to the ICB;
b) Not hold a role in another health and care organisation in the ICS area;
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit and Risk Committee; and
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.

~~1.1.4~~3.13.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; or
b) They hold a role in another health and care organisation within the ICB area.

~~1.1.5~~3.13.5 The term of office for a Non-Executive Member will be a maximum of three years and the total number of terms an individual may serve is three terms, after which, they will no longer be eligible for re-appointment.

~~1.1.6~~3.13.6 Initial appointments may be for a shorter period in order to avoid all Non-Executive Members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

~~1.1.7~~3.13.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of an independent Non-Executive Member up to the maximum number of terms permitted for their role.

~~1.1.8~~3.13.8 The Chair may appoint one Non-Executive Member to be the ICB Board Deputy Chair. The Deputy Chair will be appointed by the Board following consideration by the Remuneration Committee, based on the recommendation from the Chair.

~~1.2~~3.14 Board Members: Removal from Office

~~1.2.1~~3.14.1 Arrangements for the removal from office of Board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

~~1.2.2~~3.14.2 With the exception of the Chair, Board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;
b) If they fail to attend a minimum of 75% of the meetings to which they are

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invited unless agreed with the Chair, in extenuating circumstances;

c) If they are deemed to not meet the expected standards of performance at their annual appraisal;
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the reputation and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently);
e) Defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise;
f) Are deemed to have failed to uphold the Nolan Principles of Public Life;
g) Are subject to disciplinary proceedings by a regulator or professional body;
h) They materially fail to comply with the terms of the ICB's Constitution;
i) The person has refused without reasonable cause to undertake any training which the ICB requires all staff and Board members to undertake;
j) The person, where the Chair reasonably considers (having sought appropriate clinical advice) lacks capacity, for the purposes of the Mental Capacity Act 2005, to manage and administer his/her property and/or affairs; or
k) The person is an active member of a body or organisation with policies or objectives such that his/her membership would be likely to cause the ICB to be in breach of its statutory obligations or to bring the ICB into disrepute.

~~1.2.3~~3.14.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.2 apply.

~~1.2.4~~3.14.4 If a Board member, other than an employee of the ICB, meets any of the criteria in 3.13.2, the following process will apply:

a) The Chair will convene a meeting of the Board, in private.
b) The approval of three quarters of the Board's membership is required to remove that individual from the Board, with the agreement of the Chair.

~~1.2.5~~3.14.5 Executive Directors (including the Chief Executive) will cease to be Board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

~~1.2.6~~3.14.6 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care.

~~1.2.7~~3.14.7 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) Terminate the appointment of the ICB's Chief Executive; and
b) Direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

~~1.3~~3.15 Terms of Appointment of Board Members

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~~1.3.1~~3.15.1 With the exception of the Chair, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB's website and any guidance issued by NHS England or other relevant body. Remuneration for Chairs, will be set by NHS England. Remuneration for Non-Executive Members will be set by a specially constituted Remuneration Committee which will not include Non-Executive Members of the ICB.

~~1.3.2~~3.15.2 Other terms of appointment will be determined by the Remuneration Committee.

~~1.3.3~~3.15.3 Terms of appointment of the Chair will be determined by NHS England.

~~2.~~4. Arrangements for the Exercise of our Functions

~~2.1~~4.1 Good Governance

~~2.1.1~~4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

~~2.1.2~~4.1.2 The ICB has agreed a Code of Conduct and Behaviours which sets out the expected behaviours that members of the Board and its Committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours is published in the Governance Handbook.

~~2.2~~4.2 General

~~2.2.1~~4.2.1 The ICB will:

a) Comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) Comply with directions issued by the Secretary of State for Health and Social Care;
c) Comply with directions issued by NHS England;
d) Have regard to statutory guidance including that issued by NHS England;
e) Take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England; and
f) Respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

~~2.2.2~~4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

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~~2.3~~4.3 Authority to Act

~~2.3.1~~4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) Any of its members or employees;
b) A committee or sub-committee of the ICB.

~~2.3.2~~4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other

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body enters such arrangements; they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

~~2.3.3~~4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the Board must authorise the arrangement, which must be described as appropriate in the SoRD.

~~2.4~~4.4 Scheme of Reservation and Delegation

~~2.4.1~~4.4.1 The ICB has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full on the ICB's website (www.southwestlondon.icb.nhs.uk).

~~2.4.2~~4.4.2 Only the Board may agree the SoRD and amendments to the SoRD may only be approved by the Board.

~~2.4.3~~4.4.3 The SoRD sets out:

a) Those functions that are reserved to the Board;
b) Those functions that have been delegated to an individual or to committees and sub committees; and
c) Those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

~~2.4.4~~4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the Board for the exercise of their delegated functions.

~~2.5~~4.5 Functions and Decision Map

~~2.5.1~~4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

~~2.5.2~~4.5.2 The Functions and Decision Map is published on the ICB's website (www.southwestlondon.icb.nhs.uk).

~~2.5.3~~4.5.3 The map includes:

a) Key functions reserved to the Board of the ICB;
b) Commissioning functions delegated to committees and individuals;
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; and

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d) functions delegated to the ICB (for example, from NHS England).

~~2.6~~4.6 Committees and Sub-Committees

~~2.6.1~~4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees. The Board may also create Task and Finish Groups to undertake specific, time limited pieces of work.

~~2.6.2~~4.6.2 All committees and sub-committees are listed in the SoRD.

~~2.6.3~~4.6.3 Each committee, sub-committee, or Task and Finish Group established by the ICB operates under Terms of Reference agreed by the Board. All Terms of Reference are published in the Governance Handbook.

~~2.6.4~~4.6.4 The Board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to:

a) Abide by the Terms of Reference for that committee or sub- committee, which will document the appropriate reporting and assurance arrangements.

~~2.6.5~~4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB Members or employees.

~~2.6.6~~4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

~~2.6.7~~4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the Standing Orders as well as the Standing Financial Instructions and any other relevant ICB policy.

~~2.6.8~~4.6.8 The following committees will be maintained:

a) **Audit and Risk Committee**: This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit and Risk Committee will be chaired by a Non-Executive

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Member (other than the Chair and Deputy Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee**: This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a non-executive member other than the Chair or the Chair of Audit and Risk Committee.

2.6.94.6.9 The Terms of Reference for each of the above committees are published in the Governance Handbook.

2.6.104.6.10 The Board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including Terms of Reference, are published in the Governance Handbook.

2.74.7 Delegations made under section 65Z5 of the 2006 Act

2.7.14.7.1 As per 4.3.2, the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

2.7.24.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

2.7.34.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the Board.

2.7.44.7.4 The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the ICB's Governance Handbook.

2.7.54.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

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~~3.~~5. Procedures for Making Decisions

~~3.1~~5.1 Standing Orders

~~3.1.1~~5.1.1 The ICB has agreed a set of Standing Orders which describe the processes that are employed to undertake its business. They include procedures for:

a) Conducting the business of the ICB;
b) The procedures to be followed during meetings; and
c) The process to delegate functions.

~~3.1.2~~5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in Terms of Reference which have been agreed by the Board.

~~3.1.3~~5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

~~3.2~~5.2 Standing Financial Instructions (SFIs)

~~3.2.1~~5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

~~3.2.2~~5.2.2 A copy of the SFI's is published on the ICB's website (www.southwestlondon.icb.nhs.uk).

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4.6. Arrangements for Conflict of Interest Management and Standards of Business Conduct

4.16.1 Conflicts of Interest

4.1.16.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

4.1.26.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the ICB's website (www.southwestlondon.icb.nhs.uk).

4.1.36.1.3 All Board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

4.1.46.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

4.1.56.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Managing Conflicts of Interests (including Gifts and Hospitality) Policy and the Standards of Business Conduct Policy.

4.1.66.1.6 The ICB has appointed the Audit and Risk Committee Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's senior governance advisor, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;

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d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation; and
e) Provide advice on minimising the risks of conflicts of interest.

~~4.2~~6.2 Principles

~~4.2.1~~6.2.1 In discharging its functions, the ICB will abide by the following principles as they relate to its arrangements for managing conflicts of interest:

a) The Nolan Principles;
b) Ensuring clear policy guidance is provided to all those performing a role on behalf of the ICB;
c) Monitoring compliance in accordance with published guidance;
d) Ensuring all interests are proactively declared;
e) Keeping an audit trail of actions taken; and
f) Such other principles as contained in the ICB's Managing Conflicts of Interests (including Gifts and Hospitality) Policy and procedures.

~~4.3~~6.3 Declaring and Registering Interests

~~4.3.1~~6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB;
b) Members of the Board's committees and sub-committees; and
c) Its employees.

~~4.3.2~~6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB's website (www.southwestlondon.icb.nhs.uk).

~~4.3.3~~6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

~~4.3.4~~6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

~~4.3.5~~6.3.5 All declarations will be entered in the registers as per 6.3.1.

~~4.3.6~~6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

~~4.3.7~~6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this

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information.

~~4.3.8~~6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

~~4.4~~6.4 Standards of Business Conduct

~~4.4.1~~6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) Act in good faith and in the interests of the ICB;
b) Follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles); and
c) Comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

~~5.~~7. Arrangements for ensuring Accountability and Transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Meetings and publications

7.2.1 Board meetings, and committees composed entirely of Board members or which include all Board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.2.2 Papers and minutes of all meetings held in public will be published.

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

7.2.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

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7.2.6 Information will be provided to NHS England as required.

7.2.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:

a) Managing Conflicts of Interests (including Gifts and Hospitality) Policy and procedures;
b) Registers of interests; and
c) Those listed in 1.7.3.

7.2.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the "Joint Forward Plan"). The plan will in particular:

a) Describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.
b) Explain how the ICB proposes to discharge its duties under sections 14Z34 to 14Z45 (general duties of integrated care Boards), and Sections 223GB and 223N (financial duties).
c) Set out any steps that the ICB proposes to take to implement the South West London joint local Health and Wellbeing Strategy.
d) Set out any steps that ICB proposes to take to address the particular needs of children and young persons under the age of 25.
e) Set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.3 Scrutiny and Decision Making

7.3.1 The ICB will have five Non-Executive Members who will be appointed to the Board, including the Chair; and all the Board and Committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.3.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) Establishing decision-making structures within the ICB that are aligned with the NHS Provider Selection Regime for arranging healthcare services.
b) Ensuring appropriate governance structures are in place to address challenges arising from provider selection decisions.
c) Ensuring that there are processes in place for the ICB to demonstrate the proper execution of their responsibilities under the NHS Provider Selection Regime.

d) Ensuring contracts awarded by the ICB are published and records of decision making kept, in accordance with good governance data processing principles.
e) Ensuring organisational compliance with the SWL ICB Contracting and Procurement policy and processes.
f) Ensuring that local internal audit arrangements are in place to review decisions made under the NHS Provider Selection Regime.

7.3.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.4 Annual Report

7.4.1 The ICB will publish an Annual Report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) Explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care Boards);
b) Review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan);
c) Review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised); and
d) Review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

~~6.~~8. Arrangements for Determining the Terms and Conditions of Employees

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8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The Board has established a Remuneration Committee which is chaired by a Non-Executive Member other than the Chair or Audit and Risk Committee Chair.

8.1.3 The membership of the Remuneration Committee is determined by the Board. No employees may be a member of the Remuneration Committee but the Board ensures that the Remuneration Committee has access to appropriate advice by:

a) Members of the HR team (including the Executive Director with responsibility for the HR function) being available to attend and advise the committee as needed; and
b) The ICB's senior governance advisor, providing support, advice and

attending the committee as required.

8.1.4 The Board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the Board are published as part of the Governance Handbook on the ICB's website (www.southwestlondon.icb.nhs.uk).

8.1.6 The duties of the Remuneration Committee include:

a) Approve the terms and conditions of employment for all individuals directly appointed by the ICB as workers, clinical leads, office holders, including pensions, remuneration, fees and travelling or other allowances payable;
b) Set remuneration, allowances, terms and conditions for ICB Board members;
c) Agree any discretionary payments or terms and conditions for staff employed by the ICB;
d) Approve any termination or redundancy payments;
e) Approve the transfers of staff into or out of the ICB;
f) Ensuring the ICB follows national pay and terms and condition frameworks;
g) Setting remuneration, allowances and terms and conditions for the Chief Executive and Very Senior Managers (VSMs) in line with national

guidance; and

h) Any other relevant duties.

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

~~7.~~9. Arrangements for Public Involvement

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9.1.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the Integrated Care Board;

b) the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them; and

c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) We have six local Health and Care Plans, one for each of our Local Authority Boroughs. We will ensure these are co-developed and inform our overall system plan;

b) To ensure the local Health and Care Plans are right for our communities we co-develop them through Partner and stakeholder engagement, health and care organisations at place level, as well as key stakeholders in the borough;

c) Broad engagement – using our current community/patient group networks, and wider engagement tools such as Citizens Panels and other 'representative sample' surveys or group work;

d) Targeted engagement with communities that experience health inequalities within each borough; and

e) Targeted engagement with patients and communities that have Long Term Conditions – those that are prioritised in the local health and care plans and /or are prevalent in each borough.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities.

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS;

b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions;
c) Understand your community's needs, their relevant social histories, experience and aspirations for health and care, using engagement to find out if change is having the desired effect;
d) Build relationships with excluded groups – especially those affected by inequalities;
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners;
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust;
g) Use community development approaches that empower people and communities, making connections to social action;
h) Use co-production, insight and engagement to achieve accountable health and care services;
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities; and
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 These arrangements, include:
a) Each borough or Place has a local communications and engagement group, comprising communication and engagement professionals from all partner organisations, the NHS, Local Authorities, Healthwatch and the voluntary sector, to drive forward and deliver our priority work. These groups ensure that work and insight is coordinated across the system and that we maximise channels and reach by working in partnership;
b) These local borough groups report regularly to each place based partnership committee about past, current and planned engagement activities to contribute towards patient voice being central to influencing local decision making;
c) Informed by EHIAs, JSNAs and local insight, each borough has developed a map of key areas/communities to prioritise engagement work with. Indices of Multiple Deprivation data was overlaid with information about health inequalities. These maps will continue to be refreshed to ensure we are reaching our diverse populations working closely with the population health management team;
d) Assurance of good practice engagement happens at two levels: firstly each borough or Place has a mechanism for assuring local work;
e) Secondly we have a South West London group (including Healthwatch and the voluntary sector) to provide assurance to the ICB that the duty to involve has been met and to provide advice on engagement plans and activities to ensure they meet best practice and are inclusive of those that are seldom heard, experience health inequalities and or/have protected characteristics;
f) Listening to local people and communities is recognised as everyone's responsibility within the ICB. Training, development and toolkits to

support good practice engagement to be delivered across teams/functions. Teams are encouraged to factor in communications and engagement requirements at an early stage of their planning so that they can be appropriately resourced and meaningfully delivered;

g) The Board will receive reports which provide an overview of the engagement activities across the ICB – noting the communities it has reached, impact that it has made, decisions it has influenced and any lessons learned;
h) To support transparent decision making, ICB papers will be published in advance of meetings, including the engagement reports, and meetings will be held in public. Our 'involving people and communities' section of our website will include opportunities for people to be involved and provide information about past, current and planned engagement activities;
i) We will use the following methodologies to reach our local people and communities;
j) Broad community engagement - working with the voluntary and community sector to host 'community conversations,' to hear and respond to feedback, answer questions and gather insight. We also widen our reach through organic social media via NHS and partner channels, and paid digital adverts on platforms such as Facebook, Nextdoor and Instagram;
k) We champion 'every contact counts' supporting staff to have 'confident conversations' with local people and patients;
l) Community champions and influencers - working with key local influencers (faith leaders, community champions, health care professionals, GPs and their practices) to lead and host conversations for us building trust and confidence within our diverse communities;
m) Grassroots support programme – to improve our reach into health inclusion communities facilitating and intensifying meaningful, respectful and culturally appropriate activity in our local boroughs;
n) Surveys and questionnaires – for example working with our 'People's Panel' (a virtual group of local people who broadly reflect the population of South West London). These surveys have led to deeper dives into specific areas; and
o) Targeted focus groups and one-to-one interviews - particularly for those who are digitally excluded to help inform and shape our work.

Appendices

Appendix 1: Definitions of Terms Used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB Board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this Constitution.
Committee	A committee created and appointed by the ICB Board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.

Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description; • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description; and • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Appendix 2: Standing Orders

1. Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of South West London Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1 The Standing Orders are effective from 1 July 2022.

2.2 Standing Orders will be reviewed on an annual basis or sooner if required.

2.3 Amendments to these Standing Orders will be made as per paragraph 1.6.2 of the SWL ICB Constitution.

2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2 These Standing Orders apply to all meetings of the Board, including its committees and sub-committees unless otherwise stated. All references to Board are inclusive of committees and sub-committees unless otherwise stated.

3.3 All members of the Board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the ICB's senior governance advisor, will provide a settled view which shall be final.

3.5 All members of the Board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6 If, for any reason, these Standing Orders are not complied with, full details of

the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification and the Audit and Risk Committee for review.

4. Meetings of the Integrated Care Board

4.1 Calling Board Meetings

4.1.1 Meetings of the Board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the Board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Board specifying the matters to be considered at the meeting.
c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the Board.

4.2.2 If the Chair is absent, or is disqualified from participating by a conflict of interest, the Deputy Chair shall preside over meetings in the Chair's stead.

4.2.3 If both the Chair and Deputy Chair are absent or disqualified from participating by a Conflict of interest the assembled voting members of the Board may appoint one of their number to act as a temporary Deputy for the purpose of chairing the meeting.

4.2.4 The Board shall appoint a Chair to all committees and sub- committees that it has established. The appointed committee or sub- committee Chair will preside over the relevant meeting. Terms of Reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the Board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website (www.southwestlondon.icb.nhs.uk).

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board.

4.5 Nominated Deputies

4.5.1 With the permission of the person presiding over the meeting, the Partner Members of the Board may nominate a deputy to attend a meeting of the Board that they are unable to attend. The deputy must be of an equivalent position to the Board member they are deputising for. The deputy may speak and vote on their behalf.

4.5.2 The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6 Virtual attendance at meetings

4.6.1 The ICB Board and its committees may choose to meet physically (for example, for the purpose of an AGM), at its discretion. However, where necessary, the ICB Board and its committees may be held virtually.

4.7 Quorum

4.7.1 The quorum for meetings of the Board will be 50% members, including:

a) The Chair or Deputy Chair;
b) Either the Chief Executive or the Chief Finance Officer;
c) Either the Executive Medical Director or the Chief Nursing Officer;
d) At least one other Non-Executive Member;
e) At least one Partner Member;

4.7.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum;
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum;
c) A nominated deputy permitted in accordance with standing order 4.5 will count towards quorum for meetings of the board.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate Terms of Reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

a) The quorum will remain at 50% of total Board members (i.e. no reduction in the quoracy outlined in 4.7.1 of these standing orders).

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the Board who are present at the meeting will be eligible to cast one vote each;
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so;
c) For the sake of clarity, any additional Participants and Observers (under 2.3 of the Constitution) will not have voting rights;
d) A resolution will be passed if more votes are cast for the resolution than against it;
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting)

will have a second and casting vote; and

f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 Where helpful, the Board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent decisions

4.9.4 In the case urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible the following will apply.

4.9.5 The powers which are reserved or delegated to the Board may, for an urgent decision, be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having been made to consult with as many members as possible in the given circumstances.

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the Board for formal ratification and the Audit and Risk Committee for oversight.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960, all meetings of the Board and all meetings of committees which are comprised of entirely Board members or all Board members, at which public functions are exercised will be open to the public.

4.11.2 The Board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business

or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Board.

5. Suspension of Standing Orders

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least 50% of those members present.

5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit and Risk Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents

6.1 The ICB shall have a Seal. All deeds executed by the ICB shall, unless otherwise so determined, be signed by two duly authorised members of the ICB. The Chief Executive Officer shall keep a register in which s/he, or another manager of the ICB authorised by him/her, shall enter a record of the sealing of every document.

6.2 In land transactions, the signing of certain supporting documents will be delegated to managers and set out clearly in the Scheme of Reservation and Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

NHS South West London
Integrated Care Board

SFI and Scheme of Reservation and Delegation review

1. What does our governance model require?

1.1. In redesigning the governance structure, feedback was sought from Board members on the current governance function. Governance was seen as, “duplicative”, “lack of clarity”, “requires simplification”. There was a view that we should, “shift to strategy-led agendas”, and, “avoid operational detail”.

1.2. The two ICB’s new draft governance model reflects this feedback and is very clear structurally;

- Board = strategic, non-operational authority, final approval and oversight.
- Committees = scrutiny, assurance, selective approvals.
- SMT = principal forum for operational management of the ICB's business activities.

1.3. In relation to what this means for our Schemes of Reservation and Delegation (SoRD) and Standing Financial Instructions (SFIs), it forces three design decisions;

- Committees must not be approval bottlenecks. They must focus on strategy, challenge and assurance, but with suitable delegation of decision-making to Strategic Commissioning Committee.
- SMT must become the primary decision engine, moving out of committees and into SMT.
- Delegation must remove ambiguity. There are currently unclear boundaries and overlapping committees and therefore our SoRD must remove all duplication and create clean decision routes.

2. Design Principles

2.1. ✅ Principle 1: Strategic Board – only deciding strategy, major investments and risk appetite.

2.2. ✅ Principle 2: Executive-led decision system. SMT becomes the primary decision maker, committees scrutinise.

2.3. ✅ Principle 3: Single route per decision – with one owner, no parallel approvals and no duplication.

2.4. ✅ Principle 4: Assurance, not re-decision. Committees will challenge, recommend, and escalate, not re-run decisions already made.

2.5. ✅ Principle 5: Visibility replaces control layering – instead of extra approvals, use structure reporting, transparency, and escalation triggers.

3. Harmonised delegation model

Level	Value	Decision Owner	Committee Involvement
L1	<£50k	Budget Holder	None
L2	£50k-£250k	Director	Exec visibility
L3	£250k-£2.5m	Exec Director	SMT reporting
L4	£2.5m-£10m	SMT	Notify Strategic Commissioning Committee
L5	£10m-£25m	SCC	SMT prior review and recommendation
L6	>£25m	Board	Final Approval

3.1. In the above model, Board only handles L6, this removes committee duplication and lack of decision space, and L1-L4 do not go to committees.

3.2. Board has no operational approvals below L6.

3.3. Strategic Commissioning Committee has a strategic challenge role, provides commissioning direction and major service change advice and is delegated approvals at L5 for items reviewed and recommended by SMT.

3.4. Neighbourhood Delivery Committee – no financial delegation.

3.5. Audit, Risk and Assurance Committee – assurance only, no decisions.

3.6. SMT – the decision-making body for operational, financial and commissioning decisions within delegated limits.

3.7. Specialised Commissioning Alignment – given large spend, high risk, and governance complexity, propose a trigger escalation model based on above limits but noting that complexity may require consultation at committee level or consideration at the Board as per section 3.9, below.

3.8. The risk, complexity and sensitivity of individual matters will also be considered when determining the appropriate level of decision-making and may act as a trigger for escalation within the governance framework where appropriate.

Trigger	Action
>£10m specialised investment	SMT and SCC visibility
Service Reconfiguration	SCC
Financial risk	CFO sign off and SMT
National service constraint	NHSE alignment

4. Capital

Value	
<£2.5m	Chief Finance and Compliance Officer
£2.5m - £5m	CEO
£5m - £10m	CFCO and CEO / SMT
£10m - £25m	SMT
>£25m	Board

4.1. ICB letters of support for system business cases e.g. Where NHS England require ICB letters of support for capital business cases and sensitive, novel and contentious business cases.

a. Estimated cost up to £5m – CFCO
b. Estimated cost up to £10m – CFCO and CEO
c. Estimated cost up to £20m – CFCO and CEO/SMT
d. Estimated cost up to £50m – SMT and Strategic Commissioning Committee
e. Above £50m – SMT, Strategic Commissioning Committee and Board

5. SFI Alignment

5.1. The SFIs already give statutory controls, CFO responsibility and procurement compliance and audit requirements and these thresholds do not change. What does change is decision routing clarity, reduction in committee approvals and stronger executive control. “Operational decisions will be taken at the lowest appropriate level in accordance with the Scheme of Delegation. Committees shall not duplicate operational decision-making but provide assurance, scrutiny, and escalation.

6. Summary

6.1. Decisions sit with the executive (SMT), scrutiny sits with committees and a limited authority for SCC to take significant commissioning decisions as determined at L5 in the above table, and the Board focuses on strategy.

NHS South East London ICB & NHS South West London ICB Integrated Scheme of Reservation & Delegation

The arrangements made by NHS South East London Integrated Care Board (SEL) and NHS South West London Integrated Care Board (SWL) for the reservation and delegation of decisions are set out in this integrated Scheme of Reservation and Delegation (SoRD).

Each ICB remains accountable for all its functions, including those that it has delegated, however acknowledging that the current clustering arrangements in place between SEL and SWL, as the consequent Board roles held by individuals across both ICB Boards, the delegations are combined within a single document for ease of reference.

Given the individual statutory status of each ICB, delegations may differ between ICBs. These are clearly noted in the document and must be adhered to.

This SoRD may be amended from time to time to reflect changes in legislation, ICB policy or operational requirements.

The ICB will coordinate regular reviews of financial, procurement and contracts signing financial delegations for positions and limits.

This document should be read in conjunction with Board committee terms of reference, which detail the responsibilities within the remit of each committee. Specific delegations from the Board to committee are shown in the tables below.

A revised version is submitted to the Senior Management Team and Audit, Risk and Assurance Committees for endorsement before submission to the respective ICB Boards for approval.

Accountability

ICB employees are reminded of their accountability under this Scheme of Reservation and Delegation, and the associated obligations.

As an officer of the ICB with delegated authorities, as detailed in this document, you have personal accountability for:

- Complying with all the authority limits set out in this document, noting that variations exist between SEL ICB and SWL ICB delegated limits, and applying these appropriately.
- Delivering your service within the budgetary limits set, unless express agreement to a variance to budget is reached with the respective delegated officers in advance.
- Regularly monitoring income and expenditure against agreed budgets, including meeting your management accountant on a monthly basis.
- Highlighting any significant actual or forecast variances to your executive director (or the CFCO if you are an executive director yourself) and finance business partner as early as possible in order that mitigating actions can be developed and implemented.
- Ensuring awareness and compliance to the ICBs counter fraud, bribery and corruption policies within your teams at all times.
- Ensuring adherence to the respective ICBs Standard of Business Conduct Policy.
- Complying with all organisational policies and procedures.
- Ensuring appropriate local systems are in place to ensure these delegations are operated effectively.
- Providing the necessary reports to respective ICB committees, to enable those committees to conduct their assurance duties as required.

Failure to adhere to organisational policies and procedures, including adherence with the delegated authority limits within the Scheme of Reservation and Delegation and Operational Scheme of Delegation may result in disciplinary action in line with the organisations Policy.

Section A:

NHS South East London ICB & NHS South West London ICB Integrated Scheme of Reservation & Delegation

V1

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
STRATEGY				
Agree the vision and values and overall strategic direction of the ICB	✓			
Agree the overall South East London and South West London Neighbourhood strategy	✓			
Agree joint working on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability	✓			
GOVERNANCE ARRANGEMENTS				
Prepare the ICB's overarching Scheme of Reservation and Delegation			✓	
Approval of the group's overarching Scheme of Reservation and Delegation.	✓			
Prepare the ICB's operational scheme of delegation.			✓	
Approval of the ICB's operational scheme of delegation.	✓ (as part of SoRD)			
Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's constitution or standing orders.	✓			

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
Prepare detailed financial policies that underpin the ICB's standing financial instructions			✓	
Approve policies required to ensure ICB meets statutory or legislative guidance	✓			
Approve operational policies required to provide internal direction (which do not relate to specific statutory or legislative guidance)				Senior Management Team
Approve any changes to the ICB's committee structure	✓			
Approval of the arrangements for discharging the ICB's statutory financial duties.	✓			In consultation with Audit, Risk and Assurance Committee
Exercise or delegation of those functions of the ICB which have not been reserved to the board or other committee or sub-committee or [specified] employee		✓		
Authority to make decisions relating to operational matters, within the financial limits specified in the Operational Scheme of Delegation, where not explicitly delegated elsewhere or defined elsewhere in the Scheme of Delegation				Senior Management Team
APPROVAL OF PLANS				
Approval of the NHS Joint Forward plan	✓			
APPROVAL OF BUDGETS AND FINANCE MATTERS				
Approval of the ICB's annual corporate budgets	✓			
Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the ICB				Audit, Risk and Assurance

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
				Committee
Approval of the ICB's annual report and annual accounts				Audit, Risk and Assurance Committee
OPERATING STRUCTURES AND HR MATTERS				
Approval of the ICB's operating structure (in relation to organisational structures within the ICB)	✓			
Approval of terms and conditions, pensions, remuneration, fees and allowances payable to board members, employees and to other persons providing services to the ICB outside of agenda for change				Remuneration Committee
Approval of the use of any Redundancy Scheme (RS)				Remuneration Committee
Approval of TUPE or other staff transfer schemes				Remuneration Committee
Approval of the arrangements for discharging the ICB's statutory duties as an employer	✓			
Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers	✓			
CLINICAL QUALITY AND PATIENT SAFETY				

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
Approve arrangements to minimise clinical risk and maximise patient safety				Patient Safety Committee
Approve arrangements to secure continuous improvement in quality and patient outcomes				Strategic Commissioning Committee
Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.				Patient Safety Committee
RISK & ASSURANCE MATTERS				
Approval of the ICB's counter fraud and security management arrangements				Audit, Risk and Assurance Committee
Approval of the ICB's risk management arrangements.				Audit, Risk and Assurance Committee
Approval of changes to the provision or delivery of assurance services to the ICB including internal audit and counter fraud				Audit, Risk and Assurance Committee
Approve the appointment (and where necessary dismissal) of external auditors (and where necessary change/removal) of external audit				Audit, Risk and Assurance Committee acting as Auditor Panel
CORPORATE MATTERS				

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
Approve ICBs publication scheme		✓		
Approval of the ICB's contracts for corporate support (for example finance provision)		✓		
COMMISSIONING, CONTRACTING AND RISK POOLING				
Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Integrated Care Boards or pooled budget arrangements under section 75 of the NHS Act 2006).	✓			
Approval of the ICB's contracts for any contracting / commissioning support including in respect of any commissioning functions delegated by NHSE		✓		
Approval of a new pooled budget, with a South East or South West London local authority	✓			
Approve decisions delegated to joint committees established under section 75 of the 2006 Act.	✓			
Approve primary care commissioning arrangements in South East and South West London (Bexley, Bromley, Greenwich, Lambeth, Southwark, Lewisham and Kingston, Richmond, Croydon, Wandsworth, Merton, Sutton)				SEL: Strategic Commissioning Committee
Approval of the arrangements for promoting integration and co-ordinating the commissioning of services with other integrated care boards, provider collaboratives, place and/or with the local authority/ies, where appropriate	✓			
Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions for promoting improvement in the quality of				Strategic Commissioning Committee

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
services and promoting the involvement of each patient, patient choice, public engagement and consultation				
Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions to promote reductions in inequalities	✓			

Section B:

NHS South East London ICB & NHS South West London ICB
Integrated Operational Scheme of Delegation (schedule of matters delegated to officers and committees)

1. Introduction

1.1 This Operational Scheme of Delegation has been developed in conjunction with the organisation's Standing Financial Instructions and will provide guidance for the ICB.

1.2 The delegation shown below is the lowest level to which authority is delegated. Authority can be delegated upwards with no further action being required. However, delegation to lower levels is only permitted with written approval of the Chief Executive Officer. Decision making with a financial impact must be carried out in accordance with the ICB's Standing Orders, Prime Financial Policies and detailed financial procedures. All financial limits in this schedule of matters delegated to Officers are subject to sufficient budget being available.

1.3 The Standing Financial Instructions set out the financial responsibilities of the various Committees, Groups and individuals within the ICB.

2. Levels of Delegation

2.1 The Operational Scheme of Delegation covers only matters delegated by NHSE to the ICB and those matters reserved for the ICB Board its committees, Executive Officers and/or Partners.

2.2 Further delegation may be approved:

a. by the ICB Board in approving specific management policies.

b. by the ICB Chief Executive.

c. as part of Financial Procedures approved by the Chief Finance and Compliance Officer (CFCO).

2.3 Each Executive Director will need to consider the arrangements for authorisation of expenditure against delegated budgets and further delegation of management/professional responsibilities.

2.4 In accordance with the Scheme of Delegation the ICB Board exercises financial supervision and control by:

a. Authorising the operational plan.

b. Requiring the submission and approval of budgets within approved allocations / overall income.

c. Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money).

d. Defining specific responsibilities placed on members of the ICB Board, its Committees, Partners and employees as indicated in the Scheme of Delegation.

2.5 Once the ICB Board, has reviewed and approved the Operating Plan and any supporting financial plan / budget, the Board, will delegate approval to the Chief Executive; the Chief Finance and Compliance Officer and other Executive Directors and employees to commit these resources for the purpose set out in the plan subject to the financial thresholds set out in this document.

2.6 Levels of Sub-Delegation

The Delegation of financial limits are also linked to the position/role of the staff member and the Levels outlined in Schedule 1 will be those set on the financial system.

2.7 Types of Delegation Authority

The types of financial delegation outlined in this document include:

a. Expenditure approval delegations.

b. Invoices and credit note requests.

c. Business case approval delegations.

d. Procurement delegations.

e. Contracts signing delegations.

f. Other non-financial delegations.

3. Principles

3.1 General Delegation Principles

3.2 Delegates Must:

a. Act within your authority by ensuring you hold the relevant delegation
b. Understand your authority by referring to relevant guidance, limitations and directions.
c. Act with the ICB's values in mind.
d. Avoid conflicts of interest.
e. Consider the ICB's business needs.
f. Seek expert advice when making a decision.
g. Make decisions objectively, reasonably and fairly.

3.3 Delegates Must Not:

a. Exercise delegations in respect of someone outside of your immediate line of control.
b. Exercise powers in respect of a position higher than your own.
c. Exercise a delegation in respect of yourself (i.e. confer a personal benefit).
d. Exercise a delegation on behalf of an absent employee unless it is within the scope of your delegated authority, or you are officially acting in the position.

3.4 Compliance

a. All delegates are required to comply with manuals and directives issued by the ICB.
b. Delegated authority is subject to internal controls and to any overriding National laws.

3.5 Responsibility

a. Delegations are made to positions, not to persons, and are specific to the position's work unit and/or role. Ultimate responsibility for performance of the functions or exercise of the authority or power rests with the authority holder.

b. Where an authority holder delegates an authority to an individual position, the person occupying that position becomes personally accountable for the delivery of that authority.

c. The delegation to a position is unique and is not transferable by the delegate.

d. Delegations extend to the Officer substantively appointed to that position and any person acting in that position for a specified period unless otherwise excluded in the terms of the temporary appointment. Delegations do not extend to volunteers.

e. Where the Scheme of Delegation specifies a delegate, the position to which the delegate reports is also deemed to have the delegated authority except where otherwise determined by legislation, policy or a Chief Executive instruction.

f. Where the permanent Officer takes leave, it is their responsibility to instruct the relieving Officer (and the finance department) of the level of delegation that is attached to the position and the responsibilities associated with the delegation for the agreed period. In case of the Chief Executive Officer their responsibility would be delegated to the Deputy Chief Executive Officer in the first instance for any leave.

3.6 Application

a. Delegates are expected to exercise their powers, authorities, duties or functions delegated to them in a responsible, efficient, consistent and cost-effective manner.

b. Discretion is to be utilised by the delegate in determining whether to exercise a delegation or refer the matter to a higher authority.

c. When an Officer is exercising their financial delegation, they are required to clearly provide their name, position and date when signing.

3.7 Financial Delegation Principles

3.8 Delegates Must:

a. Only approve expenditure in cost centres under the delegate's authority.
b. Only approve expenditure where there is sufficient budget to cover the cost.
c. Only approve expenditure on goods and services related to official work and business use.
d. Only approve expenditure where all relevant ICB's procedures and policies have been followed.
e. Only approve expenditure to the financial limit of the delegation.
f. Only approve expenditure where evidence exists that goods have been received and/or services have been performed in accordance with and at the rate/s of an agreed contract or arrangement.
g. Employees are to note that an expenditure approval is to be given prior to any commitment being made, contract signed, or purchase order raised.

3.9 Delegates Must Not:

a. approve a gift or settlement of any legal claim unless specifically delegated this authority.
b. transfer the financial delegation granted by the ICB Chief Executive to another employee.
c. break one purchase down into several smaller items to avoid breaching the financial limit of the delegation.
d. approve expenditure on capital works, contracts or special payments unless specifically delegated this authority.
e. exceed their delegation limits even if automated systems permit this to occur.
f. Approve any expenditure incurred by the delegate on travel, meals, conferences and other similar expenditure.
g. Assume the financial delegation of an absent delegate if you are not authorised to do so.

3.10 Suspension, Revocations and Reductions in Financial Delegations

a. The terms of any financial delegation cannot be exceeded under any circumstances.
b. Financial delegations cannot be sub-delegated once granted by the ICB Chief Executive.
c. Improper performance of responsibilities may result in disciplinary action being taken against the employee concerned.
d. The power to revoke, suspend or reduce financial delegations granted to positions within the ICB rests with the Chief

Executive in respect of delegations made.

e. If circumstances arise which warrant the suspension, revocation or reduction of a financial delegation, full details must be forwarded to the ICB's Chief Finance and Compliance Officer. The ICB's Chief Finance and Compliance Officer will submit an appropriate recommendation to the Chief Executive for consideration.

f. If the recommendation is approved, the delegation will be amended to reflect that reduction, suspension or revocation.

3.11 Reviewing and Maintaining the Scheme of Delegations

a. This Scheme of Delegation may be amended from time to time to reflect changes in legislation, ICB policy or operational requirements.

b. The ICB will coordinate regular reviews of financial, procurement and contracts signing financial delegations for positions and limits. A revised version is submitted to the Senior Management Team (SMT) and Audit, Risk and Assurance Committee for endorsement before submitting it to the ICB Board for approval.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
1	**Bank Accounts** Maintenance and operation in accordance with banking mandates.	All banking must be managed in accordance with organisational Standing Financial Instructions (SFIs) and Standing Orders (SOs).
2	**ICB Budgets** All ICB staff have the responsibility of keeping expenditure to within agreed budgets. The following delegated authority to spend is only extended to where the approved budget is available: a) At individual budget level (Pay and non-Pay) b) At a service level c) For the totality of service covered by directorate d) For the totality of the budget delegated to Place e) The totality of the ICB budget **In the event of an urgent unpredicted need for expenditure which does not have allocated budget, no expenditure must be committed to without prior discussion with the Chief Finance and Compliance Officer or Chief Executive.** **Management of budgets – variations to agreed budgets:** a) Approving expenditure where there is a variation to budget, or in the tender price up to 10% or £100,000 whichever is the higher. b) Approving expenditure where there is a variation to budget or in the tender price greater than 10% or £100,000 and less than 20% or £250,000, whichever is the higher. c) Approving expenditure where there is a variation to budget or in the tender price greater than 20% or £250,000, whichever is the higher. **Budget Virements:** a) At individual budget level within a service up to £10,000 b) At individual budget level within a service over £10,000 and < £100,000	a) Budget Holders b) Head of Service/Departmental Manager c) Executive Director d) Place Executive Director e) Chief Executive a) Chief Finance and Compliance Officer or Chief Executive Officer b) Chief Finance and Compliance Officer and Chief Executive Officer c) ICB Board a) Budget Holders b) Executive Directors

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	c) Between services up to £500,000 d) Services greater than £500,000 Virements should not be used to create new budgets. Virements are not permitted between pay and non-pay budgets. The virement must be signed by both the budget holder from whom the budget is transferring and the budget holder to whom the budget is transferring.	c) Chief Finance and Compliance Officer or Chief Executive Officer d) ICB Board
3	**Business Case and Investment Approvals** Business cases for investments must be prepared for changes to services and/or expenditure including capital or revenue, procurement of services and pathway redesigns. Business cases seeking external funding must be approved by the relevant body prior to making the external request for funds. The following delegated authority is only extended to where the approved budget is available: Capital: a) Estimated cost up to £2.50m b) Estimated cost up to £5.00m c) Estimated cost up to £10.00m d) Estimated cost up to £24.99m e) Above £25.00m The ICB is required to have oversight of significant investment (no matter whether they are revenue or capital or a combination) made by partners in the system to ensure they align with the ICS and ICP strategy and provide value for money. These business cases typically relate to additional funds made available by NHSE for specific projects and the strategic investments as part of the system-wide capital plan. On agreeing they align to the system priorities, are affordable and value for money the ICB will be expected to write a letter of support for the scheme. Where the NHS makes allocations to individual organisations within the ICS/allocation values are updated in year e.g. pay awards. These would be excluded from requiring a business case.	a) Chief Finance and Compliance Officer b) Chief Executive Officer c) CFO and CEO/SMT d) SMT e) ICB Board

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	Prior to the ICB reviewing and agreeing its support to any cases it is expected these will have been through individual partner organisations governance (in line with their SFIs and Scheme of Delegation). The appropriate approval process for a business case is determined by the value of the business case. Business cases should follow national guidance in their construct: **Letters of Support** *a) Estimated cost up to £5m* *b) Estimated cost up to £10m* *c) Estimated cost up to £20m* *d) Estimated cost up to £50m* *e) Above £50m* Revenue: Annual values L1 - <£50k L2 - £50k-£250k L3 - £250k-£2.5m L4 - £2.5m - £10m L5 - £10m - £25m L6 - >£25m Where expenditure is not fully budgeted for, the capital limits will apply – for example the CFCO will have delegated authority up to £2.50m.	a) CFCO b) CFCO and CEO c) CFCO, CEO and SMT d) SMT and SCC e) SMT, SCC and ICB Board Decision Owner — Committee Involvement Budget Holder — None Director — Exec visibility Exec Director — SMT reporting SMT — Notify SCC SCC — SMT (prior to SCC) Board — Final Approval

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
4	**Capital Schemes** The financial limits for quotations, tendering and contract procedures are set out below in section 30 and apply to capital expenditure. In addition, the following delegations apply to capital schemes: a) Selection of architects, quantity surveyors, consultant engineer and other professional advisers within EU regulations b) Financial monitoring and reporting on all capital scheme expenditure c) Granting and termination of leases with annual rent <£100,000 d) Granting and termination of leases with annual rent >£100,000 The ICB capital plan is developed and then reviewed by Senior Management Team before being approved by the ICB Board prior to publication. ICB capital includes: a) Primary care improvement grants b) Primary care ICT grants c) Buildings and equipment d) Leases (under IFRS16) – including the authority to extend or exit tenancy agreements for ICB offices It excludes tenancy agreements and void costs that should be managed in line with non-pay revenue investments/spends unless specifically listed below: a) preparation and signature of all tenancy agreements/ licences b) Extensions to existing leases c) Letting of premises to/from outside organisations d) Approval of rent based on professional assessment ICB capital projects are subject to the DHSC and Cabinet office rules for approval as in the Procurement Section. Authority to approve capital expenditure in excess of the total capital budget	a) Chief Executive or Chief Finance and Compliance Officer on recommendation of estates director b) Chief Finance and Compliance Officer c) Chief Finance and Compliance Officer d) SMT a) Chief Finance and Compliance Officer b) Chief Finance and Compliance Officer c) Chief Finance and Compliance Officer and Chief Executive d) Chief Finance and Compliance Officer Approval of an increase in the total capital budget above the value signed off by ICB Board would breach CDEL and is not permitted.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	Charitable and Endowment Funds NHS Greenwich Charitable Fund Approval of Charity purpose, vision and strategic objectives Approval of annual charitable funds budget Approval of annual report and assuring compliance Day to day control and management of charitable fund Approval of grants: a) Up to £10k b) £10k to £200k c) £200k+	 NHS South East London ICB (SEL ICB) is the Corporate Trustee for NHS Greenwich Charitable Funds. SEL ICB Board Chief Finance and Compliance Officer Chief Finance and Compliance Officer Place Executive Lead (Greenwich) a) Associate Director of Finance (Greenwich & Lewisham) b) Place Executive Lead (Greenwich) c) Chief Finance and Compliance Officer (on recommendation from Charitable Funds Committee)
5	**Clinical Trials** Authorisation of Clinical Trials	 Chief Executive Officer and Medical Director.
6	**Discretionary Grants to Local Authorities and Voluntary Bodies** Discretionary grants to local authorities and voluntary bodies should only be awarded in exceptional circumstances. The expectation of the ICB is that all contractual commitments are made through the normal procurement process for contracts and in line with the approval limits set out in section 30 below.	 For all agreements to provide grants/ MOUs to third parties including local authorities and voluntary bodies: Chief Finance and Compliance officer or Chief Executive or Chief Commissioning Officer

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
7	**Commissioning Expenditure - purchase of Healthcare from all bodies** i) Service Level Agreements (SLAs) SLAs within the annual budget: a) Signing of annual local contracts/voluntary sector contracts and SLAs up to £5m b) Signing of annual local contracts/voluntary sector contracts and minor SLAs over £5m Authorisation of monthly invoices in excess of agreed SLA value. ii) Contract Exclusions (NHS and Non-NHS) Individual Funding Requests (IFRs) a) Approval of Requisitions in line with approved IFR b) Approval of Purchase Order iii) All other contract exclusions iv) For any other funded commissioning arrangements under this category not included above: Agreement of Named Placements (not Continuing Healthcare Placements) a) Up to £50,000 and within approved budget b) Above £50,000 or in excess of available resources **Continuing Healthcare Packages** To recognise the current differences between the processes in SEL ICB and SWL ICB, different authority limits shown below for each ICB:	a) Executive Director b) Chief Executive and Chief Finance and Compliance Officer Deputy Chief Executive/ Chief Finance and Compliance Officer and reported to SMT for information. a) IFR Lead after IFR panel approval of expenditure b) Procurement Operations Manager Executive Director Chief Finance and Compliance Officer, or Chief Executive Officer, or Chief Commissioning Officer a) Head of service b) Executive Director

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	SWL ICB Delegation for all placements, value relates to the period of award up to the next review point. a) Up to £1,500 per week or £75,000 per annum b) Up to £4,000 per week or £200,000 per annum c) Up to £10,000 per week or £500,000 per annum d) Above £10,000 or over £500,000 per annum SEL ICB a) Agreement of named placements up to £1,650 per week b) between £1,651 and £3,450 per week c) for values exceeding those above d) Signing of Contract for placements e) Approval of invoices within package contract value as per ISFE limits f) Authorisation of monthly invoices in excess of contract value **Joint commissioning with Local Authorities** Where services are being commissioned jointly with local authorities, delegated responsibility for the arrangements will by held by the Place Executive Leads, with assurance and co-ordination delivered by the Neighbourhood Delivery Committee.	a) Deputy director of CHC *b)* Operational Place lead *On recommendation of the Deputy Director of CHC* *c)* Chief Nursing and Quality Officer *On recommendation of the Operational Place lead* *d)* Senior Management Team *On recommendation of the Chief Nursing and Quality Officer* a) CHC teams within boroughs b) Head of service c) Executive Director d) Head of service up to value of £100,000 and Executive Director for over £100,000 e) As per ISFE limits set per user f) Executive Director Place Executive lead holds delegated responsibility, with assurance and oversight through Neighbourhood Delivery Committees.
8	**Complaints (Patients and Relatives)** a) Overall responsibility for ensuring that all complaints are dealt with effectively b) Responsibility for ensuring that complaints are investigated thoroughly c) Medico – Legal Complaints - Co-ordination of their management	a) Chief Executive b) Relevant Executive Director c) Director of Corporate Services

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
9	**Condemning & Disposal of capitalised equipment** Items obsolete, redundant, stolen, and irreparable or cannot be repaired cost effectively. *Note: these write-offs, once agreed, will impact on individual budgets – there is no central provision. A bad debt write-off for these purposes is the writing off of any income due to the ICB whether or not invoiced – it does not include adjustments relating to invoices raised in error.*	Approval for disposal to be made by two officers - the Chief Finance and Compliance Officer plus either the Chief Executive or Director of Corporate Services. All disposals to be reported to the next meeting of the Audit Risk and Assurance Committee.
10(a)	**Payments to Independent Contractors - GP contract payments including pensions SEL ICB ONLY** Notifying GP practices of approved annual allocation Approval of regular monthly instalments schedules of approved reimbursements: a) <£20,000,000 as per SE London schedule b) >£20,000,001 as per SE London schedule Further reimbursement of expenditure within approved allocation, including Out of Hours (OOH) Community Schemes and Local Incentive Schemes expenditure: a) Up to £10,000 b) £10,001 to £50,000 c) Over £50,000	Executive Director a) Head of service and Associate Director of Corporate Finance b) As above plus Director of Operational Finance a) Borough Head of Primary Care (or equivalent) b) Borough Director of Primary Care (or equivalent) c) Executive Director
10(b)	**Payments to Independent Contractors – Primary Care Dental, Ophthalmology and Community Pharmacy** Approval of regular monthly instalments schedules of approved reimbursements: a) less than £20,000,000 as per SE London schedule b) greater than £20,000,001 as per SE London schedule Approval of contract changes on dental system	a) Director or Chief Commissioning Officer and Associate Director of Corporate Finance b) Director or Executive Director and Director of Corporate Finance

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
		Director or Executive Director
11	**Medicines Optimisation** Authorisation of New Drugs: a) Estimated total yearly cost per drug of up to £25,000 per 100,000 population (£500,000 for South East London based on 2 million population) b) Estimated total yearly cost per drug above £25,000 per 100,000 population (£500,000 for South East London based on 2 million population)	a) Chief Pharmacist b) SCC on the recommendation of medicines optimisation team Where NICE guidance is not followed, this should be reported to the Board at the next opportunity.
12	**Legal matters** Engagement of legal advice **Where costs are estimated to exceed £100k, SMT to be alerted.** Legal settlements	Approval by an Executive Director and Director of Corporate Services. Chief Executive and Chief Finance and Compliance Officer approval
13	**Engagement of Agency Staff** All agency Costs of £600 or more per day (excluding VAT) or over 6 months in duration (regardless of cost) will require approval by NHSE via submission of a business case.	<u>For SEL ICB</u> Prior to engaging any agency/interim staff, staff must follow the Hiring of Interim Resources Policy and comply with the NHS England and ICB guidance. All requests for agency staff (regardless of the daily rate and length of contract) require the approval of the VR panel before any appointment can be made. Prior endorsement is required from finance and HR. **For booking of agency/interim staff and approval of invoices, within budget:** a) Up to £10,000 – budget holder b) £10,001 to £50,000 – head of service c) Over £50,000 – Executive director The sums above exclude VAT, agency fees and expenses. **For booking of Bank or Agency Staff – in excess of budget:**

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
		Employment of fixed term contractors is approved by Executive Director – following approval by the VR panel Fixed Term contractors should be considered where the requirement is time limited. In all cases HR advice should be taken prior to recruitment to understand any ICB liability that may be incurred at the end of the assignment. Approval is via the VR panel.
14	**Extended Role Activities** Approval of Nurses to undertake duties/procedures which can properly be described as beyond the normal scope of Nursing Practice.	Chief Nursing and Quality Officer
15	**Facilities for staff not employed by the ICB to gain practical experience** a) Professional Recognition, Honorary Contracts and other Memorandums of Understanding b) Non-Medical Work experience students	a) Chief Nurse or Medical Director (as appropriate) - HR to be advised b) An ICB Director - HR to be advised
16	**Review of fire precautions at ICB sites**	Director of Corporate Services in conjunction with local authority/landlord as appropriate
17	**Hospitality and Gifts** Responsibility for implementing arrangements to ensure Conflicts of Interest and Gifts and Hospitality policy is adhered to. Limits as determined in the ICBs Conflicts of Interest/ Standards of Business Conduct Policy.	Director of Corporate Services
18	**Arrangements for Internal and External Audit – including the implementation of Audit Recommendations**	All audit plans will be approved by the ICB's Audit, Risk and Assurance Committee on the recommendation of the Chief Finance and Compliance Officer or Director of Operational Finance.
19	**Approval of any proposed non-audit based professional services to be delivered by the ICB's external auditor**	Chief Finance and Compliance Officer AND the Chair of the Audit, Risk and Assurance Committee *Prior endorsement required by:* Senior Management Team Approval noted by the Audit, Risk and Assurance Committee

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
20	**Insurance Policies including NHSLA** Negotiation and agreement of premiums Ensuring the ICB has arrangements in place for the provision of adequate insurance cover for the ICB that are not indemnified through the NHS Resolution	 Director of Corporate Services Chief Executive and Chief Finance and Compliance Officer, via Director of Corporate Services
21	**Certification of invoices where no Purchase Order or contractual arrangement is in place** a) Up to £10,000 b) £10,001 to £50,000 c) £50,001 to £250,000 d) £250,001 to £1,000,000 e) £1,000,001 to £5,000,000 f) £5,000,001 to £10,000,000 g) Up to £500.0m h) Up to £1.0bn	 a) Budget managers at Bands 6 and 7 b) Budget managers at Band 8a and 8b c) Assistant/Associate Directors at Band 8c and 8d d) Directors at Band 9 e) ICB Operational Director of Finance f) Borough, Place Directors or equivalent (VSM) g) Deputy Chief Executive Officer h) Chief Executive Officer and Chief Finance and Compliance Officer
22	**Losses, Write-off & Compensation** a) Losses and Cash due to theft, fraud, overpayment etc. b) Fruitless Payments (including abandoned Capital Schemes) c) Claims Abandoned d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson) or other e) Compensation payments made under legal obligation f) Extra Contractual payments to contractors g) Ex-gratia Payments to Patients and staff for loss of personal effects h) Ex-gratia payments for Clinical negligence (negotiated settlements following legal advice) – up to £250,000 including claimant's legal costs i) Ex-gratia payments for personal injury claims involving negligence where legal advice obtained and followed j) Other ex-gratia payments except cases of maladministration where there is no financial loss by claimant - up to £50,000 k) Write back of Non-NHS Debtors < £250,000 l) Write back of Non-NHS Debtors > £250,000	 a) Chief Finance and Compliance Officer b) Chief Finance and Compliance Officer c) Chief Finance and Compliance Officer d) Chief Finance and Compliance Officer e) Chief Finance and Compliance Officer and Chief Executive f) Chief Finance and Compliance Officer g) Chief Finance and Compliance Officer h) Chief Finance and Compliance Officer i) Chief Finance and Compliance Officer j) Chief Finance and Compliance Officer k) Chief Finance and Compliance Officer l) Audit, Risk and Assurance Committee
23	**Maintenance & Update of ICB Financial Procedures**	Chief Finance and Compliance Officer

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
24	**Management Consultants** All contracts for management consultants will require agreement in line with any ICB process and reporting to NHS England in addition to the process below. All contracts for management consultants over £50,000 require a business case to be submitted to NHS England for approval prior to any appointment being made. All requests for management consultancy must be assessed as being consistent with IR35 compliance before any appointment can be made. a) Obtaining at least 3 quotations / carrying out competitive interviews, **within budget**, where aggregate commitment in any one year or total commitment is to £24,999. b) Obtaining at least 3 competitive tenders / quotes or undertaking competitive interviews **within budget**, where aggregate commitment in any one year is £25,000 or more c) Authorising contracts of engagement following the above. d) Authorisation of consultants **in excess of budget.**	a) Executive Director b) Executive Director c) Executive Director d) Chief Finance and Compliance Officer or Chief Executive
25	**Personnel & Pay** This is subject to compliance with all ICB recruitment processes, e.g. submission to VR/recruitment panel. a) Authority to fill funded post on the establishment with permanent staff b) Authority to appoint staff to post not on the agreed establishment c) All requests for upgrading/re-grading to be dealt with in accordance with ICB procedures and recruitment panel approval.	a) Pre-approval by Director, Finance lead and HR. Once confirmation/approval received from VR panel/RSC, JD and advert to be sent to the Resources team by recruiting manager. HR to be informed. b) As above for a). Chief Executive approval will be required should there be no recruitment panel in place. c) Once approval received, finance department and workforce department to be informed of outcome for budgetary and ESR purposes.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	d) Approval of the extension of staff on fixed term contracts within budget.	d) Fixed term contracts should only be extended in specific circumstances. In all cases this should be discussed with HR and the relevant financial officer prior to submission of a request to the VR/recruitment panel.
	e) Pay i) Staff appointments – Executive directors and other directors referenced on the ICB Board ii) Approval of remuneration arrangements (including additional allowances above basic salary) – all staff levels excluding Executive Directors and Directors referenced in the Board iii) Approval of remuneration arrangements for Executive Directors and other Directors referenced on the ICB Board iv) Authority to complete standing data forms affecting pay, new starters, variations and leavers v) Authority to authorise overtime/flexible working vi) Authority to authorise travel & Subsistence expenses on Workforce vii) Approval of staff timesheets – both substantive and temporary staff	e) i) Chief Executive and Chair ii) Human Resources and finance leads and relevant executive director iii) Remuneration Committee iv) Budget holder and Associate Director of Corporate Finance. HR to be informed. All staff change forms must be approved by a Director and either the Chief Financial Officer or Director of Corporate Finance. v) Line Manager (with guidance from a Director) vi) Line Manager vii) Line Manager
	f) Leave i) Approval of Annual Leave ii) Approval to carry forward annual leave iii) Payment of Annual Leave in exceptional circumstances iv) Special leave for bereavement up to 5 days v) Extended Special Leave for bereavement vi) Special leave arrangements • carers leave - up to 3 days in any six-month period • carers leave - up to 5 days in any six-month period vii) Leave without pay viii) Time off in lieu ix) Maternity and Paternity Leave – paid and unpaid	f) i) Line Manager ii) Annual leave carry over will be approved in line with the annual leave policy for each respective ICB. iii) Chief Executive iv) Head of Service v) Executive Director vi) • Head of Service. HR to be informed • Executive Director. HR to be informed vii) Executive Director viii) Line manager ix) Automatic approval as per guidance and ICB Policy; HR to be informed.
	g) Sick Leave (in exceptional circumstances) i) Extension of sick leave – in line with contract of employment ii) Extension of sick leave – any non-contractual payments iii) Return to work part-time on full pay to assist recovery	g) i) To seek advice from the Director of HR before any extension is agreed ii) Remuneration Committee iii) Executive Director with advice with advice from occupational health and HR.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	h) Study Leave i) Study leave outside the UK ii) All other study leave (UK) i) Removal Expenses, Excess Rent and House Purchase (to be agreed prior to advertising posts). Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview): i) Up to £2,000 ii) Over £2,000 j) Grievance Procedure All grievance cases must be dealt with strictly in accordance with the applicable ICB Grievance Procedure and the advice of HR k) Authorised Car & Mobile Phone Users i) Requests for new posts to be authorised as car users ii) Requests for new posts to be authorised as mobile telephone users l) Redundancy Authorisation to agree voluntary redundancy and determine compulsory redundancies in accordance with policy m) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health. n) Employment of voluntary workers / work experience. o) Approval of expense claim within assigned delegation limit (refer schedule 1) and claim is allowable per the NHS Terms and Conditions of Service handbook p) Approval of expense claim above assigned delegation limit (refer schedule 1) and claim is allowable per the NHS Terms and Conditions of Service handbook	h) i) Chief Executive in line with ICB training policy ii) Executive Director in line with ICB training policy i) Executive Director, and notification to HR ii) Chief Executive and notification to HR As per applicable (i.e. SEL or SWL) ICB procedure k) i) As per applicable ICB policy ii) As per applicable ICB policy l) Remuneration Committee with support from HR and appropriate permission/approvals from NHS England. Chief Finance and Compliance Officer to be consulted at all times. m) Chief Executive or Executive Director following advice from HR **and** occupational health. n) An ICB Director with advice from HR o) Employees line manager p) Executive Director
26	**Petty Cash Disbursements**	The ICB has no petty cash function.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
27	**Quotation, Tendering & Contract Procedures** For Health Care services of any Contract Value, The Health Care Services (Provider Selection Regime) Regulations 2023 (PSR) and supporting Statutory Guidance, must be followed. PSR Provider Representations: Decisions following escalation of Representations made against a Provider Selection Regime decision, to the NHSE Independent Patient Choice and Procurement Panel PSR Urgent Awards or Urgent Contract Modifications: Where: a) a new service needs to be arranged rapidly in an unforeseen emergency or local, regional or national crisis, e.g., to deal with a pandemic. b) urgent quality/safety concerns pose risks to patients or the public and necessitate rapid changes. c) an existing provider is suddenly unable to provide services under an existing contract (for example, a provider becomes insolvent or experiences a sudden lack of critical workforce) and a new provider needs to be found. An urgent award or modification must only be made when all the below apply: a) the award or modification must be made urgently the reason for the urgency was not foreseeable by and is not attributable to the relevant authority. b) delaying the award of the contract to conduct a full application of the regime would be likely to pose a risk to patient or public safety. Urgent Awards or Urgent Contract Modifications must not be used if the urgency is attributable to the ICB not leaving sufficient time to make procurement	SMT Approved by the Chief Finance and Compliance Officer (up to £100,000) and Chief Finance and Compliance Officer and Chief Executive (£100,000 and over); reported to the Audit, Risk and Assurance Committee. Where the Chief Executive is requesting an Urgent Award or Urgent Contract Modification, approval is by the Chair and the Chief Finance and Compliance Officer.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	decisions and run a provider selection process– poor planning is not an acceptable reason to use these provisions. With the exception of Section (i) below, relating to Contract Variations, the remainder of this section (30) only applies to non-healthcare services. For non-health care services the following applies: This section does not apply to Management Consultants (see section 26) (or other services included elsewhere within this schedule) a) Goods/services up to £24,999 - (Minimum of 1 written quote required) b) Goods/services from £25,000 - £75,000 (Minimum of 3 written quotations required) c) Goods/services from £75,000 - £100,000 (Minimum of 3 competitive tenders required) d) Goods/services from £100,000 - £200,000 (Minimum of 3 competitive tenders required) e) Goods/services over £200,000 - (Minimum of 4 competitive tenders required) f) Waiving of quotations and tenders subject to Standing Financial Instructions g) Opening Tenders and Quotations h) Authorisation of payments to public partnership schemes under existing contracts i) Contract variations i) Variation of +/- 20% of contract value and less than £100,000 ii) Variation of over 20% of contract value and/or more than £100,000 Exceptions and instances where formal tendering/quotes need not be applied: Where: a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £24,999 or	a) Head of Service b) Associate Director or Director c) Executive Director d) Chief Finance and Compliance Officer e) Chief Executive f) Approved by the Chief Finance and Compliance Officer (up to £100,000) and Chief Finance and Compliance Officer and Chief Executive (£100,000 and over); reported to the Audit, Risk and Assurance Committee. Where the Chief Executive is requesting the tender waiver, approval is by the Chair and the Chief Finance and Compliance Officer. g) Two senior officers/managers designated by the CEO/CFCO and not from the originating department. h) Chief Finance and Compliance Officer i) Executive Director ii) Chief Finance and Compliance Officer

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with. Formal tendering procedures may be waived by the Chief Executive and Chief Financial Officer in the following circumstances: c) in very exceptional circumstances where formal tendering/quoting procedures would not be practicable or the estimated expenditure would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate record; d) where the requirement is covered by an existing contract; e) where PASA agreements or Public Sector Framework Agreements are in place; f) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members; g) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender; h) where specialist expertise is required and is available from only one source; i) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; j) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; k) for the provision of legal advice and services providing that any legal firm or partnership commissioned is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Executive, Chief Financial Officer, Chief of Staff will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work. l) where allowed and provided for in the Capital Investment Manual.	

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure, except in exceptional circumstances. The Chief Executive & Chief Financial Officer will abide by the anti-bribery policy for the ICB at all times when approving tender waivers. Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and reported to the Audit Committee. **Selection of preferred tenderer(s)/compliant direct contract award under either the *Public Procurement Regulations 2015* or the *Provider lection Regime Regulations 2023*** This delegation has application when a formal competitive tender process is conducted. At the conclusion of the tender evaluation stage, the evaluation team will make a decision on the award of contracts and will prepare a recommendation report that recommends the preferred tenderer(s). The report will detail the factors (including price, quality, and timing) that define the tender that provides the best overall value for money, and provide a comparison with the details of the nearest competing bids, where appropriate, with reasons for their rejection. The Delegated Officers have authority to approve the recommendation report. Following approval award, post-tender negotiations can be initiated with the successful tenderer to improve the successful offer, where appropriate, and the formal contract should be prepared. Where a purchase exceeds the limit set in the Public Contracts Regulations 2015, but only a single provider is identified having advertised our requirements, approval must be sought from the Chief Finance and Compliance Officer together with one other executive prior to award of the contract.	

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	Capital <u>Revenue</u> Up to £2,500,000 (if within delegated budget) Over £2,500,000 to £5,000,000 (if within delegated budget) Over £5,000,000 up to £25,000,000 Over £25,000,000 <u>Authority to approve acceptance of late tenders</u> Tender received within two hours after the specified tender closing time Tender received more than two hours after the specified tender closing time **Commercial contracts**	 Chief Finance and Compliance Officer Contract and Procurement group *Prior endorsement required by* Place, Primary Care Executive or Department as appropriate Senior Management Team Prior endorsement required by: Contract and Procurement group Place, Primary Care Executive or Department as appropriate Strategic Commissioning Committee *Prior endorsement required by:* Senior Management Team, Contract and Procurement group Place, Primary Care Executive or Department as appropriate ICB Board *Prior endorsement required by:* Contract and Procurement group, Senior Management Team AND Strategic Commissioning Committee Place, Primary Care Executive or Department as appropriate Executive director or manager Chief Finance and Compliance Officer

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	A commercial contract could take the form of a deed, contract, agreement, release, discharge, indemnity, guarantee, consent, instrument, and any other documents which binds the ICB legally to another party by imposing an obligation on each party a) Less than £2,500,000 b) Over £2,500,000 up to £7,500,000 *c)* Over £7,500,000 and Better Care Fund investment/ Section 75 agreement	a) Chief Executive OR Chief Finance and Compliance Officer OR Chief Commissioning Officer *Prior approval required by:* Contracting and Procurement Group b) Chief Executive OR Chief Finance and Compliance Officer OR Chief Commissioning Officer *Prior approval required by:* Contracting and Procurement Group c) ICB Chair or Chief Executive or Chief Finance and Compliance Officer or Chief Commissioning Officer *Prior approval required by:* Strategic Commissioning Committee
28	**Research Projects** Authorisation of Research Projects	SMT in conjunction with the Chief Nursing and Quality Officer
29	**Register of Interests** The keeping of a Declaration of Interests Register	Director of Corporate Services.
30	**Commercial Sponsorship** Sponsorship of events, including courses, conferences and meetings by external bodies should only be approved if it can be demonstrated that the event will result in clear benefits for SEL ICB and the wider NHS.	Approval by the Chief Executive or Chair only and entry in declarations of interest register required.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
31	**Extension of Contract** Where an extension to an existing contract (both NHS and non-NHS) is required and is **allowable in the contract and is within budget**, details should be provided of the term of extension and the monetary value of the extension. Before any contract extension is agreed, a review will be required that demonstrates positive assurance in respect of value for money, performance and quality. Set up of new suppliers	Approval of the contract extension (including the review of the contract) is as per the delegated limits as set out in section 8 above. There is no automatic delegated approval for contracts to be extended. Instead, a contract tender waiver (for non-healthcare services) or Urgent Award/Urgent Contract Modification (for healthcare services) would need to be produced and approved in accordance with the limits set out in section 30 above. Requests need to be submitted to the Financial Controller, with supporting evidence. Once approved the request will be forwarded to the national SBS team for actioning.
32	**Raising of sales orders** Authorisation of sales orders for goods or services provided by the ICB: a) Up to £10,000 (credit memo up to £10,000) b) £10,001 to £100,000 (credit memo £10,001 up to £50,000) c) £100,001 to £250,000 (credit memo £50,001 to £250,000) d) £250,001 to £500,000 (credit memo £250,001 to £1,000,000) e) £500,001 to £1,000,000 f) £1,000,001 to £2,500,000 (credit memo up to £5,000,000) g) £500,001 to £2,500,000 (credit memo up to £10,000,000) h) Up to £5,000,000 (credit memo up to £500.0m) i) Up to £1.0bn (credit memo up to £1.0bn) j) No delegated financial responsibility	a) Budget managers at Bands 6 and 7 b) Budget managers at Band 8a and 8b c) Assistant/Associate Directors at Band 8c and 8d d) Directors at Band 9 e) ICB Finance Directors f) ICB Finance Directors g) Borough Directors or equivalent (VSM) h) Deputy Chief Executive i) Chief Executive and Chief Finance and Compliance Officer j) System Administration
33	**Sealing of Documents**	Two of the following are required to seal documents: Chief Executive Officer Chief Finance and Compliance Officer Chief Medical Officer Chief Nursing Officer

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
34	**Disposal of Records** Physical records, either on site or held in archive by a third party, should be disposed of in accordance with the ICBs approval Records Retention Schedule.	Director of Corporate Services
35	**Authority to sign non legally binding administrative arrangements** *This delegation has application when the ICB is entering into non-legally binding administrative arrangement with one or more other parties. The non-legally binding administrative arrangements could relate to one of the following:* • *Memoranda of Understanding (either intra-ICB, with other NHS organisations, or with a commercial third party)* • *Service level agreements (intra/Inter ICB, other NHS Organisations)* • *Operating level agreements (intra/Inter ICB, other NHS Organisations)*	Chief Executive or Chief Finance and Compliance Officer or Chief Commissioning Officer

Section C:

Delegation levels

Revenue

Level	Value	Decision Owner	Committee Involvement
L1	<£50k	Budget Holder	None
L2	£50k-£250k	Director	Exec visibility
L3	£250k-£2.5m	Exec Director	SMT reporting
L4	£2.5m-£10m	SMT	Notify SCC
L5	£10m-£25m	SCC	SMT prior review and recommendation
L6	>£25m	Board	Final Approval

Capital

Value	
<£2.5m	Chief Finance and Compliance Officer
£2.5m - £5m	CEO
£5m - £10m	CFCO and CEO / SMT
£10m - £25m	SMT
>£25m	Board

NHS South West London
Integrated Care Board

Standing Financial Instructions

Standing Financial Instructions

Document Control

Status:	Final
Version:	3.0
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Applies To:	All individuals working for, or on behalf of SWL ICB.

Brief Description:

SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services

Contents

Controlled Document

The current version of this document is available electronically on the intranet and/or website. All other electronic or paper versions of this document sourced from any network drive, email or other sources are uncontrolled and should be checked against the current intranet/website version prior to use.

1. Purpose and statutory framework

1.1. These Standing Financial Instructions (SFIs) shall have effect as if incorporated into the Integrated Care Board's (ICB) constitution. In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022, the ICB must publish its constitution.

1.2. In accordance with the Act, as amended, NHS England is mandated to publish guidance for ICBs, to which each ICB must have regard, in order to discharge their duties.

1.3. The purpose of this governance document is to ensure that the ICB fulfils its statutory duty to carry out its functions effectively, efficiently and economically. The SFIs are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.

1.4. SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.

1.5. The ICB is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.

1.6. Each ICB is to be established by order made by NHS England for an area within England, the order establishing an ICB makes provision for the constitution of the ICB.

1.7. All members of the ICB (its board) and all other staff should be aware of the existence of these documents and be familiar with their detailed provisions. The ICB SFIs will be made available to all staff on the intranet and website for each statutory body.

1.8. Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Chief Executive or the Chief Finance and Compliance Officer must be sought before acting.

1.9. Failure to comply with the SFIs may result in disciplinary action in accordance with the ICBs applicable disciplinary policy and procedure in operation at that time. Where failure to comply constitutes a criminal offence this may lead to a criminal investigation and the consideration of criminal sanctions.

2. Scope

2.1. All members of staff and officers of the ICB, without exception, are within the scope of the SFIs without limitation. The term ‘staff’ includes, permanent and fixed term employees, secondees and contract workers. The term ‘officer’ includes any individual that is appointed to represent South West London ICB.

2.2. Within this document, words imparting any gender include any other gender. Words in the singular include the plural and words in the plural include the singular.

2.3. Any reference to an enactment is a reference to that enactment as amended.

2.4. Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

3. Roles and responsibilities

3.1. Staff

All ICB Officers are severally and collectively, responsible to their respective employer(s) for:

- abiding by all conditions of any delegated authority;
- the security of the statutory organisation's property and avoiding all forms of loss;
- ensuring integrity, accuracy, probity and value for money in the use of resources; and
- conforming to the requirements of these SFIs.

3.2. Chief Executive Officer

The ICB constitution provides for the appointment of the Chief Executive. The Chief Executive is the Accountable Officer for the ICB and is personally accountable to NHS England for the stewardship of ICB's allocated resources.

The Chief Finance and Compliance Officer reports directly to the ICB Chief Executive and is professionally accountable to the NHS England regional Finance Director.

The Chief Executive will delegate to the Chief Finance and Compliance Officer the following responsibilities in relation to the ICB:

- preparation and audit of annual accounts;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners;
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
- meeting statutory requirements relating to taxation;
- ensuring that there are suitable financial systems in place (see Section 6)
- meets the financial targets set for it by NHS England;
- use of incidental powers such as management of ICB assets, entering commercial agreements;
- ensuring the Governance Statement and Annual Accounts & Reports are signed;
- ensuring planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the Board in achieving ICB objectives, including consideration of place-based budgets;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- Executive Members (Partner Members and Non-Executive Members) and other members of staff are notified of and understand their responsibilities within the SFIs;
- specific responsibilities and delegation of authority to specific job titles are confirmed;
- financial leadership and financial performance of the ICB;
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and
- the Chief Finance and Compliance Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

3.3. Audit, Risk and Assurance Committee

The Board and Chief Executive Officer should be supported by an Audit, Risk and Assurance Committee, which should provide proactive support to the Board in advising on:

- the management of key risks;
- the strategic processes for risk;
- the operation of internal controls;
- control and governance and the governance statement;
- the accounting policies, the accounts, and the annual report of the ICB;
- the process for reviewing of the accounts, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.
- Seeking assurance that the ICB has adequate arrangements in place for countering fraud and bribery, and compliance with NHS Counter Fraud Authority (NHS CFA) requirements. This will include but is not limited to reports from the Local Counter Fraud Specialist (LCFS), the annual self-assessment submission to NHS CFA Counter Fraud Functional Standard Return, NHS CFA inspection reports and actions resulting from counter fraud activity including NHS CFA quality assessment reports will be monitored.
- The Audit, Risk and Assurance Committee is also responsible for approving the annual counter fraud work plan and the outcomes of all anti-fraud and bribery work within the ICB. The ICB will be liable to prosecution if a person associated with it bribes another person intending to obtain or retain business or an advantage in the conduct of business for the ICB, unless it can show that despite a particular case of bribery it nevertheless had adequate procedures in place to prevent persons associated with it from bribing.

4. Management accounting and business management

4.1. The Chief Finance and Compliance Officer is responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB.

4.2. The Chief Finance and Compliance Officer will delegate the budgetary control responsibilities to budget holders through a formal documented process.

4.3. The Chief Finance and Compliance Officer will ensure:

- the promotion of compliance to the SFIs through an assurance certification process;
- the promotion of long-term financial heath for the NHS system;
- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;
- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;
- that the budget holders are supported in proportion to the operational risk; and
- the implementation of financial and resources plans that support the NHS 10 year and London Health plan objectives.

4.4. In addition, the Chief Finance and Compliance Officer should have financial leadership responsibility for the following statutory duties:

- the duty of the ICB to perform its functions as to ensure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and
- the duty of the ICB, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for the ICB and its partner trusts.

4.5 The Chief Finance and Compliance Officer and any senior member of staff responsible for finance within the ICB should also promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

5. Income, banking statement and debt recovery

5.1. Income

An ICB has power to do anything specified in section 7(2) of the Health and Medicines Act 1988 for the purpose of making additional income available for improving the health service.

The Chief Finance and Compliance Officer is responsible for:

- ensuring order to cash practices are designed and operated to support, efficient, accurate and timely invoicing and receipting of cash. The processes and procedures should be standardised and harmonised across the NHS System by working cooperatively with any Shared Services provider; and
- ensuring the debt management strategy reflects the debt management objectives of the ICB and the prevailing risks.

5.2. Banking

The Chief Finance and Compliance Officer is responsible for ensuring the ICB complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes.

The Chief Finance and Compliance Officer will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and;
- the ICB has effective cash management policies and procedures in place.

5.3. Debt Management

The Chief Finance and Compliance Officer is responsible for the ICB debt management strategy.

This includes:

- a debt management strategy that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;
- ensuring the debt management strategy covers a minimum period of 3 years and must be reviewed and endorsed by the Audit, Risk and Assurance Committee on behalf of the ICB Board every 12 months to ensure relevance and provide assurance;
- accountability to the ICB Board that debt is being managed effectively;
- accountabilities and responsibilities are defined with regards to debt management to budget holders; and
- responsibility to appoint a senior member of staff responsible for day-to-day management of debt.

6. Financial systems and processes

6.1. Provision of financial systems

The Chief Finance and Compliance Officer is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.

The systems and processes will ensure, inter alia, that payment for goods and services is made in accordance with the provisions of these SFIs, related procurement guidance and prompt payment practice.

As part of the contractual arrangements for ICBs, members of staff will be granted access where appropriate to the Integrated Single Financial Environment ("ISFE2"). This is the required accounting system for use by ICBs, Access is based on single access log on to enable users to perform core accounting functions such as to transacting and coding of expenditure/income in fulfilment of their roles.

The Chief Finance and Compliance Officer will, in relation to financial systems:

- promote awareness and understanding of financial systems, value for money and commercial issues;
- ensure that transacting is carried out efficiently in line with current best practice – e.g., e-invoicing;
- ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;
- ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB;
- ensure that risk is appropriately managed;
- ensure identification of the duties of staff dealing with financial transactions and division of responsibilities of those staff;
- ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB;
- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and
- where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance and Compliance Officer shall periodically seek assurances that adequate controls are in operation.

7. Procurement and purchasing

7.1. Principles

- The Chief Finance and Compliance Officer will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.

- The ICB must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR) and Healthcare Services Provider Selection Regime Regulations 2023 (PSR) as well as any other associated statutory requirements whilst securing value for money and sustainability.

- The ICB must consider, as appropriate, any applicable NHS England guidance that does not conflict with the above.

- The ICB must have a Procurement Policy which sets out all of the legislative requirements.

- All revenue and non-pay expenditure must be approved, in accordance with the Scheme of Reservation and Delegation, prior to an agreement being made with a third party that enters a commitment to future expenditure.

- All members of staff must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB Standards of Business Conduct Policy.

- Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.

- Undertake any contract variations or extensions in accordance with PCR 2015/ PSR 2023 and the ICB Procurement Policy.

- Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the Audit, Risk and Assurance Committee.

8. Staff costs and staff related non-pay expenditure

8.1. Chief People Officer

The Chief People Officer [CPO] (or equivalent people role in the ICB) will lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

Operationally the CPO will be responsible for:

- defining and delivering the organisation's overall human resources strategy and objectives; and
- overseeing delivery of human resource services to ICB employees.

The CPO will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments.

Where a third-party payroll provider is engaged, the CPO shall closely manage this supplier through effective contract management.

The CPO is responsible for management and governance frameworks that support the ICB employees' life cycle.

9. Annual reporting and Accounts

9.1. The Chief Finance and Compliance Officer will ensure, on behalf of the Chief Executive Officer and ICB Board, that:

- the ICB is in a position to produce its required monthly reporting, annual report, and accounts; and
- the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year.

An annual report must, in particular, explain how the ICB has:

- discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
- review the extent to which the Board has exercised its functions in accordance with its published forward plans and capital resource use plan; and
- review any steps that the Board has taken to implement any joint local health and wellbeing strategy.

NHS England may give directions to the ICB as to the form and content of an annual report.

The ICB must give a copy of its annual report to NHS England by the date specified by NHS England in a direction and publish the report.

9.2. Internal Audit

The Chief Executive, as the Accountable Officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the Chief Finance and Compliance Officer to ensure that:

- all internal audit services provided under arrangements proposed by the Chief Finance and Compliance Officer are approved by the Audit, Risk and Assurance Committee, on behalf of the ICB Board;
- the ICB must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS);
- the ICB internal audit charter and annual audit plan, must be endorsed by the ICB Accountable Officer, Audit, Risk and Assurance Committee on behalf of the Board;
- the Head of Internal Audit must provide an annual opinion on the overall adequacy and effectiveness of the ICB Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;
- the Head of Internal Audit should attend Audit, Risk and Assurance Committee meetings and have a right of access to all Audit, Risk and Assurance Committee members, the Chair and Chief Executive of the ICB.
- the appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.
- should any suspicion of fraud, bribery or corruption be identified by Internal Audit, these must be referred to the LCFS immediately.

9.3. External Audit

The Chief Finance and Compliance Officer is responsible for:

- liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements;
- ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years; and
- ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner.
- should any suspicion of fraud, bribery or corruption be identified by External Audit, these must be referred to the LCFS immediately.

10. Losses and Special Payments

10.1. HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

10.2. The Chief Finance and Compliance Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

10.3. NHS England has the statutory power to require an ICB to provide NHS England with information. The information, is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHS England may require.

10.4. ICBs will work with NHS England teams to ensure there is assurance over all exit packages which may include special severance payments. ICBs have no delegated authority for special severance payments and will refer to the guidance on that to obtain the approval of such payments.

10.5. All losses and special payments (including special severance payments) must be reported to the ICB Audit, Risk and Assurance Committee.

10.6. For detailed operational guidance on losses and special payments, please refer to the ICB losses and special payment guide which includes delegated limits at Appendix One.

11. Fraud, bribery and corruption (Economic crime)

11.1. The ICB is committed to identifying, investigating and preventing economic crime.

11.2. The ICB Chief Finance and Compliance Officer is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the Board and Audit, Risk and Assurance Committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the Board.

11.3. The ICB Chief Finance and Compliance Officer should provide clear and demonstrable support and strategic direction for counter fraud, bribery and corruption work, and review the proactive management, control and the evaluation of counter fraud, bribery and corruption work.

11.4. The ICB has an Anti-Fraud and Bribery Policy in place, agreed by the Audit, Risk and Assurance Committee. The ICB is required to complete an annual Counter Fraud Functional Standard Return (CFFSR), a self-review tool developed by the NHS CFA, to measure the effectiveness of counter fraud processes and demonstrate the level of compliance with the Government Functional Standard for Counter Fraud - www.gov.uk/government/publications/government-functional-standard-govs-013-counter-fraud, as issued by NHS CFA and any guidance issued by NHS England.. The ICB will ensure that policies and procedures for all work related to fraud and bribery are implemented. The ICB will consider the major findings of investigations and proactive work and respond accordingly.

11.5. The LCFS will provide written reports to the Audit, Risk and Assurance Committee on counter fraud work within the ICB.

11.6. Further information on fraud, bribery and corruption can be found in the ICB's Anti-Fraud and Bribery Policy.

12. Capital Investments & security of assets and Grants

12.1. The Chief Finance and Compliance Officer is responsible for:

- ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts, and NHS foundation trusts prepare a plan setting out their planned capital resource use;
- ensuring that the ICB in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHS England;
- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost;
- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and
- for every capital expenditure proposal, the Chief Finance and Compliance Officer is responsible for ensuring there are processes in place to ensure that a business case is produced.

12.2. Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

- authority to spend capital or make a capital grant;
- authority to enter into leasing arrangements.

12.3. Advice should be sought from the Chief Finance and Compliance Officer or nominated member of staff if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

12.4. For operational purposes, the ICB shall have nominated senior staff accountable for ICB property assets and for managing property.

12.5. ICBs shall have a defined and established property governance and management framework, which should:

- ensure the ICB asset portfolio supports its business objectives; and
- comply with NHS England policies and directives and with this standard.

12.6. Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money.

12.7. Grants

The Chief Finance and Compliance Officer is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to:

- any of its partner NHS trusts or NHS foundation trusts; and
- to a voluntary organisation, by way of a grant or loan.

12.8. All revenue grant applications should be regarded as competed as a default position unless there are justifiable reasons why the classification should be amended to non- competed.

13. Legal and insurance

13.1. This section applies to any legal cases threatened or instituted by or against the ICB. The ICB should have policies and procedures detailing:

- engagement of solicitors / legal advisors;
- approval and signing of documents which will be necessary in legal proceedings; and
- members of staff who can commit or spend ICB revenue resources in relation to settling legal matters.

13.2. ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the Accountable Officer.

14. Review

14.1. To ensure that these SFIs remain up-to-date and relevant, the Chief Finance and Compliance Officer will review them at least annually. Following consultation with the Chief Executive for the ICB and scrutiny by the ICB's Audit, Risk and Assurance Committee, the Chief Finance and Compliance Officer will recommend amendments, as fitting, to the ICB Board for approval.

15. Appendix One – ICB Losses and Special Payment Guide

ICB Losses and Special Payment Guidance

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Losses and Special Payments Guidance

Version number: 1.0

First published: XX-XX-2021
Next review date: 30/05/2024
Prepared by Brian Siyolwe
Document Owner; David Procter

OFFICIAL

1 Contents

Introduction and guidance statement

1.1.1 The Losses and Special Payments guidance is prepared as procedural guidance for Integrated Care Boards (ICBs).

1.1.2 The purpose of this document is to establish best practice that can be incorporated into the ICBs Standing Financial Instructions.

1.1.3 It should be noted that the user of this procedural guidance should be compliant with the respective ICB SFIs. If there is a need to interpret or difficulty in application of this guidance, please send an email to the NHS England, head of assurance and counter fraud: england.assurance@nhs.net.

1.1.4 HM Treasury retains the authority to approve losses and special payments which are classified as being either:

- novel or contentious;
- contains lesson that could be of interest to the wider community;
- involves important questions of principle;
- might create a precedent; and/or
- highlights the ineffectiveness of the existing control systems.

1.1.5 Therefore, HMT Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

1.1.6 Losses and special payments are therefore subject to special control procedures compared to the generality of payments, and special notation in the accounts to bring them to the attention of parliament. The annual accounts reporting requirements are detailed herein.

1.1.7 For the avoidance of doubt, all cases relating to ICB losses and special payments must be submitted to NHS England for approval if the proposed transaction values exceed the delegated limits that are detailed below or satisfy the conditions in section 1.1.4:

Expenditure type	Delegated limit
All losses	up to £300k
Special Payments including Extra-Contractual/ Statutory/ regulatory/ compensation & Ex gratia	up to £95k
Special severance & Retention payments	£0
Consolatory payments	£500

1.1.8 Losses and/or special payments that indicate or give rise to suspicion of fraud or corruption, please follow the guidance as provided by your LCFS.

1.1.9 In dealing with individual cases, ICBs must consider the soundness of their internal control systems, the efficiency with which they have been operated, and take any necessary steps to put failings right.

1.1.10 The outcome of the review of the case under consideration (1.1.9) must be clearly indicated when submitting cases to NHS England as part of the account's consolidation process at yearend or as part of the approval process.

Scope

2.1.1 This procedural document is applicable to the following NHS bodies;

Integrated Care Boards

Definitions

3.1.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this document will have the same meaning as set out in HMT managing public money.

3.2 Losses

3.2.1 A loss refers to any case where full value has not been obtained for money spent or committed.

3.2.2 Examples of types of losses which cannot be treated as business as usual are cash losses, bookkeeping losses, fruitless payments and claims waived or abandoned.

3.3 Special Payment

3.3.1 Special Payments relate to the following;

- any compensation payments;
- extra-contractual or ex-gratia payments; and
- any payment made without specific identifiable legal power in accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022.

3.4 Special Severance and retention payments

3.4.1 ICBs have not been delegated a limit to approve the special severance or retention payments. For detailed guidance, please refer to the special severance payments document as published on the NHSEI SharePoint finance library.

3.4.2 For clarity, any non-contractual special severance payments that are being considered for approval must be submitted to NHS England HR regional advisory teams prior to settlement.

3.4.3 The table below lists all the various expenditure classifications for losses and special payments and the applicable approvals if the final settlement sum exceeds the ICB delegated limit:

Category	Classification	Approval required from	Further approvals	Description of category
Fruitless Payment	Loss	Payment Type	Classification	Value exceeds delegated limit
Bookkeeping Losses	Loss	Assurance team	NHSE/ DHSC/ HMT	Bookkeeping losses (un-vouched or incompletely vouched payments) including missing items or inexplicable or erroneous debit balances
Constructive loss	Loss	Assurance team	NHSE/ DHSC/ HMT	A constructive loss is a similar form of payment to stores losses and fruitless payments, but one where procurement action itself caused the loss. For example, stores or services might be correctly ordered, delivered or provided, then paid for as correct; but later, perhaps because of a change of policy, they might prove not to be needed or to be less useful than when the order was placed
Administrative costs	Loss	Assurance team	NHSE/ DHSC/HMT	An expense incurred in controlling and directing an organisation,
Claims Waived or Abandoned	Loss	Assurance team	NHSE/ DHSC/ HMT	Losses may arise if claims are waived or abandoned because, though properly made, it is decided not to present or pursue them
Extra- contractual payments	Special Payment	Assurance team	NHSE/ DHSC/ HMT	Payments which, though not legally due under contract, appear to place an obligation on a public sector organisation which the courts might uphold. Typically, these arise from the organisation's action or inaction in relation to a contract. Payments may be extra-contractual even where there is some doubt about the organisation's liability to pay, e.g., where the contract provides for arbitration, but a settlement is reached without it. A payment made as a result of an arbitration award is contractual.
Extra-statutory	Special Payment	Assurance team	NHSE/ DHSC/ HMT	Payments which are within the broad intention of the statute or regulation but go beyond a strict interpretation of its terms.
Extra-regulatory payments	Special Payment	Assurance team	NHSE/DHSC/ HMT	Payments which are within the broad intention of the statute or regulation but go beyond a strict interpretation of its terms.
Compensation payments	Special Payment	Assurance team	NHSE/DHSC/ HMT	Payments made to provide redress for personal injuries, traffic accidents, and damage to property They include other payments to those in the public service outside statutory schemes or outside contracts
Special severance payments	Special Payment	NHSE Regional Director of Workforce and OD	EHRSG DHSC GAC HMT	Payments made to employees, contractors and others beyond above normal statutory or contractual requirements when leaving employment in public service whether they resign, are dismissed or reach an agreed termination of contract. Regional and further Approval is required regardless of the value of the non-contractual pay package
Ex gratia payments	Special Payment	Assurance team	NHSE/ DHSC/ HMT	Go beyond statutory cover, legal liability, or administrative rules, including payments; • made to meet hardship caused by official failure or delay; • out of court settlements to avoid legal action on grounds of official inadequacy; and, • payments to contractors outside a binding contract, e.g., on grounds of hardship
Retention payments	Special Payment	Regional Director of Workforce and OD		Payments, designed to encourage staff to delay their departures, particularly where transformations of ALBs are being negotiated, are also classified as novel and contentious. Such payments always require explicit Treasury approval, whether proposed in individual cases or in groups. Treasury approval must be obtained before any commitment, whether oral or in writing, is made.

3.5 Annual assurance statements

3.5.1 As part of the new compliance and control procedures over exit packages, ICBs must submit an annual assurance statement confirming the following:

- details of all[1] exit packages (including special severance payments) that have been agreed and/or made during the year;
- that NHS England and HMT [2]approvals have been obtained (in relation to non-contractual pay elements or amounts that exceed the ICB delegated limits) before any offers, whether verbally or in writing, are made; and
- adherence to the special severance payments guidance as published by NHS England.

3.5.2 Further guidance will be provided to ICBs on this process.

3.6 Interpretation

3.6.1 Should any difficulties arise regarding the interpretation or application of any part of this losses and special payment guidance, the advice of the NHS England Head of assurance and counter fraud (england.assurance@nhs.net) must be sought before acting.

3.7 Delegation of Function, Duties and Powers

3.7.1 The ICB Constitution must have a governing body that makes provision for the appointment of the Audit and Risk Committee.

3.7.2 The ICB standing financial instructions should clearly indicate the role that the Audit and Risk committee has in reviewing and approving losses and special payments.

3.7.3 The ICB standing financial instructions should indicate the delegated limits that have been agreed by the governing body for operational purposes.

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[1] The assurance statement must include all exit packages, thus, contractual and non-contractual.
[2] This is only applicable to elements of the exit packages that are classified as non-contractual

4.1 Capturing of losses and special payments

4.1.1 The ICB chief financial officer is responsible for ensuring that processes and procedures that facilitate the capturing and reporting of losses and special payments are in place and ensure that a losses and special payments register is maintained.

4.1.2 All losses and special payments for ICBs must be recorded in the register and reviewed as part of the internal controls process.

4.2 Parliamentary accountability and audit report

4.2.1 The ICB must maintain a losses and special payments register that provides the requested information to complete the NHS England group accounts.

4.2.2 It should be noted that ICBs do not have a mandatory requirement to produce a Parliamentary accountability and audit report as other entities that report directly to Parliament. However, it is a mandatory requirement that ICBs produce an audit certificate and report.

There will be a need to collect data for the NHS England consolidated account. NHS England will also use this information to complete the DHSC summarisation schedule for the DHSC consolidated account. Therefore, regardless of applicability of this report, all ICBs must ensure the summarisation schedule is completed.

4.2.3 If there are any individual cases or a group of losses or special payments that exceed or the aggregate value of £100,000, the related payment should be noted separately on the ICB yearend template completed for the NHS England group account.

4.3 Financial Control

4.3.1 Chief Financial Officer

4.3.2 It is noted and acknowledged that the roles and responsibilities for the chief financial officer vary in all the ICBs. The chief financial officer should implement a system of internal control that details the process for reporting losses, recording losses, monitoring and reporting the losses and special payments to the ICB's Audit and Risk committee based on existing reporting cycles.

4.3.3 The reporting cycle should also clarify the delegated sum that the chief financial officer can authorise as a loss or special payment. The delegated sum should be in line with the ICB escalation process for losses and special payments.

NHS South West London Integrated Care Board
Strategic Commissioning Committee
Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
1	April 2026	Initial core parts of ToRs developed by Directors of Commissioning in SEL ICB
2	15 May 2026	Initial draft in ToRs template by SEL governance team for engagement
3	28 May 2026	To reflect SWL F&P Committee inputs on future committee functions
4	3 June 2026	Updated to incorporate amendments proposed by SWL Director of Corporate and SEL NEM member for governance
5	10 June 2026	Updated to incorporate amendments proposed by SWL and SEL NEMs
6	28 June 2026	CEO review and comments
7	7 July 2026	Added 2 x PELs as committee members

Approved by

Version	Date	Committee / Group name

Contents

1. Constitution

1.1 The Strategic Commissioning Committee is established by the Integrated Care Board (the Board or ICB) as a committee of the Board. in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board. They will be published as part of the Governance Handbook on the ICB's website.

2. Authority

2.1 The Strategic Commissioning Committee is authorised by the Board to:

- Undertake any activity within its ToR;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Strategic Commissioning Committee) within its remit as outlined in these ToR;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Strategic Commissioning Committee members. The Strategic Commissioning Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Strategic Commissioning Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, except as outlined in these ToR.

2.3 The Strategic Commissioning Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

3. Purpose

3.1 The Strategic Commissioning Committee is established to act as the principal forum for strategic commissioning development and oversight on behalf of the Board.

3.2 The ICB's core purpose is strategic commissioning, inclusive of the development of enhanced strategic commissioning capabilities and approaches, with an increasing

focus on improving population health outcomes, reducing inequalities, delivering its strategic ambitions (including the 'left shift' towards prevention, community-based care and digital), commissioning high quality, effective and efficient services and exercising its system convening role working with partners.

3.3 The Strategic Commissioning Committee is a formal committee of the ICB Board and will be authorised by the Board to put forward proposals which meet the objectives of the ICB's strategic plan, including proposals for service change, procurement, outcomes and key enablers for strategic commissioning.

3.4 The Committee has a role in ensuring alignment of borough based joint commissioning with the ICB strategy and the effective delivery of agreed ICB priorities and outcomes where relevant. Joint commissioning will be led at place (with defined budgets and commissioning responsibility) to enable close alignment with local authority commissioning and delivery responsibilities, including public health and social care and with a focus on ensuring that joint commissioning arrangements support integration of services and care for local populations.

3.5 The Committee will have a close working relationship with the Neighbourhood Based Care Committee. The Neighbourhood Based Care Committee will be responsible for overseeing the delivery of the ICB's neighbourhood-based care agenda which includes ensuring the delivery of commissioning priorities and actions relating to the development and delivery of neighbourhood care. The Strategic Commissioning Committee will have a role in ensuring that the ICB's strategic commissioning, operational plans and use of payor/contracting functions support the effective delivery of the agreed neighbourhood care objectives and outcomes.

3.6 An annual programme of business will be agreed before the start of the financial year and will include strategic commissioning, integrated planning, affordability, delivery oversight and performance and assurance matters. The programme will remain flexible to new and emerging priorities, risks and system pressures.

4. Responsibilities of the Strategic Commissioning Committee

4.1 The committee will operate across the commissioning cycle in an advisory and scrutinising capacity, providing targeted assurance to support the Board rather than replicating an oversight role.

4.2 The committee will take decisions on matters delegated to it as determined by the ICB's SoRD.

4.3 A key role of the committee's is to advise and provide recommendations to the Board to ensure commissioning strategy is data and insights driven and reflects population need, inequalities, and the Board's agreed strategic intent, ensuring consideration of the evidence supporting health outcomes clinical outcomes and cost-effectiveness. clinical and cost-effectiveness evidence base.

4.4 Specific responsibilities of the Committee are as follows. In discharging these responsibilities the Committee will:

Delivery of the ICB strategy

4.5 Provide assurance to the Board on the delivery of the ICB's strategic ambitions, including the 'three shifts' and impact on outcomes and value.

4.6 Assure that there is alignment between commissioning priorities, operational planning, activity assumptions, workforce implications and financial frameworks to support delivery of agreed outcomes and system sustainability.

4.7 Advise the Board on major service change, reconfiguration, investment prioritisation, affordability considerations and strategic trade-offs to support Board decision making.

4.8 Provide oversight and scrutiny of strategic commissioning and procurement approaches relating to major service transformation, contracting arrangements and commercial decisions within the scope of the SoRD.

4.9 Provide strategic oversight of how the ICB uses its commissioning, contracting and 'payor function' responsibilities to shape the future health and care market to help contribute to delivery of its longer-term strategic objectives.

4.10 Provide advice, support and oversight of the development of key strategic commissioning capabilities and outputs e.g. frameworks and decision-making tools to support decision making and prioritisation, outcomes and evaluation.

4.11 Approve arrangements to secure continuous improvement in quality and patient outcomes

4.12 Ensure the ICB's underpinning care pathway and borough based joint commissioning integrated arrangements are aligned to the ICB's commissioning strategy and financial frameworks.

In-year contract delivery and performance

4.13 Review integrated system performance across commissioned services including financial, activity. quality[1], and delivery performance, together with associated risk, prioritising material variance, affordability and strategic concern.

4.14 Review delivery of savings, efficiency and productivity programmes linked to the ICB's commissioning, revenue and capital plans, including associated risks, mitigations and delivery confidence.

[1] The SCC will assume primary responsibility for the oversight of the quality of ICB-commissioned services as is required by current NHSE / NQB guidance. The ICB Patient Safety Committee will focus on assurance related to the safety and quality of care for the ICB's statutory functions, such as CHC, LeDeR. See Patient Safety Committee ToRs.

4.15 Review forecast financial and operational performance, including material risks, delivery assumptions and mitigating actions relating to commissioned services and system plans.

4.16 Escalate material financial, operational and commissioning or delivery concerns to the Board where risks, performance or affordability issues exceed agreed tolerances or require strategic decision-making.

4.17 Assure the evaluation of the impact and outcomes of services commissioned by the ICB including consideration of patients' views / voice, to ensure that lessons learned are identified and used to inform future commissioning decisions.

Other responsibilities

4.18 Approval of contracts at a level specified in the SoRD.

4.19 During the transition to new legislation, new Board membership and future ICB governance arrangements, the Committee may provide an important forum for review and discussion of key commissioning matters, supporting the ICB to conduct its commissioning business.

5. Membership and attendance

Membership

5.1 The Strategic Commissioning Committee membership is as follows:

5.1.1 Chair – Non Executive Member

5.1.2 Deputy Chair – Non Executive Member

5.1.3 ICB Chief Executive Officer

5.1.4 Chief Commissioning Officer

5.1.5 Directors of Strategic Commissioning

5.1.6 Chief Financial & Compliance Officer

5.1.7 Place Lead

5.1.8 Chief Nurse and Quality Officer

5.1.9 Medical Director

5.2 The role of Chair will be undertaken by Non-Executive Member.

5.3 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.4 Members may nominate deputies to represent them in their absence and make decisions on their behalf, subject to the approval of the Chair.

5.5 Members will possess between them knowledge, skills and experience in the issues pertinent to the Strategic Commissioning Committee's business. When determining the membership of the Strategic Commissioning Committee, active consideration will be made to diversity and equality.

Chair and Vice Chair

5.6 The Strategic Commissioning Committee will be chaired by a member appointed on account of their specific knowledge skills and experience making them suitable to chair the Strategic Commissioning Committee.

5.7 Strategic Commissioning Committee members may appoint a Vice Chair who will be nominated by the Chair of the Strategic Commissioning Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside. If the Chair or Vice Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

5.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.9 The Strategic Commissioning Committee shall have the following non-voting attendees (as and when required), noting this list is not intended to be exhaustive and may also change over time as agreed with the Committee Chair:

- Chief Pharmacist for the ICB,
- Director of Delivery for Neighbourhoods and Population Health
- Director of Insights
- Additional Place Leads
- Director of Public Health

5.10 Attendees may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.11 Attendees may nominate deputies to represent them in their absence, with agreement of the Chair.

5.12 The Strategic Commissioning Committee may call additional experts to attend meetings on a case-by-case basis to inform discussion.

5.13 The Strategic Commissioning Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.14 The Chair of the ICB will be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

5.15 The Strategic Commissioning Committee Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

6. Meeting Frequency, Quoracy and Decisions

6.1 The Strategic Commissioning Committee will usually meet every two months. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

6.2 The Board, Chair or Chief Executive may ask the Strategic Commissioning Committee to convene further meetings to discuss particular issues on which they want the committee's advice.

6.3 Meetings will be held in-person, unless previously agreed by the Chair. The Strategic Commissioning Committee may choose to meet online, via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate the following members will be required:

6.4.1 Chair or Deputy Chair;

6.4.2 One Director of Strategic Commissioning;

6.4.3 Finance Representative;

6.4.4 Place Lead

6.4.5 Medical Director or Chief Nurse and Quality Officer

6.5 If any member of the Strategic Commissioning Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

6.7 Decisions will be taken in accordance with the Standing Orders. The Strategic Commissioning Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.8 Only members of the Strategic Commissioning Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.9 Where there is a split vote, with no clear majority, the Chair of the Strategic Commissioning Committee will hold the casting vote.

6.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through email or other electronic communication.

6.11 Any decisions taken virtually must be recorded at the next scheduled meeting.

7. Accountability and reporting

7.1 The Strategic Commissioning Committee is accountable to the ICB Board and shall provide reports to the Board on how it discharges its responsibilities and shall draw to the attention to any issues that require disclosure or require action.

7.2 The Strategic Commissioning Committee shall make any such recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

7.3 The minutes of the meetings shall be formally recorded by the secretary and approved at the next scheduled meeting.

7.4 The Strategic Commissioning Committee will report to the Board at least annually to describe how it has fulfilled its ToR, give details of any significant issues that it has considered, and how they were addressed.

8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Strategic Commissioning Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Strategic Commissioning Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

ICB values

9.1 Members will be expected to conduct business in line with the ICB values and objectives.

9.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and Administration

10.1 The Strategic Commissioning Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken, agreed with the Chair, and a record of matters arising. Action points and issues, with progress updates, will be carried forward between meetings;
- The Chair is supported to prepare and deliver reports to the Board; and
- The Strategic Commissioning Committee is updated on pertinent issues / areas of interest / policy developments.

11. Review

11.1 The Strategic Commissioning Committee will review its effectiveness at least annually and recommend any changes it considers necessary to the Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to the Board for approval.

NHS South West London
Integrated Care Board

Neighbourhood Strategic Delivery Committee

Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
1	April 2026	Initial core parts of ToRs developed by directors of Neighbourhood Delivery in SEL and SWL
2	15 May 2026	Initial draft in ToRs template by SEL governance team for engagement
3	3 June 2026	Updated to incorporate amendments proposed by SWL Director of Corporate and SEL NEM member for governance
4	12 June 2026	Updated to incorporate suggestions from ICB NEMs
5	28 June 2026	CEO review and comments.

Approved by

Version	Date	Committee / Group name

Contents

1. Constitution

1.1 The Neighbourhood Strategic Delivery Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a committee of the Board. in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

2. Authority

2.1 The Neighbourhood Strategic Delivery Committee is authorised by the ICB Board:

- Undertake any activity within its ToR.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Neighbourhood Strategic Delivery Committee) within its remit as outlined in these ToR.
- Commission any reports it deems necessary to help fulfil its obligations.
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Neighbourhood Strategic Delivery Committee members. The Neighbourhood Strategic Delivery Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Neighbourhood Strategic Delivery Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, except as outlined in these ToR.

2.3 The Neighbourhood Strategic Delivery Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

3. Purpose

3.1 The purpose of the Neighbourhood Strategic Delivery Committee will be to act as the principal forum for agreeing the overall SWL ICB approach to development of the Neighbourhood Health Service and assuring progress in delivering the Neighbourhood Health Service on behalf of the Board.

3.2 The committee will develop proposals for care models, strategic plans, outcomes and key enablers for integrated neighbourhood health and care.

3.3 The Committee has a role in ensuring alignment of other system plans with the Neighbourhood Delivery Plan and the effective delivery of agreed ICB priorities and outcomes where relevant. Whilst those other plans (e.g. digital, estates and people) may be led by other parts of the system, the Neighbourhood Delivery Committee will work with the relevant accountable bodies across the system with the aim of ensuring that relevant transformation and delivery plans support the delivery of integrated neighbourhood health and care.

3.4 The Committee will be responsible for ensuring the delivery of commissioning priorities and actions relating to the development and delivery of neighbourhood care as set by the Strategic Commissioning Committee. The Neighbourhood Strategic Delivery Committee will not make decisions on any commissioning activities (i.e. the award of new contracts).

3.5 The Committee will also operate as a key component of the wider system partnership arrangements, working in close alignment with system groups responsible for system sustainability, workforce, digital and estates. Executive members of the committee will provide the primary link between these forums, ensuring strategic alignment and coordinated delivery across the system.

4. Responsibilities of the Neighbourhood Strategic Delivery Committee

4.1 The Committee will undertake the following responsibilities:

- Advise and provide recommendations to the Board on the strategic direction of the integrated neighbourhood health and care, the overall delivery roadmap and milestones and setting of population health outcomes.

    - Provide oversight of the development of key neighbourhood strategies and resources including the model of care.
    - Approve plans with integrator partnerships for the development of integrated neighbourhood health and care.
    - Monitor delivery progress, ensuring plans are adjusted as required to secure delivery of agreed outcome and milestones. This will include driving improvement further and faster where it is feasible to do so.
    - Provide assurance to the Board on the delivery of commissioning priorities and actions relating to the development and delivery of neighbourhood care as set by the Strategic Commissioning Committee, managing unwarranted variation in approach.
    - Provides assurance to the Board on the ICB's response to NHS England and The Department of Health and Social Care's neighbourhood health requirements.

- Assures the work of ICB executives as part of other groups across London and within South West London to facilitate the development to the tools and infrastructure required to enable integrated neighbourhood health and care.
- Through the Committee's executive membership links to system partnership groups in SWL on system sustainability, workforce, digital and estates, and also the London Neighbourhood Board.

5. Membership and attendance

Membership (to be finalised by agreement in SEL and SWL)

5.1 The Neighbourhood Strategic Delivery Committee membership is as follows:

- Co-Chair – Non-Executive Member
- Co-Chair – Local Authority representative (executive member representing the local authority sector in SWL)
- ICB Partner Member (Primary Care)
- Place representatives (including representatives from ICB place leadership and provider integrators) - To be agreed in SEL and SWL ICBs.
- Director of Delivery for Neighbourhoods and Population Health for SEL and TBC for SWL ICB
- Director of Strategic Commissioning
- Director of Public Health
- VCSE Alliance Representative (Subject to agreement)
- ICB Medical Director

5.2 The role of Chair will be undertaken by the ICB Non-Executive Director and the Local Authority Member, who will act as co-Chair.

5.3 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.4 Members may nominate deputies to represent them in their absence and make decisions on their behalf, subject to the approval of the Chair.

5.5 Members will possess between them knowledge, skills and experience in the issues pertinent to the Neighbourhood Strategic Delivery Committee's business. When determining the membership of the Neighbourhood Strategic Delivery Committee, active consideration will be made to diversity and equality.

Chair and vice chair

5.6 The Neighbourhood Strategic Delivery Committee will be chaired by a member appointed on account of their specific knowledge skills and experience making them suitable to chair the Neighbourhood Strategic Delivery Committee.

5.7 Neighbourhood Strategic Delivery Committee members may appoint a Vice Chair who will be nominated by the Chair of the Neighbourhood Strategic Delivery Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside. If the Chair or Vice Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

5.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.9 The Neighbourhood Strategic Delivery Committee shall have the following non-voting attendees (as and when required):

- Other Directors and/or Managers as appropriate;

5.10 Attendees may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.11 Attendees may nominate deputies to represent them in their absence, with agreement of the Chair.

5.12 The Neighbourhood Strategic Delivery Committee may call additional experts to attend meetings on a case-by-case basis to inform discussion.

5.13 The Neighbourhood Strategic Delivery Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.14 The Chair of the ICB will be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

5.15 The Neighbourhood Strategic Delivery Committee Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate discussion of particular matters.

6. Meeting Frequency, Quoracy and Decisions

6.1 The Neighbourhood Strategic Delivery Committee will usually meet once each quarter. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

6.2 The Board, Chair or Chief Executive may ask the Neighbourhood Strategic Delivery Committee to convene further meetings to discuss particular issues on which they want the committee's advice.

6.3 Meetings will be held in-person, unless previously agreed by the Chair. The Neighbourhood Strategic Delivery Committee may choose to meet online, via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate the following members will be required:

- One of Non-Executive Member – Co-Chair or local authority representative – Co-Chair (proposed)
- Place representatives (including representatives from ICB place leadership and provider integrators) - To be agreed in SEL and SWL ICBs.
- Director of Delivery for Neighbourhoods and Population Health for SEL and SWL ICB

6.5 If any member of the Neighbourhood Strategic Delivery Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

6.7 Decisions will be taken in accordance with the Standing Orders. The Neighbourhood Strategic Delivery Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.8 Only members of the Neighbourhood Strategic Delivery Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.9 Where there is a split vote, with no clear majority, the Chair of the Neighbourhood Strategic Delivery Committee will hold the casting vote.

6.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through email or other electronic communication.

6.11 Any decisions taken virtually must be recorded at the next scheduled meeting.

7. Accountability and reporting

7.1 The Neighbourhood Strategic Delivery Committee is accountable to the ICB Board and shall provide reports to the ICB Board on how it discharges its responsibilities and shall draw to the attention to any issues that require disclosure or require action.

7.2 The Neighbourhood Strategic Delivery Committee shall make any such recommendations to the Board as it deems appropriate on any area within its remit where action or improvement is needed.

7.3 The minutes of the meetings shall be formally recorded by the secretary and approved at the next scheduled meeting.

7.4 The Neighbourhood Strategic Delivery Committee will report to the ICB Board at least annually to describe how it has fulfilled its ToR, give details of any significant issues that it has considered, and how they were addressed.

7.5 The Committee will, as required and through its executive members, act to ensure there is alignment between its work and that of system partnership Boards for sustainability, workforce, estates and digital.

8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Neighbourhood Strategic Delivery Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Neighbourhood Strategic Delivery Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

ICB values

9.1 Members will be expected to conduct business in line with the ICB values and objectives.

9.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and Administration

10.1 The Neighbourhood Strategic Delivery Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken, agreed with the Chair, and a record of matters arising. Action points and issues, with progress updates, will be carried forward between meetings.
- The Chair is supported to prepare and deliver reports to the ICB Board and.
- The Neighbourhood Strategic Delivery Committee is updated on pertinent issues / areas of interest / policy developments.

11. Review

11.1 The Neighbourhood Strategic Delivery Committee will review its effectiveness at least annually and recommend any changes it considers necessary to the ICB Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to the ICB Board for approval.

NHS South West London Integrated Care Board
Patient Safety Committee

Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
1	8 May 2026	Core components drafted by SWL governance team, SWL CNO and CMO, based on previous RemCo ToRs and aligned with NHS England guidance.
2	1 June 2026	Updated from earlier draft developed with executive leads to full ToRs template
3	15 June 2026	Updated by SWL and SEL Governance teams to reflect split of responsibilities with SCC
4	28 June 2026	CEO review and comments.

Approved by

Version	Date	Committee / Group name

Contents

1. Constitution

1.1 The Patient Safety Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a committee of the Board. in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board

2. Authority

2.1 The Patient Safety Committee is authorised by ICB Board to:

- Undertake any activity within its ToR.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Patient Safety Committee) within its remit as outlined in these ToR.
- Commission any reports it deems necessary to help fulfil its obligations.
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Patient Safety Committee members. The Patient Safety Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Patient Safety Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, except as outlined in these ToR.

2.3 The Patient Safety Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

3. Purpose

3.1 Under the current NHS Operating Model and Strategic Commissioning Framework the key requirements for quality oversight in an ICS published by the National Quality Board remain. All health and care organisations remain accountable for quality and have a responsibility to work together to proactively share intelligence, drive improvement and mitigate and escalate quality risks.

3.2 The ICB Patient Safety Committee will undertake assurance and oversight on behalf of the ICB for the identification, monitoring and escalation of quality, safeguarding and ICB operational performance issues in relation to ICB statutory responsibilities and duties. The Commissioning Strategy Committee will consider the quality of commissioned services as part of its role in assuring the delivery by providers of services commissioned by the ICB.

3.3 The ICB Patient Safety Committee will provide oversight and assurance to the Board that the ICB continues to meet its responsibilities for system quality as defined by the National Quality Board. The Committee is established to ensure that the ICB is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022.

3.4 The committee will provide oversight and assurance to the Board and that where NHSE have requested targeted measures for improvement through contractual levers these are being monitored and actioned.

3.5 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

3.6 The duties of the Patient Safety Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

4. Responsibilities of the Patient Safety Committee

4.1 Specific responsibilities of the Committee are as follows:

4.2 The Committee is responsible for ensuring the robustness of the systems in place across the ICB to secure effective quality and safeguarding governance and assurance. As such the Committee will approve arrangements to minimise clinical risk and maximise patient safety.

4.3 The Committee will ensure that these systems and processes allow the ICB to comply with all relevant legislation and national guidance, to effectively deliver its strategic objectives and commission sustainable, high-quality care whilst also ensuring appropriate safeguards are in place to protect the most vulnerable.

4.4 The Committee will approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.

4.5 The Committee will provide assurance that the ICB is meeting its system level responsibilities as defined by National Quality Board (NQB) in that the ICB is expected to:

- maintain System Quality Groups (SQG) as a forum for intelligence sharing and partnership working to improve quality.
- ensure the SQG has representation from all system partners as per the NQB guidance, including Integrated Health Organisations (IHO) as appropriate.
- review SQG footprints, aligning with cluster/ merged footprints as appropriate.
- be represented at the Regional Quality Group, ensuring effective escalation.

4.6 The Committee will receive reports from the System Quality Group (SQG) to review and identified themes and shared learning from Serious Case Reviews, Adult Learning Reviews and Domestic Homicide reviews drawing on intelligence and collaboration with place based Local Safeguarding Partnerships, Safeguarding Boards and Safer Community Partnerships, working collaboratively with ICB partners to do so.

4.7 Oversee and scrutinise the ICB's response to all relevant directives, regulations, national standard, policies, reports, reviews inspections, and best practice as issued by the Department for Health and Social Services (DHSC), NHS England and other regulatory bodies / external agencies (e.g. the Care Quality Commission (CQC), National Institute for Health and Care Excellence (NICE).

4.8 Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites.

4.9 Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from deaths (including coronial inquests and Prevention of Future Death reports).

4.10 Provide the ICB with assurance that it is delivering its statutory duties for safeguarding adults, children, children looked after and Special Educational Needs and Disability as laid out in Section 11 - The Children Act, 2004, Working Together to Safeguard Children, 2018, The Care Act, 2014, Promoting the Health and Wellbeing of Looked After Children 2015, SEND code of practice 0- 25yrs, 2015.

4.11 Comprehensively scrutinise the robustness of the arrangements for, and assure compliance with, the ICB's statutory responsibilities for:

- infection prevention and control.
- medicines optimisation and safety.
- equality and diversity where these relate to specific performance standards or matters of care quality.

4.12 To arrange a rolling programme of deep-dive reviews across both the committee and SQG with the aim of understanding in detail key areas of ICB performance and quality and contributing through this process to improvement activities and the promotion of shared learning.

4.13 Ensure that the SQG maintains effective processes for system-wide learning from significant events including themes and trends from incidents and safeguarding reviews. This assurance will be provided via SQG reports and supplementary papers. The Committee's role is to ensure that lessons learned are implemented and make a difference.

4.14 Follows National Quality Board guidance to maintain its system level responsibilities for quality on behalf of the ICB. This means the Patient Safety Committee will work in collaboration with other ICB committees (especially Commissioning Committee, the System Quality Group, regional groups for example Regional Quality Group and Joint Strategic Oversight Groups).

4.15 The Committee will receive and review a risk report to agree on the main risks related to quality. Whilst responsibility for detailed review and remedial action on risks rests with the ICB executive leadership, the Committee is expected to maintain an awareness of quality and performance related risks and assure itself that the proposed actions are adequate.

4.16 Work in support of the ICB Strategic Commissioning Committee to provide assurance that the ICBs responsibilities for contractual oversight of quality are being met.

5. Membership and attendance

Membership

5.1 The Patient Safety Committee membership is as follows:

- Non-Executive Member (Chair)
- Non-Executive Member
- ICB Chief Nursing Officer
- ICB Medical Director

5.2 The role of Committee Chair will be undertaken by a Non-Executive Member (who cannot be the Chair of the ICB or the Audit and Risk Committee Chair).

5.3 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.4 Members may nominate deputies to represent them in their absence and make decisions on their behalf, subject to the approval of the Chair.

5.5 Members will possess between them knowledge, skills and experience in the issues pertinent to the Patient Safety Committee's business. When determining the membership of the Patient Safety Committee, active consideration will be made to diversity and equality.

Chair and Vice Chair

5.6 The Patient Safety Committee will be chaired by a member appointed on account of their specific knowledge skills and experience making them suitable to chair the Patient Safety Committee.

5.7 Patient Safety Committee members may appoint a Vice Chair who will be nominated by the Chair of the Patient Safety Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside. If the Chair or Vice Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

5.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.9 The Patient Safety Committee shall have the following non-voting attendees (as and when required):

- ICB Director of Quality (SRO for Quality)
- Other Directors and/or managers as appropriate;
- Other partners, as required for specific agenda items;
- Representatives from other organisations, as required.

5.10 Attendees may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.11 Attendees may nominate deputies to represent them in their absence, with agreement of the Chair.

5.12 The Patient Safety Committee may call additional experts to attend meetings on a case-by-case basis to inform discussion.

5.13 The Patient Safety Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.14 The Chair of the ICB will be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

5.15 The Patient Safety Committee Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

6. Meeting Frequency, Quoracy and Decisions

6.1 The Patient Safety Committee will usually meet once every two months. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

6.2 The Board, Chair or Chief Executive may ask the Patient Safety Committee to convene further meetings to discuss particular issues on which they want the Patient Safety Committee's advice.

6.3 Meetings will be held in-person, unless previously agreed by the Chair. The Patient Safety Committee may choose to meet online, via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate the following members will be required:

- Non-Executive Member (Chair)

And two of the following:

- Non-Executive Member
- Chief Nurse and Quality Officer
- Chief Medical Officer

6.5 If any member of the Patient Safety Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

6.7 Decisions will be taken in accordance with the Standing Orders. The Patient Safety Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.8 Only members of the Patient Safety Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.9 Where there is a split vote, with no clear majority, the Chair of the Patient Safety Committee will hold the casting vote.

6.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through email or other electronic communication.

6.11 Any decisions taken virtually must be recorded at the next scheduled meeting.

7. Accountability and reporting

7.1 The Patient Safety Committee is accountable to the ICB Board and shall provide reports to the Board on how it discharges its responsibilities and shall draw to the attention to any issues that require disclosure or require action.

7.2 The Patient Safety Committee shall make any such recommendations to the ICB Board it deems appropriate on any area within its remit where action or improvement is needed.

7.3 The minutes of the meetings shall be formally recorded by the secretary and approved at the next scheduled meeting.

7.4 The Patient Safety Committee will report to the Board at least annually to describe how it has fulfilled its ToR, give details of any significant issues that it has considered, and how they were addressed.

8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Patient Safety Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Patient Safety Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

ICB values

9.1 Members will be expected to conduct business in line with the ICB values and objectives.

9.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and Administration

10.1 The Patient Safety Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken, agreed with the Chair, and a record of matters arising. Action points and issues, with progress updates, will be carried forward between meetings.
- The Chair is supported to prepare and deliver reports to the ICB Board]; and
- The Patient Safety Committee is updated on pertinent issues / areas of interest / policy developments.

11. Review

11.1 The Patient Safety Committee will review its effectiveness at least annually and recommend any changes it considers necessary to the ICB Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to the ICB Board for approval.

NHS South West London
Integrated Care Board

Audit, Risk and Assurance Committee
Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
1	May 2026	Initial draft developed by ICB governance teams in SWL and SEL
2	13 May 2026	Draft for engagement
3	3 June 2026	Updated to incorporate amendments proposed by SWL Director of Corporate and SEL NEM member for governance
4	10 June 2026	Updated to include amendments suggested by NEMs

Approved by

Version	Date	Committee / Group name

Contents

1. Constitution

1.1 The Audit, Risk and Assurance Committee is established by the Integrated Care Board (the Board) as a Committee of the Board in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board. They will be published as part of the Governance Handbook on the ICB's website.

1.3 The Committee is a non-executive Committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The Audit, Risk and Assurance Committee is authorised by Board to:

- Undertake any activity within its ToR.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Audit, Risk and Assurance Committee) within its remit as outlined in these ToR.
- Commission any reports it deems necessary to help fulfil its obligations.
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Audit, Risk and Assurance Committee members. The Audit, Risk and Assurance Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Audit, Risk and Assurance Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, except as outlined in these ToR.

2.3 The Audit, Risk and Assurance Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

3. Purpose

3.1 To contribute to the overall delivery of the ICB's strategic and statutory objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB, and providing independent scrutiny that enhances decision-making, strengthens accountability, and supports continuous improvement.

3.2 The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

4. Responsibilities of the Audit, Risk and Assurance Committee

4.1. The Committee will undertake the following principal duties:

4.2. Governance and internal control

- To review the adequacy and effectiveness of governance, risk management, assurance and internal control systems across the ICB that support the achievement of its objectives, and to highlight any areas of weakness to the Board.
- To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.
- To ensure that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.
- To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of governance and internal control, together with indicators of their effectiveness.
- To identify opportunities to improve governance and internal control processes across the ICB.
- To have oversight of urgent decisions exercised by the Board.

4.3. Internal audit

- To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:
  - Considering the provision of the internal audit service and the costs involved.
  - Approving the appointment of the ICB's internal auditor service.
  - Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.

- Considering the findings of all internal audit reports, including the Head of Internal Audit Opinion (and management's response) and ensure coordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

4.4. External audit

- To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and review and assess the implications and management's responses to their work. This will be achieved by:
  - Considering the performance of the external auditors, as far as the rules governing the appointment permit.
  - Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
  - Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fees.
  - Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
  - The Audit, Risk & Assurance Committee shall not have responsibility for appointment or selection of the external auditors.

4.5. Risk Management

- Report to the Board with a clear assessment of whether principal risks to the delivery of the organisation's corporate objectives are controlled within appetite (where appropriate) and supported by sufficient, reliable assurance.
- To review the adequacy and effectiveness of the organisations risk management framework and its implementation across the ICB.
- To receive regular updates on the ICB's Board Assurance Framework.
- Undertake periodic structured deep-dives into principal risks to assess control effectiveness, test assurance robustness, and identify required management actions.

4.6. Assurance

- To review and triangulate assurance from internal audit, external audit, regulatory bodies, and other ICB sources of information and business intelligence to form an

independent, evidence-based view of the ICB's control environment.

- To maintain and scrutinise the Assurance Map aligned to strategic objectives, assessing the adequacy, balance and interdependency of assurance across the three lines model and identifying gaps, duplication or over-reliance on single sources.

- Monitor and independently test the implementation and effectiveness of agreed actions arising from audit and other reviews, ensuring that issues are genuinely resolved in practice and that underlying risks have been demonstrably reduced.

- Review and assess intelligence on organisational culture including speaking up and escalation mechanisms, to assess whether risks and issues surface within the organisation are followed up and resolved.

- To receive regular reports on tender waivers approved within the ICB.

- To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

- Working with chairs of ICB committees, to review the work of other committees in the ICB with the aim of providing relevant assurance to the Audit and Risk Committee's own areas of responsibility.

- To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

- To review the findings of external bodies including the ICB's external regulators, and consider the implications for governance of the ICB. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

- Pay due regard to risk and assurance activities of providers with a view to sharing understanding and learning across the health and care system in circumstances where that may offer mutual benefit to all partners.

4.7. Counter fraud

- To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet the NHS Counter Fraud Authority's (NHSCFA) Requirements for the Counter Fraud Functional Standard and review the outcome of work in these areas. This should include assurance that the ICB has the appropriate "reasonable procedures to prevent the occurrence of

fraud" to mitigate the exposure of the ICB to the Failure to Prevent Fraud offence governed by the Economic Crime and Corporate Transparency Act 2023.

- To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss the outcomes of the annual Counter Fraud functional Standard Return (CFFSR).

- To ensure that the counter fraud service submits an Annual Report and CFFSR, outlining work undertaken during each financial year to meet the Requirements of the NHSCFA Counter Fraud Functional Standard.

- To ensure that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining work undertaken during each financial year to meet the NHS Standards for Commissioners, Fraud, Bribery and Corruption.

4.8. Freedom to Speak Up

- To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

4.9. Information Governance (IG)

- To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

- To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

- To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

- To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance

4.10. Financial Reporting

- To monitor the integrity of the annual financial statements of the ICB and any formal announcements relating to its financial performance.

- To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

- To review and recommend to the Board the annual report and annual financial

statements (including accounting policies) for submission, and reporting to the Board, focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the committee
- Changes in accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the Financial Statements
- Significant judgements and estimates made in the preparation of the Financial Statements
- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of financial reporting.

4.11. Conflicts of Interest

- The chair of the committee will be the nominated Conflicts of Interest Guardian.
- The committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective, including receiving reports relating to non-compliance with the ICB's policy and procedures relating to conflicts of interest.

5. Membership and attendance

Membership

5.1. The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

5.2. The Board will appoint no fewer than three members of the Committee comprising three Non-Executive Members of the Board. Other members of the Committee need not be members of the Board, but they may be.

5.1 The role of Chair will be undertaken by ICB Non-Executive Member.

5.2 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.3 Members may nominate deputies to represent them in their absence and make decisions on their behalf, subject to the approval of the Chair.

5.4 Members will possess between them knowledge, skills and experience in the issues pertinent to the Audit, Risk and Assurance Committee's business. When determining the membership of the Audit, Risk and Assurance Committee, active consideration will be made to diversity and equality.

Chair and vice chair

5.5 The Audit, Risk and Assurance Committee will be chaired by a member appointed on account of their specific knowledge skills and experience making them suitable to chair the Audit, Risk and Assurance Committee.

5.6 Audit, Risk and Assurance Committee members may appoint a Vice Chair who will be nominated by the Chair of the Audit, Risk and Assurance Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside. If the Chair or Vice Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

Attendees

5.7 The Audit, Risk and Assurance Committee shall have the following non-voting attendees:

- Chief Finance and Compliance Officer or their nominated deputy
- Representatives of internal and external audit, and the local counter fraud service provider
- ICB Director of Corporate Services
- Other attendees as appropriate, agreed in advance with the committee chair
- Representatives from other organisations, as required.

5.8 Attendees may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.9 Attendees may nominate deputies to represent them in their absence, with agreement of the Chair.

5.10 The Audit, Risk and Assurance Committee may call additional experts to attend meetings on a case-by-case basis to inform discussion.

5.11 The Audit, Risk and Assurance Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.12 The Audit, Risk and Assurance Committee Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate private discussion of particular matters.

6. Meeting Frequency, Quoracy and Decisions

6.1 The Audit, Risk and Assurance Committee will usually meet quarterly. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

6.2 The Board, Chair or Chief Executive may ask the Audit, Risk and Assurance Committee to convene further meetings to discuss particular issues on which they want the Audit, Risk and Assurance Committee advice.

6.3 Meetings will be held in-person, unless previously agreed by the Chair. The Audit, Risk and Assurance Committee may choose to meet online, via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate the following members will be required:

- 2 x ICB Non-Executive Directors

6.5 If any member of the Audit, Risk and Assurance Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

6.7 Decisions will be taken in accordance with the Standing Orders. The Audit, Risk and Assurance Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.8 Only members of the Audit, Risk and Assurance Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.9 Where there is a split vote, with no clear majority, the Chair of the Audit, Risk and Assurance Committee will hold the casting vote.

6.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through email or other electronic communication.

6.11 Any decisions taken virtually must be recorded at the next scheduled meeting.

7. Accountability and reporting

7.1 The Audit, Risk and Assurance Committee is accountable to the ICB Board and shall provide reports to the ICB Board on how it discharges its responsibilities and shall draw to the attention to any issues that require disclosure or require action.

7.2 The Audit, Risk and Assurance Committee shall make any such recommendations to the ICB Board it deems appropriate on any area within its remit where action or improvement is needed.

7.3 The minutes of the meetings shall be formally recorded by the secretary and approved at the next scheduled meeting.

7.4 The Audit, Risk and Assurance Committee will report to ICB Board at least annually to describe how it has fulfilled its ToR, give details of any significant issues that it has considered, and how they were addressed.

8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Audit, Risk and Assurance Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Audit, Risk and Assurance Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

ICB values

9.1 Members will be expected to conduct business in line with the ICB values and objectives.

9.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and Administration

10.1 The Audit, Risk and Assurance Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken, agreed with the Chair, and a record of matters arising. Action points and issues, with progress updates, will be carried forward between meetings;
- The Chair is supported to prepare and deliver reports to the ICB Board and
- The Audit, Risk and Assurance Committee is updated on pertinent issues / areas of interest / policy developments.

11. Review

11.1 The Audit, Risk and Assurance Committee will review its effectiveness at least annually and recommend any changes it considers necessary to ICB Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to ICB Board for approval.

NHS South West London Integrated Care Board

Remuneration Committee

Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
1	8 May 2026	Core components drafted by SWL and SEL governance teams based on previous RemCo ToRs and aligned with NHS England guidance.
2	1 June 2026	Added initial draft to ToRs template

Approved by

Version	Date	Committee / Group name

Contents

1. Constitution

1.1 The Remuneration Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a committee of the Board. in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

2. Authority

2.1 The Remuneration Committee is authorised by the ICB Board to:

- Undertake any activity within its ToR.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Remuneration Committee) within its remit as outlined in these ToR.
- Commission any reports it deems necessary to help fulfil its obligations.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Remuneration Committee members. The Remuneration Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Remuneration Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, except as outlined in these ToR.

2.3 The Remuneration Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

3. Purpose

3.1. The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary: Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including very senior managers/directors (including board members) and Non-Executive Members excluding the Chair.

3.2. The Board has also delegated the following functions to the Committee:

- Ensuring the ICB follows national pay and terms and condition frameworks to set the pay policy for ICB employees.
- Setting remuneration, allowances, performance-related pay incentives and terms and conditions for the Chief Executive and Very Senior Managers

(VSMs) in line with national guidance.

- Setting remuneration, allowances and terms and conditions for Integrated Care Board members, where required.
- Agreeing any discretionary payments or terms and conditions for staff employed by the ICB.
- Approving any termination or redundancy payments.
- Approving TUPE or other staff transfers into or out of the ICB.
- Setting the ICB pay policy and standard terms and conditions of employment for all individuals appointed by the ICB as clinical leads, workers, office holders (this may include pensions, remuneration, fees, travelling or other allowances payable), and any pay awards for these individuals.

4. Responsibilities of the Remuneration Committee

Specific responsibilities of the Committee include:

For the Chief Executive, Directors and other Very Senior Managers:

4.1 Through the Chief Executive, Directors and other Very Senior Managers to: determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, and other additional benefits.

4.2 Through the Chair: provide feedback on the Chief Executive's performance so as to support the monitoring and evaluation of their performance.

4.3 To consider and approve proposals to establish any new management posts at Very Senior Manager grade.

4.4 To oversee and advise the Board on arrangements for redundancy, termination payments, the use of Pay in Lieu of Notice proposals or any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

4.5 As permitted, to approve the use of the model voluntary redundancy scheme (VRS) and seek NHS England regional approval.

For ICB Board Members:

4.6 Determine remuneration, allowances and terms and conditions for Integrated Care Board members[1].

[1] When determining Non-Executive Board member remuneration the ICB Chair, Chief Executive and either a NHSE or partner representative will meet. Non-Executive Members will not be involved in discussion about their own pay.

For all staff:

4.7 Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change).

4.8 Determine the arrangements for redundancy, termination payments, the use of Pay in Lieu of Notice proposals or any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

4.9 Agree any discretionary payments or terms and conditions for staff employed by the ICB.

Additional functions included in the scope of the Committee include:

4.10 Setting the ICB pay policy and standard terms and conditions of employment for all individuals appointed by the ICB as clinical leads, workers, office holders (this will include pensions, remuneration, fees, travelling or other allowances payable), and any pay awards for these individuals.

4.11 Assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and Proper Person Test (FPPT).

4.12 Approving TUPE or other staff transfers into or out of the ICB.

5. Membership and attendance

Membership

5.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

5.2 The Remuneration Committee membership is as follows:

- Non-Executive Member (Chair)
- Non-Executive Member
- Non-Executive Member

5.3 The role of Chair will be undertaken by Non-Executive Member

5.4 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.5 Members may nominate deputies to represent them in their absence and make decisions on their behalf, subject to the approval of the Chair.

5.6 Members will possess between them knowledge, skills and experience in the issues pertinent to the Remuneration Committee's business. When determining the

membership of the Remuneration Committee, active consideration will be made to diversity and equality.

Chair and Vice Chair

5.7 The Committee will be chaired by an independent member of the Board which could either be the Chair or a Non-Executive Member, appointed on account of their specific knowledge skills and experience making them suitable to chair the Remuneration Committee.

5.8 Remuneration Committee members may appoint a Vice Chair who will be nominated by the Chair of the Remuneration Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside. If the Chair or Vice Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

5.9 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.10 Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

5.11 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- The ICB's most senior HR Advisor or their nominated deputy.
- Chief Finance Officer or their nominated deputy.
- Chief Executive or their nominated deputy.
- The Director of Corporate Services.

5.12 The Board may appoint independent members or advisers to the Remuneration and Nominations Committee who are not members of the Board.

5.13 The Committee Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5.14 No individual should be present during any discussion relating to:

- Any aspect of their own pay.
- Any aspect of the pay of others when it has an impact on them.

5.15 Attendees may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.16 Attendees may nominate deputies to represent them in their absence, with agreement of the Chair.

5.17 The Remuneration Committee may call additional experts to attend meetings on a case-by-case basis to inform discussion.

6. Meeting Frequency, Quoracy and Decisions

6.1 The Remuneration Committee will usually meet a minimum of twice annually. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

6.2 The Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the advice.

6.3 Meetings will be held in-person, unless previously agreed by the Chair. The Remuneration Committee may choose to meet online, via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate the following members will be required:

- Non-Executive Member
- Non-Executive Member

6.5 If any member of the Remuneration Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

6.7 Decisions will be taken in accordance with the Standing Orders. The Remuneration Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.8 Only members of the Remuneration Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.9 Where there is a split vote, with no clear majority, the Chair of the Remuneration Committee will hold the casting vote.

6.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through email or other electronic communication.

6.11 Any decisions taken virtually must be recorded at the next scheduled meeting.

7. Accountability and reporting

7.1 The Remuneration Committee is accountable to the ICB Board and shall provide reports to the Board on how it discharges its responsibilities and shall draw to the attention to any issues that require disclosure or require action.

7.2 The Remuneration Committee shall make any such recommendations to the ICB Board it deems appropriate on any area within its remit where action or improvement is needed.

7.3 The minutes of the meetings shall be formally recorded by the secretary and approved at the next scheduled meeting.

7.4 The Remuneration Committee will report to the ICB Board at least annually to describe how it has fulfilled its ToR, give details of any significant issues that it has considered, and how they were addressed.

8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Remuneration Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Remuneration Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

ICB values

9.1 Members will be expected to conduct business in line with the ICB values and objectives.

9.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and Administration

10.1 The Remuneration Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken, agreed with the Chair, and a record of matters arising. Action points and issues, with progress updates, will be carried forward between meetings.
- The Chair is supported to prepare and deliver reports to the ICB Board.
- The Remuneration Committee is updated on pertinent issues / areas of interest / policy developments.

11. Review

11.1 The Remuneration Committee will review its effectiveness at least annually and recommend any changes it considers necessary to the ICB Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to the ICB Board for approval.

NHS South West London
Integrated Care Board

South West London ICB Board ways of working: position statement

DRAFT v. 9: 25 June 2026

1. Our role and purpose as a Board

1.1. The Board of the Integrated Care Board (ICB) for South West London (SWL) is a unitary board (of Executives and Non-Executives) that sets the overall strategic direction and provides oversight of the ICB as a strategic commissioning organisation.

1.2. At present in South West London, the ICB's Strategic Commissioning Plan has four broad aims: i) to improve population health outcomes; ii) to ensure the system is sustainable; iii) to improve patients' experience of healthcare services and iv) secure access to high quality and safe services.

1.3. The Board is collectively accountable for assuring that the organisation delivers on its full range of statutory duties.

1.4. Executive members are responsible for operational delivery, within the risk appetite and strategic parameters set by the Board, as well as holding specified statutory functions on behalf of the Board. Their role is to provide operational insight and delivery accountability.

1.5. Non-executives (and other partner members) provide independent oversight and external perspective.

2. How we make decisions

2.1. As a unitary board, we take decisions, based on 4 principles:

2.1.1. **Accountability**: We are accountable for understanding and taking action that secure the best possible health outcomes equitably for South West Londoners now and in the medium and long term.

2.1.2. **Inclusivity**: We value, hear and respond to the voices of our residents/patients our staff and our wider partners and actively seek out diverse perspectives.

2.1.3. **Collaborative**: We identify, convene and cooperate with those partners and communities that contribute, through their services, resources and authority to the improved health and wellbeing of our population, building on a strength-based approach. We hold both ourselves to account for the agreements we make and expect the same from those we collaborate with. This includes working in close collaboration with partner providers, VCSE and local authorities at the ICB and place/ neighbourhood levels.

2.1.4. **Subsidiarity**: This means issues and decisions should be dealt with at the most local level consistent with their effective resolution. In this, the Board recognises that delivery occurs through executive leadership, system partners and place-based partnerships.

2.2. We take timely decisions, at the right level, and hold ourselves accountable for performance, based on the lifecycle of strategic commissioning (understanding need, defining long-term strategy, delivering through resource allocation and evaluating impact).

2.3. We consider options and trade-offs, underpinned by evidence (including clinical and cost-effectiveness), rather than narrative updates.

2.4. The Board is responsible for setting the risk appetite and tolerance for the organisation and, through this, we balance risk-taking with governance, and aim to innovate how healthcare is delivered, fostering a culture of experimentation and learning.

2.5. We constructively challenge issues (not people), to test assumptions, avoid groupthink and ensure alternative perspectives have been considered.

2.6. We are an outward-facing Board, owning and explaining major system decisions publicly, adhering to our statutory obligations regarding transparency and decision making.

2.7. Committee chairs are responsible for approving and presenting reports to the Board (in conjunction with the lead Executive member for the Committee) and will consider matters of business to 'alert, 'advise' or 'assure' the Board.

3. How we behave with each other

3.1. We treat each other with respect and listen to views and perspectives different to our own; we encourage open and honest dialogue.

3.2. We come prepared to take decisions and once a decision is made, we speak with one voice.

3.3. We hold ourselves accountable, taking feedback from each other and striving to improve ourselves. We reflect informally on our effectiveness at the end of each meeting and formally on an annual basis.

3.4. In Board meetings we give the papers and each other full attention.

4. Information, agendas and documents

4.1 There should be no surprises. The Board expects documents that are concise and transparent, highlighting the purpose of the paper, the recommendation, main risks and issues. The Executive poses specific questions for the Board to consider.

4.2 Information presented to the Board should support effective assurance: integrating quality, finance, performance and risk to provide a clear view of delivery. Reporting should be insight-led, highlighting key risks, trade-offs and areas requiring Board attention, rather than detailed descriptive updates.

4.3 The 'pipeline' of future work including prospective items for decision are planned in advance and clearly understood, leaving room for flexibility to allow for changes in context or urgent decisions that are required.

4.4 Board agendas should be explicitly designed to reflect the Board's strategic role, with a clear distinction between items for decision, strategic discussion and assurance.

4.5 Board agendas will contain standing items (e.g. regular reports), and other items on the agenda will be items requiring decision, assurance or issues posing a major risk to the organisation. Sufficient time should be allocated for in-depth conversations.

4.6 Follow-up to Board decisions and actions is systematically tracked, with clear ownership (to either executive members or Committees depending on the item) and reporting back to the Board to confirm delivery and impact.

5. Dependencies

5.1. Achievement of the ICB's objectives, delivery of its duties and adherence to its agreed ways of working only work if the broader partnerships within which the ICB plays a core role also function effectively.

5.2. There are therefore critical dependencies in the ICB undertaking the above ways of working which rely on successful partnerships which are not directly governed by the ICB governance structure. These include, but are not limited to the SWL System Sustainability Group, People Board, Estates Board, and Digital Board, and at place level, Health and Wellbeing Boards and neighbourhood place partnerships in each borough.

NHS South West London
Integrated Care Board

Annual Report and Accounts 2025/26

Agenda item: 5

Report by: Dinah McLannahan, Chief Finance and Compliance Officer/Ben Luscombe, Director of Corporate Affairs

Paper type: Information

Date of meeting: Wednesday, 15 July 2026

Date published: Wednesday, 8 July 2026

Purpose

The purpose of the paper is to present to the Board at a meeting held in public the ICB's audited Annual Report and Accounts for 2025/26.

Executive summary

NHS South West London's Annual Report and Accounts for 2025/26 is presented to the Board in line with NHS England guidance, which requires presentation at a meeting held in public by 30 September 2026.

The Annual Report has been produced in accordance with the NHSE requirements of the Department of Health and Social Care group accounting manual 2025/2026 published in January 2026. The audited annual report and accounts were submitted to NHS England on Wednesday 17 June 2026, ahead of the deadline of Friday 19 June 2026, following the issue of an unqualified opinion by the ICBs external auditors.

The annual accounts reported achievement of all the ICBs financial duties and targets for 2025/26 and were commended by the external auditors for their high quality. The annual report has been produced in compliance with NHS guidance, and the report is used by NHS England as a principal source of assurance for the ICB's annual assessment.

You can read the ICB's Annual Report and Accounts on our website, which meets the requirement to publish these by 30 September 2026. A summary annual report for ease of reading will also be produced and published.

Key Issues for the Board to be aware of

- This year the Annual Report is written to reflect the new direction of travel for the NHS relating to the 10-Year Health Plan and the three shifts, as well as SWL ICB's further development as a strategic commissioning organisation as outlined in recent national guidance documents.

- NHS England London region use the ICB annual report as "its main source of evidence" for the statutory assessment of each ICB. This year's Key Lines of Enquiry (KLOEs) were published on Wednesday 22 April as part of the NHS England guidance for the 2025/26

annual assessment of integrated care boards (ICBs). Responses to each of these KLOEs are contained within the final draft.

- The Audit and Risk Committee reviewed and approved the final draft of the NHS South West London 2025/26 Annual Report at their meeting on 9 June 2026 before submission to NHS England.

Recommendation

The Board is asked to:

- Note the ICB 2025/26 annual report and accounts.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest

No specific issues or information giving rise to conflicts of interest are highlighted in this paper.

Corporate objectives

The Annual Report provides the overview for the ICB's work during 2025/26 including delivery against the ICB objectives and will form the basis for NHS England's assessment of our work. This includes:

- System leadership and support
- Improving population health and healthcare
- Tackling unequal outcomes, access and experience
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

Risks

- The Annual Report includes a section on how the ICB manages risks.

Mitigations

- N/A

Financial/resource implications

- The Annual Accounts report the financial performance of the ICB for the 2025/26 financial year.

Green/Sustainability Implications

- It is a requirement for the Annual Report to have a sustainability section that outlines the actions the ICB has taken and progress it has made during the financial year 2025/26 in this key area.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?

- It is a requirement for the Annual Report to include core information in a Reducing Health Inequalities section which will follow guidance set out in NHSE Guidance for NHS commissioners on equality and health inequalities legal duties published November 2023.

- In addition, highlights from the ICB's equality, diversity and inclusion work has been included throughout the narrative of the document.

Patient and public engagement and communication

- The Annual Report includes a chapter to meet requirements on the ICB's work to engage with people and communities. This year there is also a supplementary stand alone report to detail the ICB's engagement with people and communities.

- The Annual Report and Accounts are required to be presented at a meeting held in public by the end of September 2026. This report presented at the Board meeting held in public meets this obligation.

Previous committees/groups

Committee name	Date	Outcome
Senior Management Team	Thursday 22 January 2026	SMT agreed the approach and timeline and made recommendations on content collection.
Audit and Risk Committee	Tuesday 27 January 2026	The Audit and Risk Committee agreed the approach and timeline.
Audit and Risk Committee	Tuesday 24 March 2026	The Audit and Risk Committee were asked to review and comment on the first draft of the Annual Report.
Audit and Risk Committee	Tuesday 9 June 2026	The Audit and Risk Committee reviewed and approved the final draft of the NHS South West London 2025/26 Annual Report before submission to NHS England.

Final date for approval

The Audit and Risk Committee reviewed and approved the final draft of the NHS South West London 2025/26 Annual Report at their meeting on 9 June 2026 before submission to NHS England.

Supporting documents

The Annual Report and Accounts 2025/26 can be read in full on the ICB's website.

Authors

Neil McDowell, Director of Finance
Steve Crocker, Deputy Director – Corporate Affairs
Lizzie Whetnall, Deputy Director of Communications and Engagement

NHS South West London
Integrated Care Board

Annual Report and Accounts 2025/26

Introduction

The purpose of this paper is to provide an update for the Board on the ICB Annual Report and Accounts for the year 1 April 2025 to 31 March 2026.

Submission of Annual Accounts and Annual Report

The final, audited ICB annual accounts and annual report, together with all required supporting documentation, was submitted to NHS England in advance of the national deadline of 19 June 2026.

Governance Arrangements (including the external audit) of the Annual Accounts and Annual Report

The annual accounts and annual report were presented to the ICB Audit & Risk Committee on 9 June 2026, for approval under delegation from the Board. The ICB's external auditors presented their Audit Findings Report and Annual Audit Report to the committee members at the same meeting. The Committee considered the External Audit Findings Report and welcomed the overall positive position. Members noted the absence of material audit adjustments and recognised this as a strong outcome. An unmodified opinion to the accounts was proposed. In addition, the ICBs internal auditors delivered their annual report and the committee determined the outcomes of this report were consistent with the contents of the annual report. On this basis, the Audit & Risk Committee approved the Annual Report and Accounts.

The ICB received an unqualified opinion on the annual accounts from its external auditors. Specifically:

- An unqualified opinion on the financial statements.
- Regularity - the expenditure and income recorded in the financial statements had been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.
- Nothing to report in respect of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources.

There was no unadjusted misstatement in the ICB's annual accounts.

Aside from the usual presentational changes agreed with our external auditors, the final audited annual accounts were consistent with the draft accounts submitted at the end of April 2026.

Financial Performance of the ICB

The ICB met all of its financial duties for 2025/26, with the performance as detailed below:

- a surplus of £84k against its overall Revenue Resource Limit.

- an underspend against its Running Cost allocation (RCA) of £2.7m. This was primarily due to staffing vacancies that were held during the year ahead of the current staffing restructure programme.
- compliance with the Mental Health Investment Standard (£242k above requirement).
- all targets under the Better Payment Practice code.
- a year-end cash balance of £1.6m, well within the stipulated target.

Annual report

The annual report has been produced in accordance with NHS England and Treasury guidance. The contents have been sourced from departments across the ICB in order to ensure the contents provide commentary and analysis of the critical areas required by the guidance. This includes statutory reporting around Task Force on Climate-related Financial Disclosures (TFCD), and governance and internal control reporting.

The report has been reviewed as part of the external audit process with no material matters of concern noted. The relevant information included in the remuneration and staff report sections has been fully audited, and this has been noted in the report.

In addition to the full annual report and accounts, published in line with guidance, a summary of highlights will be published for ease of reference. This document is currently in production and will be shared on the ICBs website alongside the full annual report and accounts.

Conclusion

The final, audited versions of the Annual Report and Accounts are now available on the ICB's website in line with the 30 September 2026 deadline set by NHS England. You can read the Annual Report and Accounts here.

The requirement to also present the annual report and accounts at a meeting of the ICB held in public by this date is being met through delivery of this report to the ICB Board.

NHS South West London
Integrated Care Board

Finance and Planning Committee update

Agenda item: 6.1

Report by: Jamal Butt, Non Executive Member SWL

Paper type: Information

Date of meeting: Wednesday, 15 July 2026

Date published: Wednesday, 8 July 2026

Purpose

To provide the Board with an overview of the key issues discussed at the Finance and Planning Committee at its May meeting.

Executive summary

The Finance and Planning Committee has met once since the last update to the ICB Board, on 27 May 2026. The meeting was quorate and chaired by Jamal Butt. The following items were discussed:

ICB Business

Medium Term Planning Update

- The Committee received an update on the finalisation of the medium-term operational plan for SWL ICB. The Committee noted that NHSE has now formally accepted our plans.
- All ICBs had been required to submit narrative to describe how we intend to maximise the opportunity of the multi-year planning process and realise the benefits of the 10-year plan, particularly the development of Neighbourhood Health.
- The paper also set out progress against the investment priorities for SWL for 2026/27.
- The Committee noted the paper.

SWL ICB M1 Finance update

- The Committee noted that finances are not formally reported until M2. In lieu of this the paper set out an update on the key risks to delivery of the financial plan. Assurance was provided on the development of efficiencies and how prescribing risks are monitored in-year.
- The Committee noted the update.

SWL ICB M1 Operational update

- The paper provided the Committee with an update on M1 operational performance. Performance data was not fully validated however evidence indicated a strong start to the year for the Referral to Treatment 18-week target, whilst noting the significant challenge to deliver the required improvement for the full year. There was a small deterioration on the 4-hour A&E standard from March 2026.

- The Committee noted the report.

Finance and Planning Committee handover to new governance structure

- The Committee noted that this was the last formal meeting of the Finance and Planning Committee and that, under the revised governance arrangements in line with the Model ICB, financial oversight will be the responsibility of the Strategic Commissioning Committee and any agreed sub-committees.
- The Committee noted that the newly established System Sustainability Group will operate as a jointly chaired forum between the ICB and provider leadership, with collective responsibility for overseeing delivery of system-wide transformation and sustainability plans.
- The Committee supported the overall direction of travel; noting that, further refinement is required, particularly to ensure clear and robust arrangements for operational financial oversight and accountability within the new governance structure.

SWL ICS Business

- The M12 pre-audit financial position for 2025/26 was presented to the Committee.
- The Committee noted that responsibility for aggregating and reporting system financial performance for 2026/27 will transfer to NHSE, with the ICB no longer producing consolidated ICS reports.
- The Committee noted the report.

Business cases and contract awards

- The Committee reviewed business cases and contract awards in line with the ICB governance arrangements and responsibilities of the Committee.

Recommendation

The Board is asked to:

- Note the Committee report.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
N/A

Corporate objectives
- Delivering the financial plan
- Delivering the ICS operational plan

Risks
None as a result of this paper

Mitigations
None as a result of this paper

Financial/resource implications
None as a result of this paper

Green/Sustainability Implications
None as a result of this paper

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
None as a result of this paper

Patient and public engagement and communication
N/A

Previous committees/groups

Committee name	Date	Outcome
Finance and Planning Committee	27 May 2026	

Final date for approval
N/A

Supporting documents
None

Lead director
Dinah McLannahan, Chief Finance and Compliance Officer, SWL ICB

Author
Kath Cawley, Director of Planning, SWL ICB

NHS South West London
Integrated Care Board

SWL ICB 2026/27 Month 2 Position

Agenda item: 6.2

Report by: Dinah McClannahan, Chief Finance and Compliance Officer

Paper type: Information

Date of meeting: Wednesday, 15 July 2026

Date published: Wednesday, 8 July 2026

Purpose

This paper is being brought to update on the month 2 financial position for the 2026/27 financial year.

Executive summary

The attached paper sets out the position of the ICB at month 2.

The ICB has set itself a breakeven target for 2026/27 with a profiled adverse plan year to date (£0.8m) due to savings delivering later in the year.

Key areas to note are:

- Savings plan is £33.3m and is on plan to deliver. £5.8m of these are non-recurrent
- Right To Choose providers are still expected to exponentially increase above the plan until the new pathways have been agreed.
- Prescribing underspend is the value of the accrual from 2025/26. No data has been received for 2026/27 although noting the run rate on no cheaper stock obtainable drugs increased in the last 2 months of 2025/26.
- All Age Continuing Health Care (CHC) is showing a favourable variance although driven by lack of agreements for pay increase with non AQP providers.
- Profiling of management cost savings is causing overspends year to date, but this is just a timing issue and not unexpected.

Key Issues for the Board to be aware of

- The ICB is forecast to be on plan.
- The efficiency plan is set to deliver noting level of non-recurrent.
- Right to Choose Providers is still a significant risk until we have agreed a new commissioning approach.

NHS South West London
Integrated Care Board

Recommendation

The Board is asked to:

- Note the month 2 reporting position and the risks set out in the executive summary

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
N/A

Corporate objectives
This document will impact on the following Board objectives:

- Making best use of resources

Risks
Detailed in the paper.

This document links to the following Board risks:

- RSK -014 Financial Sustainability

Mitigations
Actions taken to reduce any risks identified:

- Set out in the paper

Financial/resource implications
Outlined in the paper

Green/Sustainability Implications
Set out in the paper (if applicable)

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
N/A

Patient and public engagement and communication
N/A

Previous committees/groups

Committee name	Date	Outcome

Final date for approval
N/A

Supporting document
Month 2 SWLICB Finance Report

NHS South West London
Integrated Care Board

Lead director

Dinah McLannahan, Chief Finance and Compliance Officer

Author

Neil McDowell, Director of Finance

NHS
South West London

SWL ICB Month 02 Finance Report

Contents

NHS South West London

ICB financial overview month 02

NHS South West London

Target	Measure	Month 02 Position	RAG Status
Planned surplus	Achieving breakeven position	Forecasting breakeven position	Achieved
Efficiency	Deliver £33.3m of efficiency savings in year.	Forecasting £33.3m of savings.	Achieved
Mental Health Investment Standard	Increase Mental Health expenditure by 2.03%, in line with NHS inflation	Projected increase 2.03%	Achieved
Running Costs	ICB running costs not to exceed £26.5m	Forecast spend £26.5m	Achieved
Better payments practice code	Paying 95% of invoices within 30 days	99% invoice paid within 30 days	Achieved
Cash Balance	Cash in bank at month end within the 1.25% draw down limit	Cash 0.58% of drawdown limit	Achieved

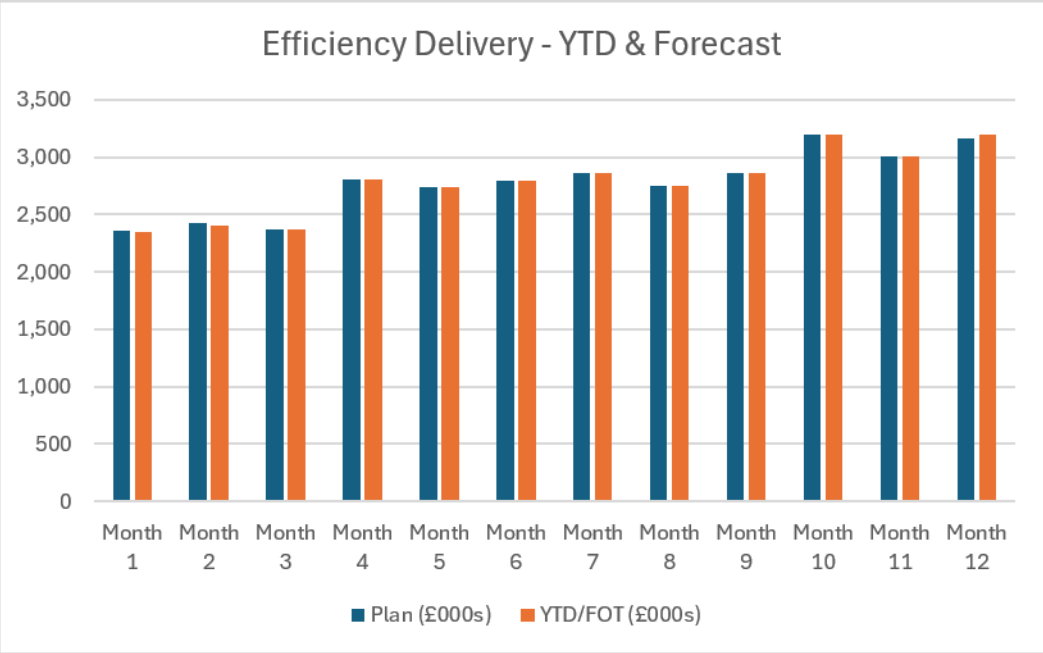
Allocation and Expenditure	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Annual Budget £000s	Forecast Outturn £000s	Forecast Variance £000s
Total Allocation (Income)	**£707,179**			**£4,382,422**		
Expenditure:						
Acute Services (NHS & non-NHS)	£326,311	£326,311	£0	£2,021,882	£2,021,882	£0
Specialist Commissioning	£86,194	£86,194	£0	£539,507	£539,507	£0
Community Health Services	£50,248	£50,248	£0	£319,650	£319,650	£0
All Age Continuing Healthcare	£31,043	£29,621	£1,422	£186,256	£186,256	£0
Corporate & Other	£13,620	£16,185	-£2,565	£115,091	£115,091	£0
Mental Health	£69,507	£69,904	-£397	£416,200	£416,200	£0
Primary Care (Incl Prescribing & Delegated)	£131,044	£130,292	£752	£783,837	£783,837	£0
Total Expenditure:	**£707,967**	**£708,755**	**-£788**	**£4,382,422**	**£4,382,422**	**£0**
Surplus/(Deficit)	**-£788**			**£0**		

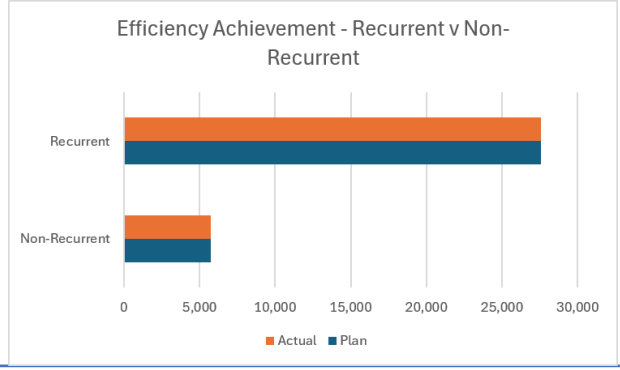
Key Messages:

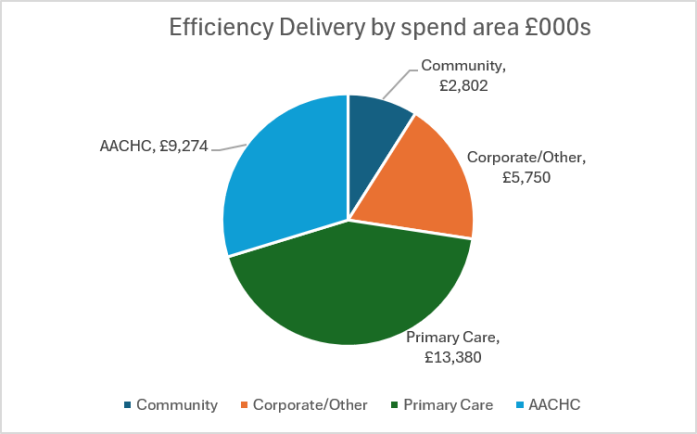
- The ICB position as at 31st May 2026 is a small deficit of £0.8m in line with the profiled plan, and a FOT to deliver a breakeven position as planned.
- The efficiency plan is on course to deliver in line with the £33.3m target and is broadly on track compared to the YTD plan.
- All Aged Continuing Healthcare (AACHC) position is based on patient levels for the first two months of the year but is not reflective of agreed rates for 26/27 hence the underspend year to date.
- Mental health services is showing a small variance of £0.4m YTD based on early expenditure trends. The main driver for the overspend is continued increases in Right to Choose assessments.
- The year to date underspend of £0.8m within primary care is due to a favourable variance on prescribing after receiving the final 2025/26 expenditure compared to what was estimated at year end.

Overview of SWL ICB's efficiency plan

NHS South West London







Narrative –

- The efficiency plan is on course to deliver the £33.3m target, with the YTD position broadly on plan.
- £5.8m of the forecast savings are non-recurrent in nature.
- Key priorities for the next month (July):
  - Monitoring meetings with place and functional leads continuing monthly to finalise supporting project documentation for all schemes identified.
  - Continue work to have robust in-year monitoring for all active efficiency schemes.

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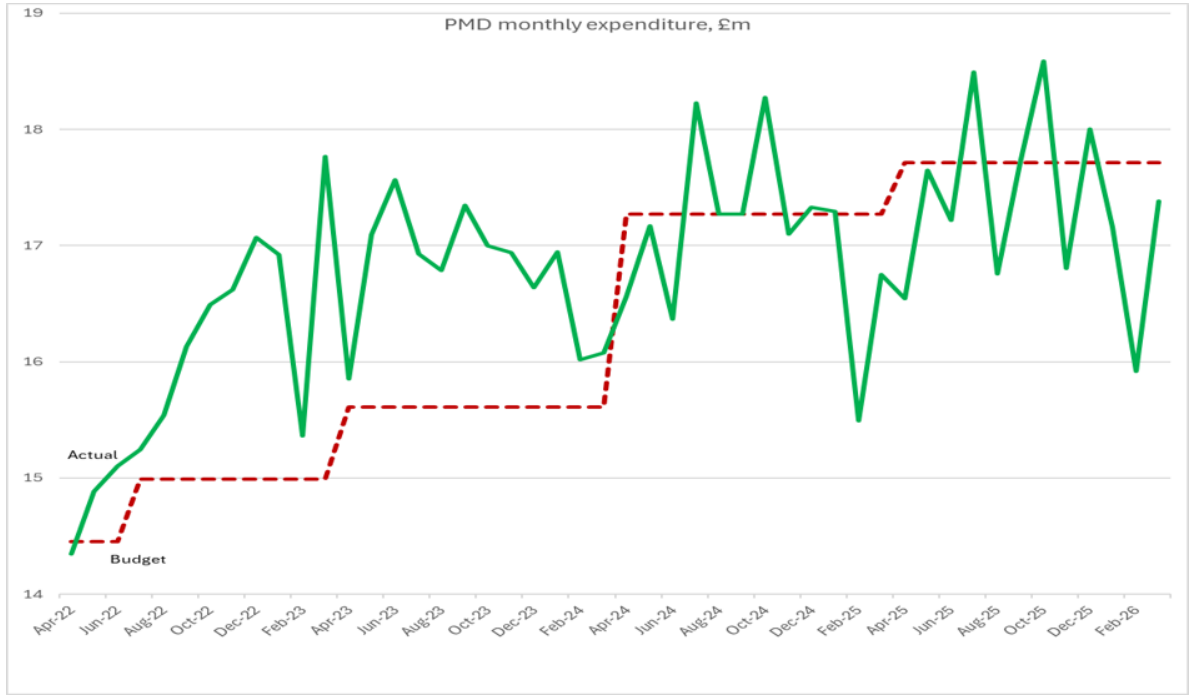
APPENDIX

A. Medicines management and prescribing overview

NHS South West London



- There is a two month lag in prescribing data so there is no information available yet relating to 2026/27, however we can look at trends approaching the new financial year.
- In 2025/26, 26.1m items were issued against an expected 26.3m;
- The average cost per issue was £7.96 against a budget of £8.07;
- The spend reduction seen in the second half of the year is partly attributed to savings due to the availability of a generic version of SGLT1-inhibitors since September 2025.
- There was a significant increase in NCSO (No Cheaper Stock Obtainable) costs in the final quarter of 2025/26 which presents a financial risk running into 26/27.

B. Mental Health Investment Standard (MHIS) overview

NHS South West London

Current Financial Position (M2)

- At Month 2, the MHIS position is reporting delivery in line with plan, with no material variance identified at this stage.
- The wider Mental Health budget is reporting a £0.3m overspend (0.5%) year to date. This is primarily driven by NCA activity (£0.2m overspend) reflecting early-year demand above plan.
- At this early stage of the year, the overall position remains stable. However, emerging pressures in NCA activity and CYP placements will require ongoing monitoring, particularly in the context of planned commissioning changes.

Mental Health Spend By Category	MHIS Ref	Total Mental Health (MHIS) BLOCK Actual(£000s)
Children & Young People's Mental Health (excluding LD)	1	30,574
Children & Young People's Eating Disorders	2	2,273
Perinatal Mental Health (Community)	3	4,250
NHS Talking Therapies, for anxiety and depression	4	32,835
A and E and Ward Liaison mental health services (adult and older adult)	5	13,244
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	8,029
Adult community-based mental health crisis care (adult and older adult)	7	25,914
Ambulance response services	8	0
Community A – community services that are not bed-based / not placements	9a	88,164
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	66,224
Mental Health Act	10	2,351
SMI Physical health checks	11	0
Suicide Prevention	12	241
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	74,898
Adult and older adult acute mental health out of area placements	14	1,091
Mental health prescribing	16	8,375
Mental health in continuing care (CHC)	17	1,300
Mental Health Placements in Hospitals	20	2,688
Mental Health Support Teams in Schools	21	8,078
Sub-total - MHIS (inc CHC, Prescribing)		**370,529**
Learning Disability	18a	16,991
Autism	18b	7,044
Learning Disability & Autism - not separately identified	18c	32,463
Sub-total - LD&A (not included in MHIS)		**56,498**
Dementia	19	8,560
Sub-total - Dementia (not included in MHIS)		**1,304**
TOTAL - Mental Health, LD&A and Dementia Spend		**56,635**
Target MHIS Spend		**370,528**
Forecast MHIS Spend		**370,529**
Excess/Shortfall in 2025/26 MHIS Delivery %		**0.00%**
Excess/Shortfall in 2025/26 MHIS Delivery		**1**

NHS South West London
Integrated Care Board

Quality & Performance Oversight Committee Update

Agenda item 6.3

Report by: Masood Ahmed, Non-Executive Member & Chair of the Quality & Performance Oversight Committee

Paper type: Information

Date of meeting: Wednesday, 15 July 2026

Date published: Wednesday, 8 July 2026

Purpose

To provide the Board with an overview from the Non-Executive Member Chair of the Committee regarding the key quality matters discussed at the South West London (SWL) ICB Quality and Performance Oversight Committee (QPOC) meeting on 10 June 2026.

Executive Summary

The Quality and Performance Oversight Committee has met once since the last update to the ICB Board. The updates below are following consideration and discussion of key items at the meeting:

Quality and Performance Board Assurance Framework and Corporate Risk Register

The Committee noted the reports highlighting:

- Overall risk profile remains stable, with 13 risks recorded (3 Board Assurance Framework risks and 10 Corporate Risk Register risks).
- NHS England's revised quality oversight arrangements represent a significant change to assurance processes, requiring alignment of governance arrangements during this transition year.
- Positive progress noted in Continuing Healthcare and maternity services.
- Continued partnership working with local authorities is required to address gaps in support for people not meeting Continuing Healthcare eligibility thresholds.

The Committee emphasised the importance of continued monitoring in light of organisational transition and system demand. More updates will be provided to the Committee on the revised quality oversight arrangements after the NHSE workshop in June 2026.

Neighbourhood Health and Care Services Update

An update on neighbourhood health and care was presented to the Committee with the following noted

- The system is progressing towards integrated, neighbourhood-based models of care focused on population outcomes rather than transactional commissioning.

- Croydon is acting as a pilot site to inform a South West London-wide quality framework and outcome measures.
- Robust clinical governance arrangements will be essential to ensure accountability across organisational boundaries.
- Delivery risks were identified, including reduced place-based capacity following organisational change, workforce challenges, and the need for clear roles and accountabilities.
- A system-wide dashboard and strengthened assurance arrangements are being developed to monitor delivery and support safe delegation of resources.

Neighbourhood Health will remain under regular Committee oversight.

NHS England Draft Oversight Framework
The draft framework was presented to the Committee with the following noted:

- The draft framework introduces 38 population-focused metrics and will require embedding across organisational planning, performance and risk management arrangements.
- The Committee highlighted the need for stronger emphasis on children, prevention and health inequalities.
- Alignment between risk reporting, performance reporting and the new oversight framework will be developed to ensure coherent assurance to the Board.

The Committee requested proposals on how NHS Oversight Framework metrics will be reported to the Committee, ensuring alignment between the Framework and both risk and performance reporting.

Committee Effectiveness Survey
The survey was presented to the Committee with the following noted:

- Feedback reiterated the need for greater strategic discussion and enhanced scrutiny time within Committee meetings.
- Stronger alignment between quality, finance and wider Committee structures will be important as governance arrangements evolve in response to organisational change.

The Committee acknowledged that governance arrangements are likely to evolve in line with wider organisational change and noted that the feedback will inform the development of future Committee structures.

SWL ICB Performance Report
The Committee received the SWL ICB performance report and noted the following:

- Elective, diagnostic and cancer services continue to demonstrate resilience.
- Pressures remain within urgent and emergency care, particularly achievement of the four-hour standard and management of patients with mental health needs.
- A joint urgent care and mental health board has been established to drive improvement and address system pressures.

SWL System Quality Report
The Committee received the SWL ICB Quality Report and noted the following:

- Sustained operational pressures in urgent and emergency care continue to impact patient flow and patient experience.
- Key quality risks include infection prevention and control, safeguarding, domestic abuse and child protection.

- Maternity services continue to improve following transition from national support arrangements to regional oversight.
- Ongoing investigations relating to pathology services and interstitial lung disease require continued Board oversight.
- Assurance was provided that robust quality governance arrangements remain in place during transition to new national and regional oversight arrangements.

Recommendation

The Board is asked to:

- Note the Quality and Performance Oversight Committee report.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
None.

Corporate objectives
Quality is underpinned by everything we do in SWL ICB. Quality supports the ICB's objectives to tackle health inequalities, improve population health outcomes and improve productivity.

Risks
Quality risks are included in the SWL ICB Corporate risk register and escalated to the Board Assurance Framework where appropriate.

Mitigations
The mitigations of the quality risk are included in the corporate risk register.

Financial/resource implications
Balancing system efficiency across SWL without compromising patient safety and quality.

Green/Sustainability Implications
Not Applicable.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
An EIA has been considered and is not needed for this report. However, EIAs are being completed as part of the process in identifying system efficiency.

Patient and public engagement and communication
We work closely with Quality and Safety Patient Partners, patients and public including specific impacted communities linking with our Voluntary Care Sector the voices of our population and using this insight to improve organisations to ensure we are listening to quality.

Previous committees/groups

Committee name	Date	Outcome
SWL Quality & Performance Committee (QPOC)	10 June 2026	Noted

Final date for approval
Not applicable

Lead Director
Elaine Clancy, Chief Nursing Officer

NHS South West London
Integrated Care Board

SWL System Quality Report

Agenda item: 6.4

Report by: Elaine Clancy, SWL ICB Chief Nursing Officer

Paper type: Information

Date of meeting: Wednesday, 15 July 2026

Date published: Wednesday, 8 July 2026

Purpose

- To provide the Board with an overview of the system quality picture across South West London (SWL), highlighting key risks identified at the SWL ICB's Quality and Operational Management Group in April and May 2026 and Quality and Performance Oversight Committee in June 2026.
- To provide the Board with assurance that mitigations are in place to manage quality risks, and that the system continues to make improvements to improve safety and quality through an increased learning culture.

Executive summary

The focus of the report is to provide the ICB Board with an update of emerging risks and mitigations, provide an outline of continuous improvements progress and provide assurance that quality risks and challenges are being addressed appropriately. The report covers the period of April and May 2026, unless stated otherwise.

1. Sustained Operational and Quality Pressures Across the System

South West London continues to experience operational pressures across urgent and emergency care, inpatient services and community services, driven by high demand, workforce challenges and financial constraints. Providers are focused on maintaining patient safety, improving flow and managing capacity, but pressures remain significant.

2. Patient Safety and Clinical Risks with Continued Oversight

Several patient safety issues require ongoing monitoring and assurance:

- Ongoing homicide investigations and complex multi-agency incidents.
- Two new Never Events reported since April 2026, with SWL remaining the second highest reporting ICB in London.
- The SWLP Faecal Immunochemical Test (FIT) incident affected over 4,200 patients and 281 GP practices, with system-wide harm reviews still underway.
- Historical Interstitial Lung Disease (ILD) review at Epsom and St Helier (ESTH) remains a significant governance issue ahead of publication of the external review planned 9 July 2026.

3. Digital Incidents Have Become a Patient Safety Concern

Digital system issues across St Georges, Epsom and St Helier Hospital Group (GESH) and Royal Marsden Hospital (RHH) are impacting data integrity, clinical decision-making and management of clinical information, with manual workarounds increasing operational risk. Digital patient safety has emerged as a growing regional concern requiring strengthened oversight and shared learning.

4. Maternity and Safeguarding

- CHS maternity services have been rated as Requires Improvement by the CQC, with actions progressing around leadership, training and governance.
- Safeguarding demand and complexity continue to increase, particularly for vulnerable children and people with complex needs in Croydon, requiring additional investment and system support.

5. Positive Progress in System Improvement and Quality Oversight

There are several encouraging developments:

- New NHS England Quality Oversight arrangements provide greater clarity around responsibilities for quality and patient safety.
- Progress is being made on the Paediatric Audiology Improvement Programme and PSIRF pilots in general practice.
- Continuous improvement work across the system is delivering innovations in mental health pathways, discharge planning and use of patient experience insights to drive improvement.

Recommendation

The Board is asked to:

- Note that as the system continues to face significant financial and operational challenges, the pressure and demand on providers and the ICB continues to be significant, the focus on safety and quality of care is constantly being prioritised.

- Note the content of the quality report and areas of focus and be assured that risks are being managed through the appropriate governance and escalation arrangements between providers and the ICB's CNO directorate. The BAF has been updated to capture the transition of the ICB, the pressures in the system and the management change impact.

- Be assured that the exceptions highlighted within the report have been presented and discussed at the Quality Operational Management Group (QOMG) April and May 2026 and Quality and Performance Oversight Committee in June 2026.

- Note that quality and equality impact assessments are being undertaken across the ICB and providers to assess, quantify and mitigate patient safety and equity risks

- Be assured of continuous improvements which have progressed, some of which are highlighted in the report to improve outcomes for patients across SWL.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
None

Corporate objectives
Quality is underpinned by everything we do in SWL ICB. Quality supports the ICB's objectives to tackle health inequalities, improve population health outcomes and improve productivity.

Risks
Quality risks are included in the SWL ICB Corporate risk register and escalated to the Board Assurance Framework where appropriate.

Mitigations
The mitigations of the quality risk are included in the corporate risk register.

Financial/resource implications
Balancing system efficiency across SWL without compromising patient safety and quality.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
An EIA has been considered and is not needed for this report. However, EIAs are being completed as part of the process in identifying system efficiencies and where significant change is service delivery or care pathways impact patients and staff.

Patient and public engagement and communication
We work closely with Quality and Safety Patient Partners, patients and public including specific impacted communities linking with our Voluntary Care Sector organisations to ensure we are listening to the voices of our population and using this insight to improve quality**.**

Previous committees/groups

Committee name	Date	Outcome
SWL ICB Quality Operational Management Group (QOMG)	March and April 2026	Internal directorate review and assurance
Senior Management Team (SMT)	June 2026	Noting
Quality and Performance Oversight Committee	June 2026	Assurance

NHS South West London
Integrated Care Board

Final date for approval
N/A

Supporting documents
Quality Report

Lead Director
Elaine Clancy, Chief Nursing Officer

NHS
South West London

SWL System Quality Report

ICB Board

July 2026

Our vision is to improve safety, experience and overall quality of the health, wellbeing and lives of those we commission care for

Introduction

NHS South West London

The report provides the ICB Board with an overview of the quality of services within South West London Integrated Care Board (ICB).

- It identifies emerging and ongoing quality risks impacting on patient safety and experience, update on improvement work and assurance that risks and challenges are being mitigated.
- The report covers the period of April and May 2026 unless stated otherwise.

The Board is asked to:

- Note the quality report, highlighting the use of increased data and metrics to support the oversight of patient safety, patient experience, and clinical effectiveness for SWL's population.
- Note the content of the quality report and be assured that risks are being managed through appropriate governance and escalation arrangements between providers and the ICB.
- Be assured that the exceptions highlighted within the report were presented and discussed at the Quality Operational Management Group (QOMG) in April and May and Quality and Performance Oversight Committee (QPOC) in June 2026.

Executive summary - Challenges

NHS South West London

- **Operational pressures across SWL**: Operational pressures continue across urgent and emergency care, inpatient services and community services driven by sustained demand, workforce pressures and system transition. Providers continue to implement their plans focused on maintaining patient safety, managing bed capacity, reducing length of stay and improving flow, alongside close collaboration with system partners to manage demand effectively to support safe delivery of services during continued financial and operational challenge.

- **Infection Prevention and Control and anti-microbial stewardship:** In November 2025, a call-to-action letter from NHSE was written to Chief Nurses, Medical Directors and Chief Pharmacists to work with prescribers and their clinical leads to make the changes required to meet the targets in the national action plan for AMR. An update was shared with Quality Operational Management group (QOM) ahead of the July 2026 board, providing assurance on current performance against AMR targets and to identify immediate actions required.

- **Hantavirus outbreak and complex health protection incidents:** UKHSA-led London workshop proposed for 19 June 2026 to strengthen multi-agency response to complex health protection incidents, supported by national guidance (Pan-London MoU and NHSE frameworks). SWL ICB is assessing Hantavirus readiness, including identifying a rapid, low-volume home testing pathway (weekly bloods and throat swabs), with options being explored with London Ambulance, Guys and St Thomas NHS Foundation Trust, and regional partners for a potential London-wide approach.

- **Stillbirths and Neonatal deaths update:** Stillbirth rates remain within the expected limits for all 4 Trusts and across SWL. February 2026 rates are below national rates for SWL overall. Neonatal death rates remain within the expected range within all SWL providers however January and February rates for SWL overall are higher than the national rates. This trend is being monitored (see appendix). ICB is continuing to support trust via LMNS and new NHSE oversight structures.

- **SWL Patient Safety Incident Investigations (PSII) Summary**: A PSII is a system-based learning response under PSIRF. It is the most comprehensive type of learning response carried out where causal factors are not understood or for nationally mandated safety incidents. Reporting PSII via STEIS to ICB has not been made mandatory so numbers will vary . **63 PSII were reported in 2025/26** , this was a reduction from 2024/25. Most PSII were related to **unexpected/potentially avoidable death** followed by **Never Events**. PSII numbers should align with the Patient Safety Incident Response Plan (PSIRP) for organisations. The ICB will continue to support providers through their internal patient safety incident and system meetings to ensure alignment with their PSIRPs (see appendix).

- **Homicides**: SWL has 4 Homicides investigations that are still ongoing breakdown as follows (see also appendix).
  - **2 homicides:** NHSE has commissioned independent investigation and still ongoing
  - **2 homicides:** The trust investigation process is still ongoing.

  The ICB has representation on the NHSE Independent Review Group, where decisions regarding the commissioning of independent investigations are made, and continues to support trusts throughout the homicide investigation process.

- **Multiagency/complex patient safety incidents supported by ICB:** Since the requirement set out in the PSIRF guidance for ICBs to support where appropriate multi-agency incidents, SWL ICB has supported three such incidents. All investigations and learning responses have been completed, with ongoing work to follow up on actions. The reviews have generated significant learning that can be used to help shape wider system processes, aligned with our strategic commissioning role going forward.

- **Never Events**: Since 1 April 2026 (and last report to board), 2 Never Events (NE's) have been reported by ESTH (a retained foreign object and a wrong site surgery). A total of 15 NE's were recorded for the year 2025/26 almost similar to year 2024/25 with 14 NE reported. (see appendix) SWL remains second highest ICB in London region for reporting NEs. ICB continues to support trusts in their on-going system actions to reduce NE's.

Executive summary - Challenges

- **Learning from Patient Safety Events (LFPSE) and General Practices:** LFPSE for general practices was launched in July 2021. CQC has issued supporting guidance for general practices. LFPSE is one of the national commitments for general practices in the National Primary Care Patient Safety Strategy and General Practice Annual Electronic Self-Declaration (eDEC) submissions. Usage of LFPSE continues to be low overall across SWL. Sutton and Croydon practices have higher reporting due to previous/current incentive schemes (see appendix-slide18). Low reporting is a trend seen nationally. Medication related events continue to be the most common theme (however this coincides with previous/current incentive scheme). SWL has developed a range of supporting materials for general practices over the years and the quality team is at hand to support. Further work is required to encourage practices to report incidents via LFPSE. This is recognised nationally as a challenge, as most practices use their local systems for incident reporting and view the use of LFPSE as a duplication of reporting processes.

- **LFPSE Challenges:**
  - **LFPSE Version 6**: Changes to LFPSE mean that trusts which have upgraded to Version 6 are no longer required to log PSIIs on STEIS, in line with guidance issued in October 2024. Most SWL trusts have now upgraded to this version. SWL providers have continued logging PSIIs on STEIS while awaiting clarification from the NHSE regional team, as practice appears inconsistent across London. Some trusts have continued to log PSIIs on STEIS, while others have stopped.

  - **Quality of LFPSE data, ICB access for large providers, and thematic analysis of data:** The ICB receives monthly access to LFPSE data for large NHS providers; however, there are identified gaps in the data and concerns regarding its accuracy. These issues have been escalated nationally through the regional team. In the meantime, the Quality team has requested BI support to assist with analysis of LFPSE data where possible.

- **Make a Difference Quality Alerts:** A total of 1,762 MkAD quality alerts were reported across SWL in 2025/26, this number trend is similar to previous years. Wandsworth and Sutton are the highest reporting boroughs. The top three themes were referral processes (21%), discharge (18%), care and treatment (16%). Work has commenced to redesign the way we manage MKaD process and engagement with system partners will commence soon .

- **CHS Maternity and UEC services:**
  - Following the Trust's inspection in Oct 2025, the CQC final report has rated the trust's maternity services as Requires Improvement. Improvements relating to; triage, training compliance, documentation and equipment assurance, including PAT testing completion are ongoing. A substantive Director of Midwifery has been appointed to support the maternity leadership and improvement actions.
  - Improvement actions are progressing following CQC warning notices for UEC services. Operational pressures in ED continue to impact corridor care.

- **CHS Increasing safeguarding demand and complexity:** CHS is experiencing increasing safeguarding demand and complexity. This is driven by rising numbers of vulnerable individuals, including children looked after (CLA), and those with complex social and mental health needs. Additional investment in safeguarding capacity and strengthened partnership working has improved system response. High compliance has been maintained in some areas, such as health assessments for children looked after, and multi-agency collaboration continues to develop. However, demand continues to rise. ICB is supporting with additional resources which were recently approved.

Executive summary - Improvements

NHS South West London

- **New NHS England Quality Oversight Arrangements**: NHS England has formally published updated guidance describing how quality, patient safety and escalation responsibilities will operate under the new NHS Operating Model. The guidance clarifies the respective roles of NHS providers, Integrated Care Boards (ICBs) NHS England Regional teams, and national oversight arrangements.

- **SWL Paediatric Audiology Services Improvement Programme:** SWL Paediatric Audiology Services Improvement Programme Stage 4 Review and Recall is underway relating to an historical Harm Review which was undertaken in 2022 by GSTT Evelina. There is good progress to date with proposed recall clinics for July 2026.

- **PSIRF Pilots in general practices**: In April 2026, the ICB met with the South London Health Innovation Network (HIN), which is leading the national PSIRF pilots within general practice, to discuss progress and the next steps for ICB support. HIN advised that it is currently preparing the Year 2 pilot evaluation report and is awaiting national guidance on whether a third year of pilots will be required. Within SWL, Sutton PCN participated in the pilot programme. In the interim, the ICB will continue to promote the programme and raise awareness among practices

- **Continuous Improvement Collaborative:** The SWL system continuous Improvement network held its last show and tell visit on the 29th April hosted by SLAM. The event was a success. The following were key highlights of improvement work in SLAM

    - **Introduction of recovery house provision**: This provides both step-down capacity and an alternative to admission and is intended to reduce pressure on inpatient beds, support earlier discharge, and improve patient pathways. However, its impact has not yet been fully realised within system performance metrics, such as emergency department breaches or length of stay.

    - **Introduction of VCSE in-reach support within inpatient settings**: This is contributing to improvements in the overall model of care. This approach enhances patient engagement, supports recovery-focused care, and strengthens discharge planning and community reintegration.

    - **Establishment of the Patient Experience Insight Group**: This is aimed at improving triangulation of complaints, Friends and Family Test data, and PALS feedback for a more systematic approach to learning from patient experience.

Recommendations

NHS South West London

The Board is asked to:

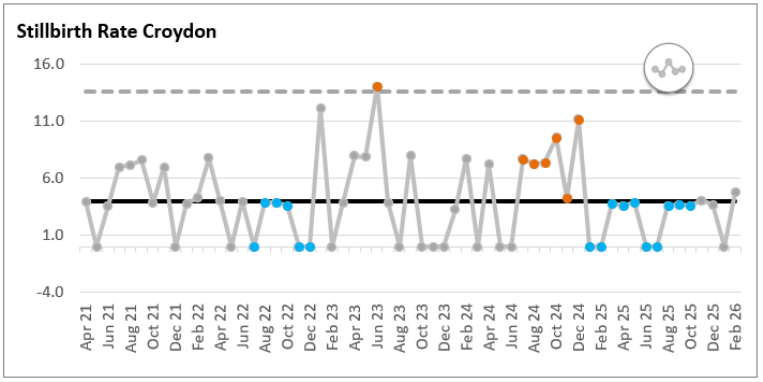
- Note that as the system continues to face significant financial and operational challenges, the pressure and demand on providers and the ICB continues to be significant, the focus on safety and quality of care is constantly being prioritised.
- Note the content of the quality report and areas of focus and be assured that risks are being managed through the appropriate governance and escalation arrangements between providers and the ICB's CNO directorate. The BAF has been updated to capture the transition of the ICB, the pressures in the system and the management change impact.
- Be assured that the exceptions highlighted within the report have been presented and discussed at the Quality Operational Management Group (QOMG) April and May 2026 and Quality and Performance Oversight Committee in June 2026.
- Note that quality and equality impact assessments are being undertaken across the ICB and providers to assess, quantify and mitigate patient safety and equity risks
- Be assured of continuous improvements which have progressed, some of which are highlighted in the report to improve outcomes for patients across SWL.

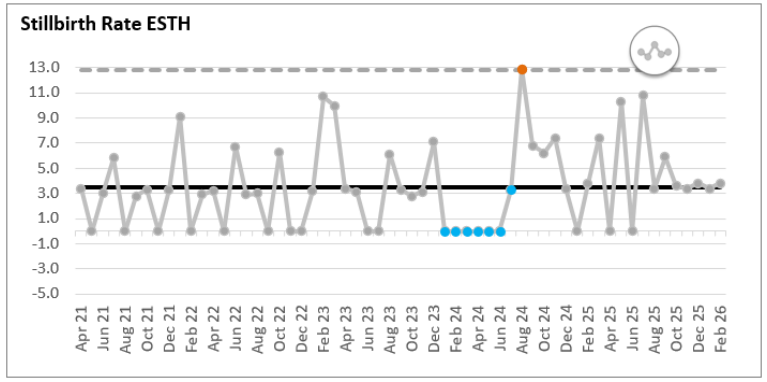
NHS
South West London

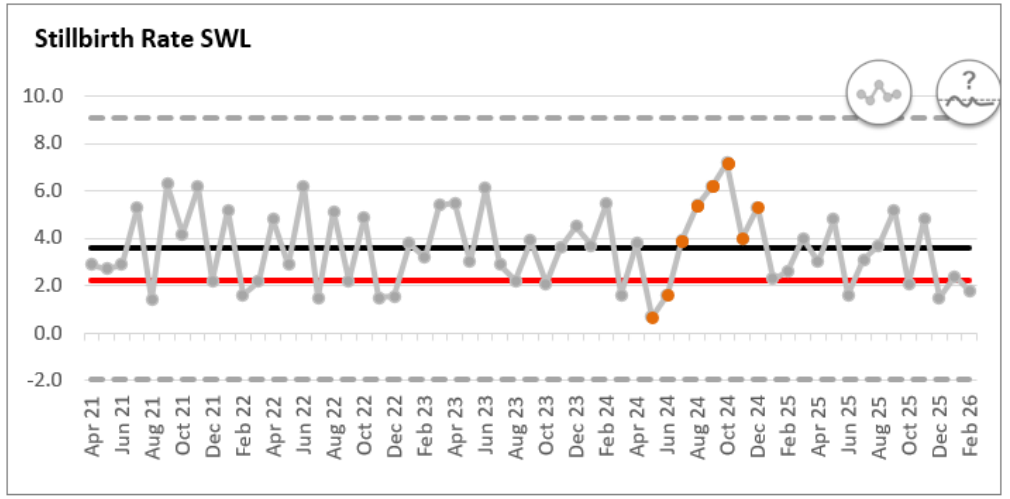
Appendices

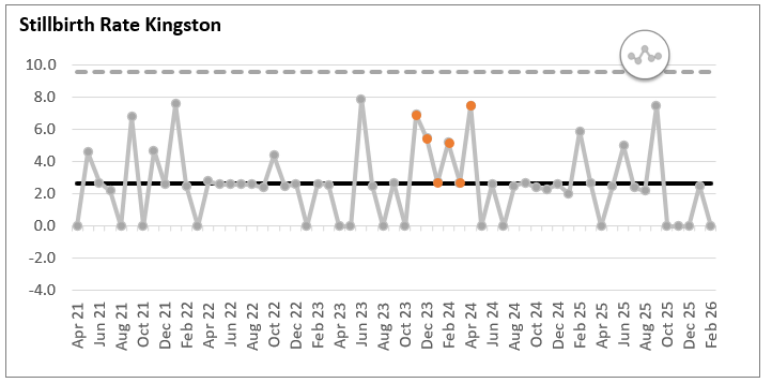
SWL Stillbirth Rates Summary

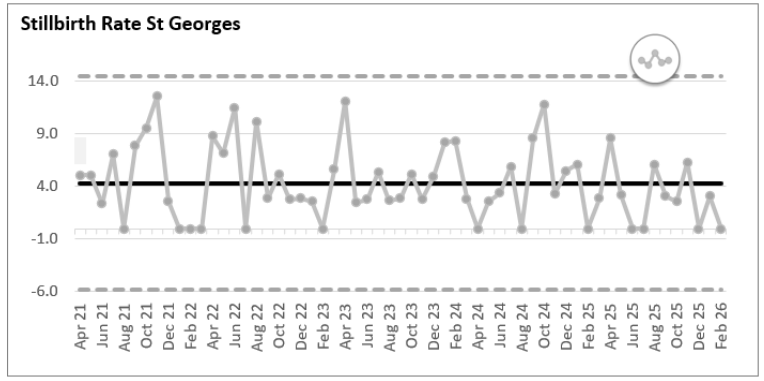
NHS
South West London











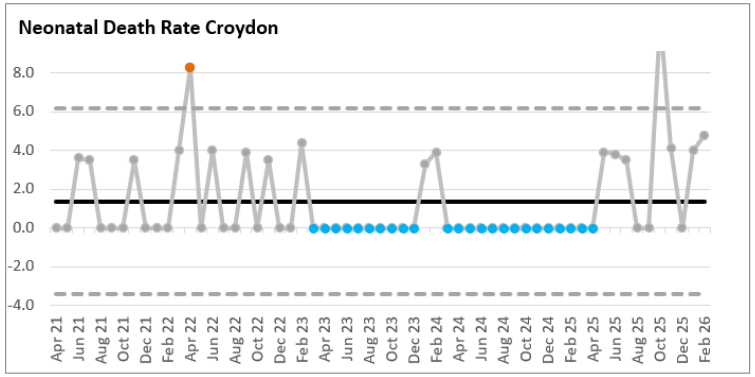
	01/01/26	01/02/26
Stillbirth Rate SWL	2.4	1.8
Stillbirth Rate Croydon	0.0	4.8
Stillbirth Rate ESTH	3.4	3.8
Stillbirth Rate Kingston	2.5	0.0
Stillbirth Rate St Georges	3.1	0.0

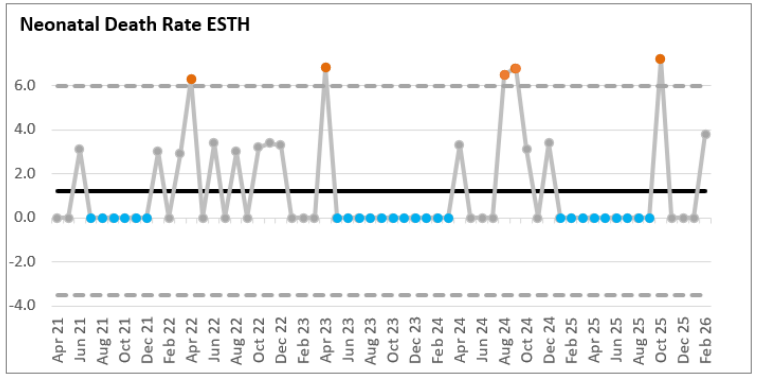
Summary (blue dots = decrease in trend, orange dots = increase in trend)

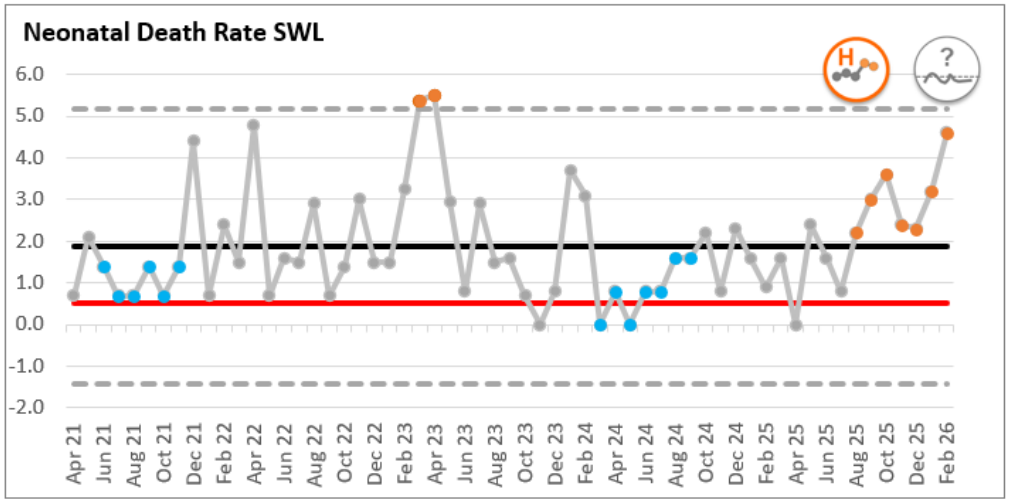
- The stillbirth rates remain within the expected limits for all 4 Trusts and across SWL combined
- National stillbirth rate = 3.9 per 1000 births
- February 2026 rates are below national rates for SWL overall
- ICB is continuing to support trust via LMNS and new NHSE oversight structures

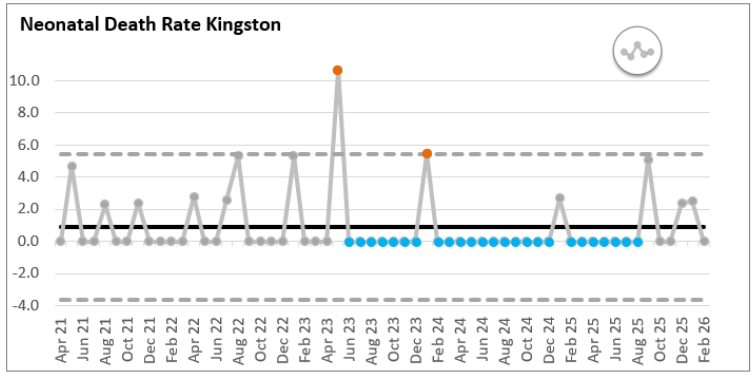
SWL Neonatal death rates update

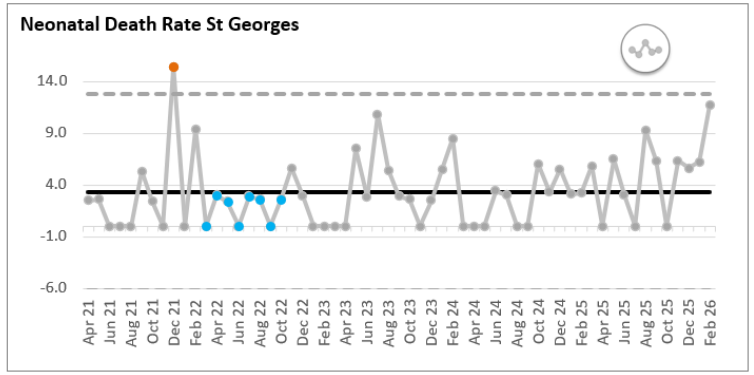
South West London











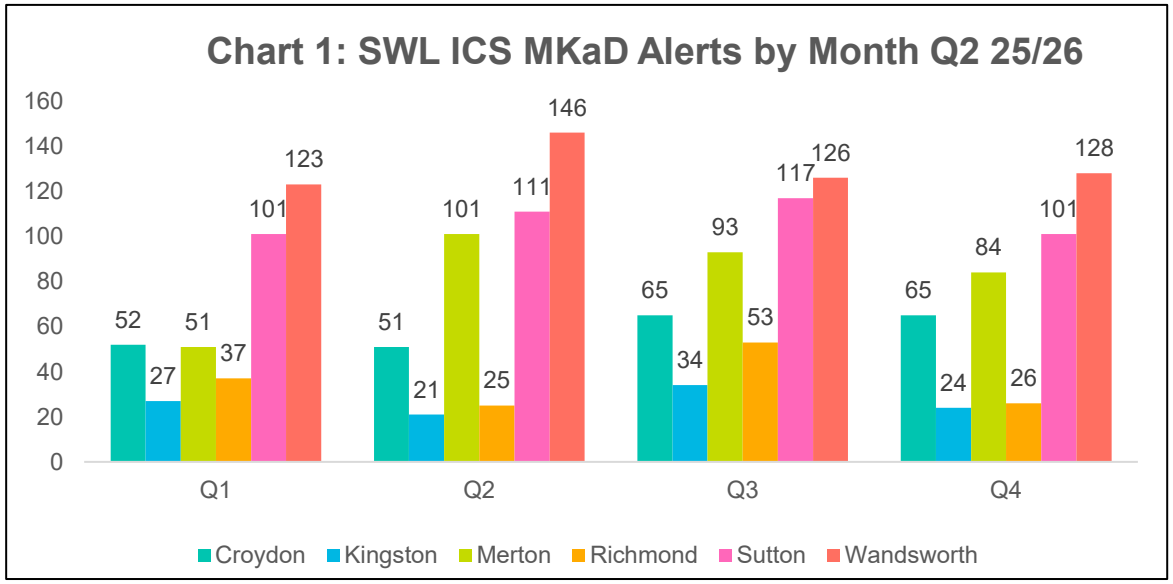
Summary (blue dots = decrease in trend, orange dots = increase in trend)

- Neonatal death rates remain within the expected range within all SWL providers
- ESTH and CUH had unusual spikes in cases for the month of October 2025 but are now back within expected limits – this activity has resulted in an indication of an overall increase in trend on the SPC chart for SWL, but fluctuations are to be expected. This trend will be monitored.
- National neonatal death rates = 2.9 per 1000 births
- January and February rates for SWL overall are higher than the national rates
- ICB is continuing to support trust via LMNS and new NHSE oversight structures

	01/01/26	01/02/26
Neonatal Death Rate SWL	3.2	4.6
Neonatal Death Rate Croydon	4.0	4.8
Neonatal Death Rate ESTH	0.0	3.8
Neonatal Death Rate Kingston	2.5	0.0
Neonatal Death Rate St Georges	6.2	11.7

Make a Difference Quality Alerts Summary - 2025/26

NHS South West London



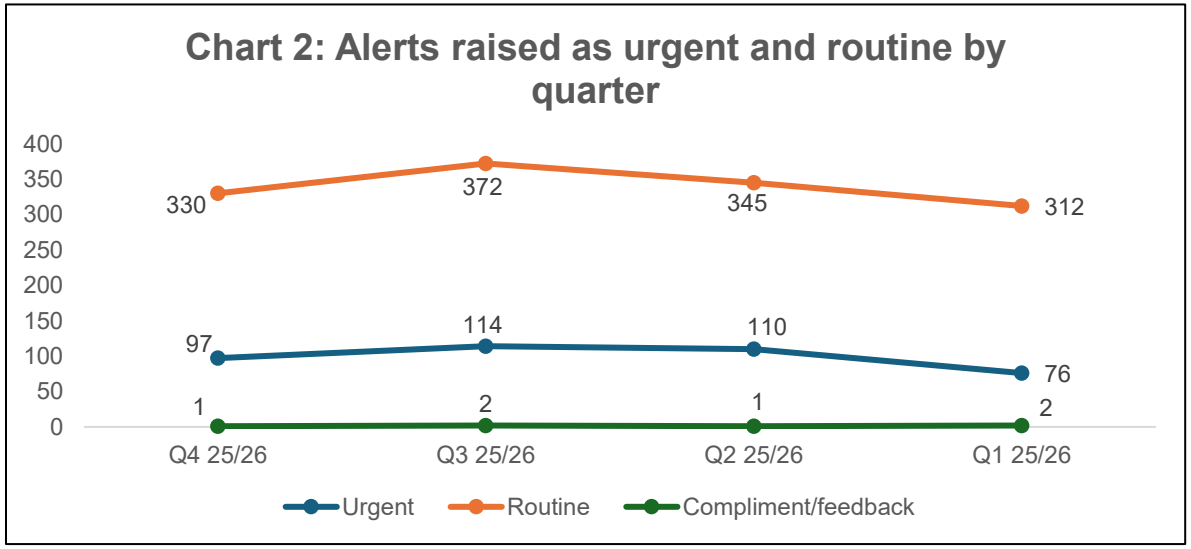


Table 1: All alerts raised by theme

Theme	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	Total
Care & Treatment	56	74	94	57	**281**
Communication	51	57	67	67	**242**
Discharge	82	79	95	60	**316**
Medication (Inc. blood products)	40	47	42	39	**168**
Referral process	105	101	90	78	**374**
Service Delivery	45	72	71	78	**266**
Other	19	26	31	39	**115**
Total	**398**	**456**	**490**	**418**	**1762**

Summary

- **1762** MkAD quality alerts were raised across SWL in 2025/26. This reflects a similar number of alerts to previous years.
- **Chart 1** illustrates the MkAD reporting trend over the year. Wandsworth and Sutton are the highest reporters with Croydon being the lowest reporting.
- **Chart 2** illustrates the alerts by classification as ‘urgent’ or ‘routine’. Compliments/feedback are not subject to classification and so have been presented separately.
- **Table 1** illustrates the top primary themes identified in 2025/26. The top 3 highest reported themes are referral process (21%), discharge (18%), care and treatment (16%),
- There have been changes made to thematic classification processes to ensure alignment with wider ICB Radar functions.
- There are ongoing discussions to support redesign of MkAD function as we continue with organisation changes

SWL Never Events (NE) Summary

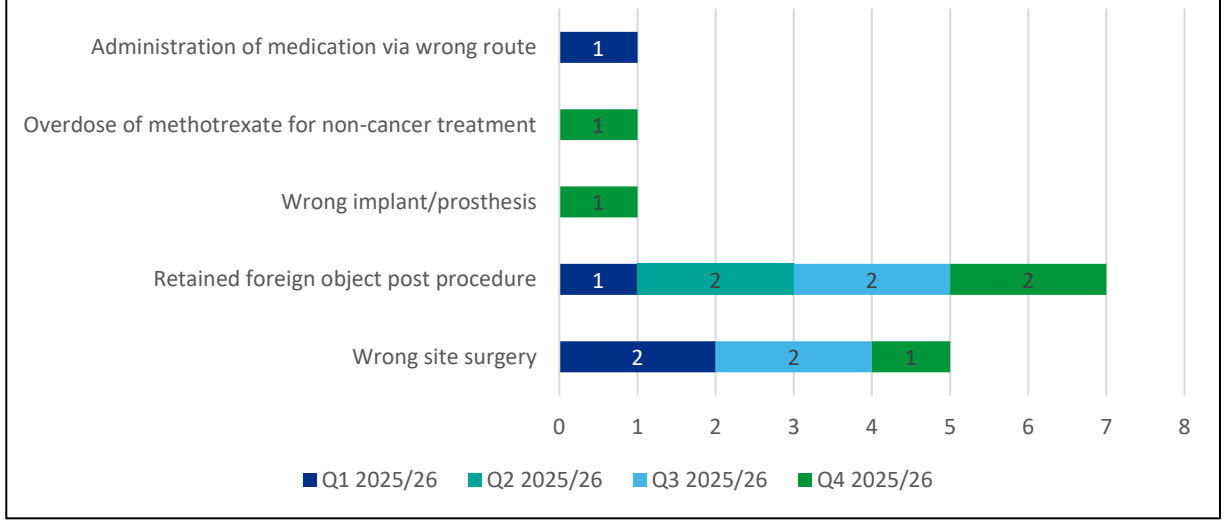
NHS South West London

Table 1: NE Type	2024/2025	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	2025/26	Q1 2026/27
Retained Foreign Object	**4**	1	2	2	2	7	1
Wrong site Surgery	**6**	2		2	1	5	1
Wrong implant/prosthesis	**4**				1	1	
Administration of medication by the wrong route	**0**	1					
Overdose of methotrexate for non-cancer treatment	**0**				1	1	
Total	**14**	**4**	**2**	**4**	**5**	15	**2**

Table 2: SWL Never Events by Provider

Providers	2024/25 Totals	2025/2026 Totals	2026/2027 up to April 2026
CHS	1	2	
ESH	5	5	1 (+1 declared 6th May 2026)
KRFT	4	2	
SGH	4	6	

Graph 1: SWL ICS: Never Events reported over the last 4 quarters



Summary

- Table 1 and 2 show Never Events (NE) reported across SWL by type and provider. NE are preventable safety incidents that should not occur in healthcare if guidance and procedures are properly followed.
- Since 1 April 2026 and last report to QPOC, 2 NE have been reported by ESTH (x1 retained foreign object and x1 wrong site surgery)
- A total of 15 NE were recorded for the year 2025/26 similar to year 2024/25 with 14 NE reported. SWL remains second highest ICB in london region for reporting NE.

What are our plans to improve?

ICB continues to support trusts in their on-going system actions to reduce NE. Ongoing trust initiatives include:

- Reviewing the impact of human factors and actions.
- Focused work on culture and psychological safety.
- Audits, training, education, learning events, and refining policies and processes
- Initiating quality improvement work.

SWL Patient Safety Incident Investigations (PSII) Summary

South West London

Table 1	2024/25	2025/26				2025/26	2026/27
	2024/25	Q1	Q2	Q3	Q4	Total	Q1
CHS	33	5	9	3	1	18	5
KHFT	26	3	3	4	10	20	4
ESH	6	2		2	3	7	4
SGH	23	3	3	3	8	17	
SWL StG	11	1	2	1	3	7	1
RMH	5	Recording of PSII on STEIS has been varied					
Healthshare	1						
SLAM	5	Recording of PSII in STEIS has been varied					
Total	**112**	**14**	**17**	**13**	**25**	**69**	**14**

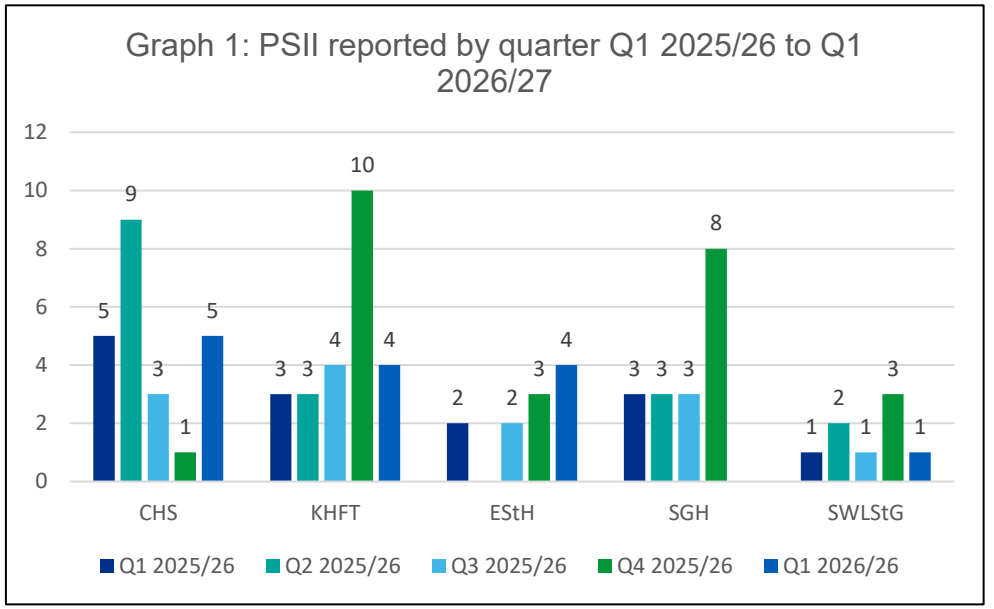


Table 2	2025/26	Q1 26/27
Incident demonstrating existing risk that is likely to result in significant future harm	4	
Incident threatening an organisation's ability to continue to deliver an acceptable quality of healthcare services	1	
Never Event	15	2
Unexpected / potentially avoidable death	29	9
Unexpected / potentially avoidable injury requiring treatment to prevent death or serious harm	14	
Unexpected / potentially avoidable injury causing serious harm	5	3
Actual / alleged abuse	1	
TOTAL	**69**	**14**

Summary

- **Table 1 and graph 1** shows all SWL PSII numbers. A PSII is a system-based learning response under PSIRF. It is the most comprehensive type of learning response carried out where causal factors are not understood, and for nationally mandated safety incidents. Reporting PSII via STEIS to ICB has not been made mandatory so numbers will vary
- Table 2 show the common incident types when PSII where undertaken.

What are our plans to improve?

- PSII numbers should align with the Patient Safety Incident Response Plan (PSIRP). The ICB will continue to support providers through their internal patient safety incident and system meetings to ensure alignment with their PSIRPs.
- Reporting of PSIIs via STEIS is expected to change, as the current temporary logging of PSIIs on STEIS has been implemented at the request of the NHSE London Region for visibility purposes, pending improvements to LFPSE functionality.

Homicides Investigations Summary

South West London

Table 1: Stage of investigation for Homicides/Non-Homicides Independent as of 31.03.2026	Number
NHSE commissioned independent investigation ongoing homicides	**1**
NHSE commissioned independent investigation ongoing non-homicides	**1**
Initial provider safety incident investigation in progress	**2**
Total	4

Summary

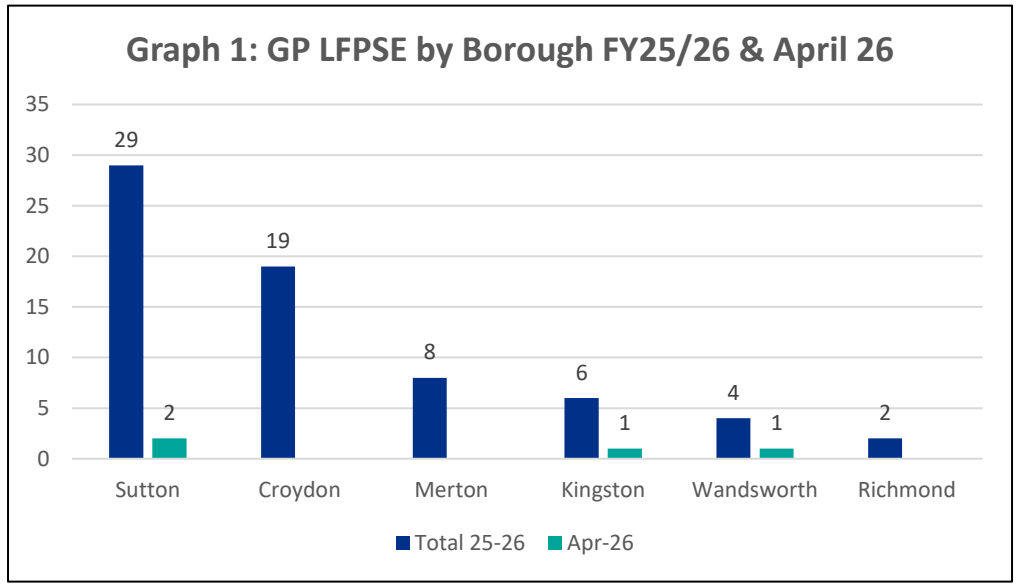
- **Table 1** shows the high-level summary of SWL Homicides / investigations that are still ongoing.
  - **2 homicides:** NHSE has commissioned an independent investigation which are still ongoing.
  - **2 homicides:** The trust investigation process is still ongoing.

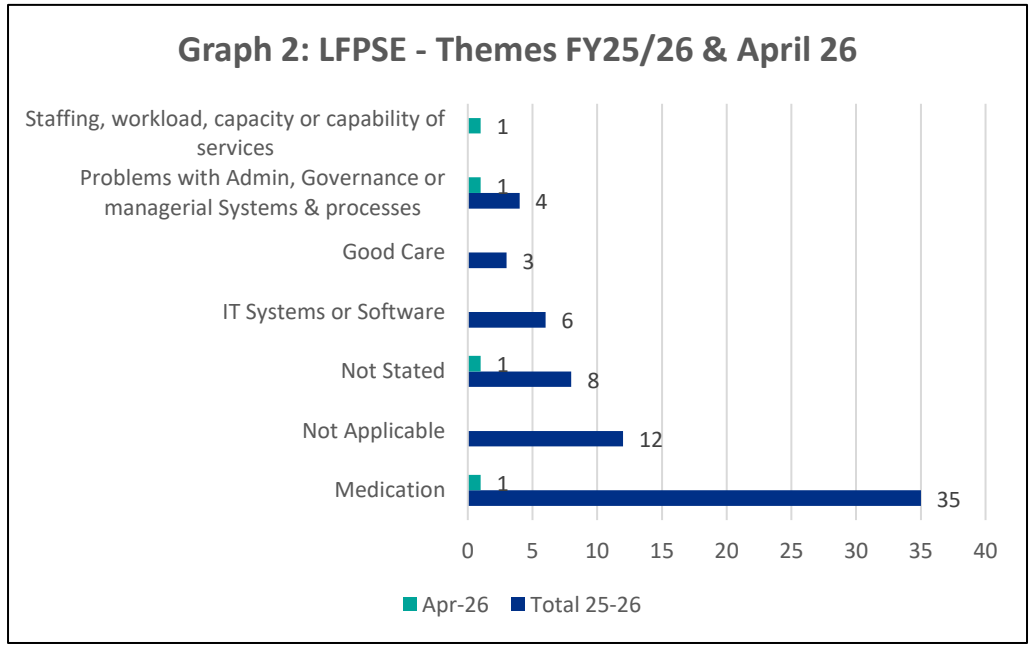
Please Note:

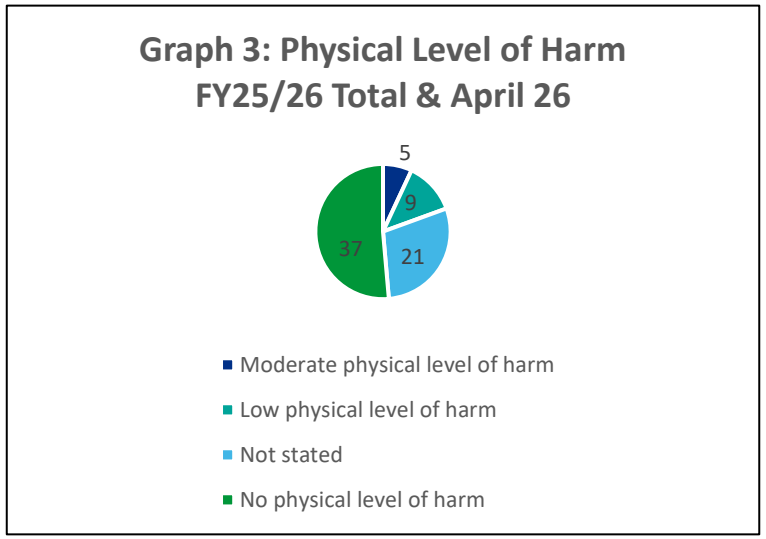
- After trusts undertake a patient safety incident investigation/learning response review, all homicides undergo an additional NHSE review at an Independent Review (IR) panel. This panel assesses whether all necessary areas have been thoroughly explored. Based on the panel's decision, an independent investigation may be commissioned. Independent investigation reports are publicly available.

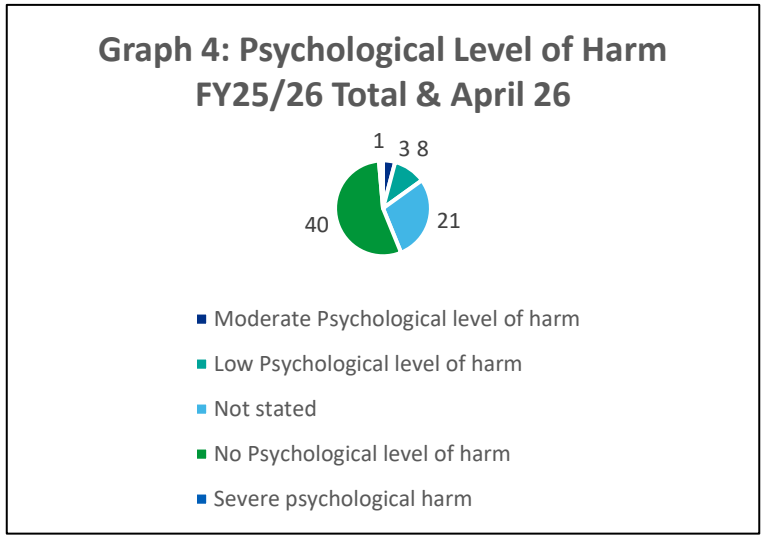
- The entire process of a homicide independent investigation, from initiation through the Independent Review, publication, action completion, and case closure, can span several years. As a result, some cases may refer to incidents from previous years.

SWL General Practices Learn from Patient Safety Events (LFPSE) Summary









Summary

- LFPSE for general practices was launched in July 2021. CQC has issued supporting guidance for general practices.
- LFPSE is one of the national commitments for general practices in the National Primary Patient Safety Strategy and General Practice Annual Electronic Self-Declaration (eDEC) submissions.
- **Graph 1 :** Shows safety incidents reported via LFPSE by general practices per borough 2025/26. Usage continues to be low overall. Sutton and Croydon practices have higher reporting due to previous/current incentive schemes. Low reporting is a trend seen nationally.
- **Graph 2:** Shows themes for 2025-26 and medication related events continue to be the most common theme (however this coincides with previous/current incentive scheme).
- **Graph 3 and 4 :** Shows most events recorded have a low level of physical or psychological harm.

What are we doing to improve?

- SWL has developed a range of supporting materials for general practices over the years, with the quality team available to provide ongoing support.
- Further work is required to encourage practices to report incidents via LFPSE. This is recognised nationally as a challenge, as most practices use their local systems for incident reporting and view the use of LFPSE as a duplication of reporting processes.

NHS South West London
Integrated Care Board

ICB Performance report – May 2026

Agenda item: 6.5

Report by: Jonathan Bates, Chief Commissioning Officer

Paper type: Information

Date of meeting: Wednesday, 15 July 2026

Date published: Wednesday, 8 July 2026

Purpose

The purpose of this report is to provide Board Members with oversight and assurance in relation to the overall performance and quality of services and health care provided to the population of South West London. The report highlights the current operational and strategic areas for consideration.

Executive summary

The ICB Performance Report provides an overview of performance against constitutional standards at an ICS level and in some cases at the provider level. This report focuses on performance for March and April 2026, using nationally published and local data.

Key Issues for the Board to be aware of

Key areas where SWL has seen improvements in performance:

- **Diagnostics carried out within 6 weeks** continued to improve in March to 91.0% against the 99% standard; the highest in London. Performance improved at Croydon Hospital (CHS), Epsom, and Kingston (KRFT) through delivery of recovery plans. Significant backlog reductions were made in Non-Obstetric Ultrasound (NOUS) at CHS and KRFT. CHS continues to have the largest NOUS backlog in SWL.
- Performance against the **18 week Referral to Treatment** trajectory improved as well as a significant reduction in **52 week waits**. Providers took part in a national Q4 Performance Sprint, which saw additional funding made available to achieve improvements. All but one SWL provider met their revised 18-week trajectory and all brought 52 week wait down below 1% of the waiting list.
- **Severe Mental Illness (SMI) physical health checks** saw a significant improvement in Q4. All Place based systems exceeded the minimum requirement of 60% by March with aggregate performance of 66% but does remain below the national ambition of 75%.

Key issues for the Board to be aware of:

- **A&E 4 hour wait** performance declined in April to 76.5% following an improvement in March. Improvement actions continue to be overseen by the SWL Urgent Emergency Care (UEC)

board. An evaluation of winter schemes was presented to the SWL UEC Board during May to inform learning for the system. The national requirement is to deliver 82% by March 2027.

- **Mental Health 12 hour breaches in A&E** have increased each month since December 2025, although this increase is less (1) in April. A SWL UEC Mental Health (MH) joint board which will oversee implementation of high impact changes, as recommended by the Get It Right First Time (GIRFT) team, met for the first time on 30 April.
- **111 call abandonment** rate increased from 2.9% in March to 3.2% in April, exceeding the 3% standard. The Clinical Assessment Service (CAS) continues to manage a large volume of high acuity cases. There continues to be a strong focus on revalidating ambulance (Category 3 and 4) and A&E dispositions, all of which help reduce pressure on A&E and other UEC services.

Recommendation

The Board is asked to:

- Consider this report and to be assured that work is ongoing in many areas to alleviate the issues that have been raised.
- Provide feedback and/or recommendations as appropriate.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
No specific conflicts of interest are raised in respect of this paper.

Corporate objectives
This document will impact on the following 2025/26 Board objectives:

- Objective 3. Focus on priority work that delivers the most impact: We will deliver our 2025/26 operating and financial plan as well as oversee system performance, quality and safety standards.

Risks
Poor performance against constitutional standards is a risk to the delivery of timely patient care.

This document links to the following Board risks:

- RSK-001 Delivering access to care (NHS Constitution Standards)
- RSK-024 Delivery against the NHS 2024/25 Elective Recovery Plans
- RSK-037 Urgent and Emergency Care

Mitigations
Action plans are in place within each Programme workstream to mitigate poor performance and achieve compliance with the constitutional standards, which will support overall patient care improvement.

Actions taken to reduce any risks identified:

- For long waiting elective patients: Increased capacity, focus on productivity by APC-led elective care programmes, mutual aid, transformation led by clinical networks.
- For 4-hour A&E performance: The two-year UEC Plan has been agreed across key stakeholders. Operational measures were defined to help the system maintain standards of care during peak winter challenges, and these were extended into March.
- For A&E avoidance and 12-hour A&E breaches, the Integrated Care Coordination hub (ICC) bases multidisciplinary professions in London Ambulance Service offices, enabling them to work with paramedics to treat patients at home and/or refer them on to the right community service – in SWL, this has seen an average of 400 patients a month, 40% of whom avoid A&E. Expansion of the frailty model of care, which is currently being implemented, should further alleviate pressures.
- For 12-hour Mental Health (MH) A&E breaches: SWL continues to focus on improving the MH crisis pathway for patients, reducing the need to attend A&E and improving access to more appropriate MH services. This is being achieved via the London Section 136 hub, 111 MH pathway, step down hostel capacity and additional bedded capacity. A programme of work, supported by the national Mental Health Intensive Support Team (MHIST) provides improvement support for the mental health UEC pathway.

Financial/resource implications
Compliance with constitutional standards, will have financial and resource implications

Green/Sustainability Implications
N/A

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
N/A

Patient and public engagement and communication
N/A

Previous committees/groups

Committee name	Date	Outcome
Quality and Performance Oversight committee	10 June 2026	

Final date for approval
N/A

Supporting document
Attached ICB Performance Report

Lead director
Jonathan Bates

Author
Gai Sivapalan

South West London Integrated Board Report

May 2026

NHS South West London

DATE REFRESHED : 28-05-2026

SRO: Jonathan Bates

Commentary on Data

- The South West London (South West London) Integrated Board report presents the latest published and unpublished data assessing delivery against the NHS Constitutional standards and locally agreed on metrics. These metrics relate to acute, mental health, community and primary care services and other significant borough/Place level indicators.
- Data is sourced through official national publications via NHS England, NHS Digital, NHS Futures (LGI FIT referrals) as well as local providers. Some data is validated data published one month or more in arrears. However, much of the data is unvalidated (and more timely) but may be incomplete or subject to change post-validation. Therefore, the data presented in this report may differ from data in other reports for the same indicator (dependent on when the data was collected).
- The report contains current operating plan trajectories.
- This is the current iteration of the Integrated Care Board Performance Report and the number of indicators will continue to be reviewed and refined as work progresses to develop reporting within the Integrated Care Board (ICB).
- Data Quality Issues:
    - Data on 45-minute handovers is from London Ambulance Service and has not been validated by South West London Trusts. Data for April 2026 was not available at the point of report production. LAS are reporting 431 x 45-minute handovers in April 2026.

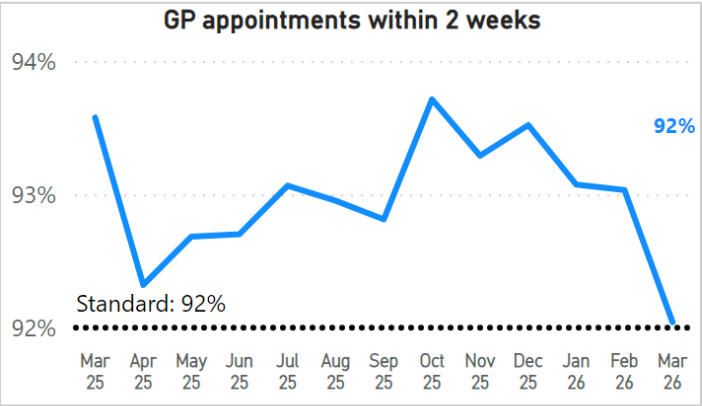
Key Findings

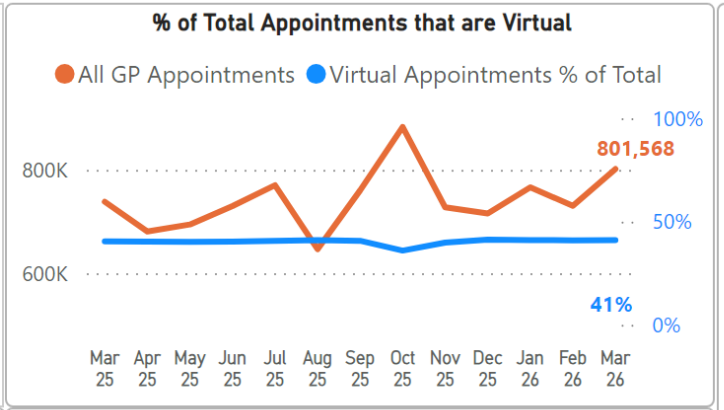
NHS South West London
Integrated Care Board

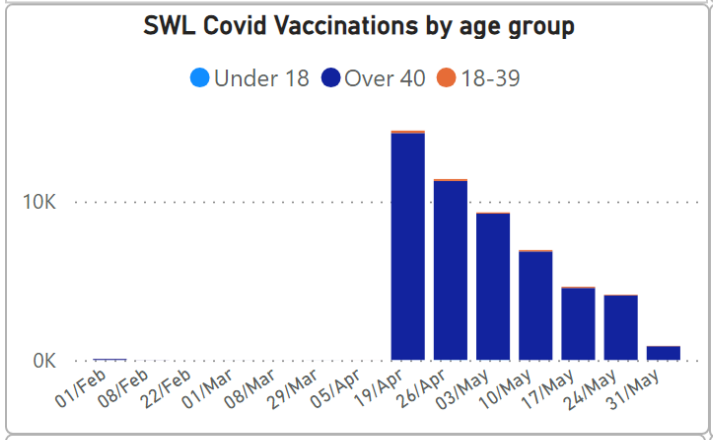
- **Appointments in general practice** The system continues to meet the standard of **GP appointments seen within 2 weeks at 92%, for March**. The Spring Covid vaccination programme is underway, as of the 17th May, SWL had the highest uptake in London; 29.4% compared to the London uptake of 23.5% although uptake is lower than had been forecast. Childhood Immunisation rates for Q3, both 4-in-1 and 6-in-1 vaccinations, are also above the London average.
- **Services contributing to A&E avoidance are performing well**. The latest **urgent community response (UCR) 2-hour performance** was 85%, against the national standard of 70%. SWL continues to have the highest number of UCR referrals in London for March. **The volume of 111 increased in April, significantly; abandoned 111 calls increased to 3.2%, just above the <3% target**. The system has invested in a range of initiatives to reduce front end pressures. In addition, an **Integrated Care Coordination (ICC) Hub initiative** provides clinical advice to crews to manage patients safely in community settings and reduce conveyances to A&E; 654 cases were managed by the ICC in April.
- April saw **a decrease of 2,903 A&E attendances** however **A&E (all types) performance decreased to 76.5%,** below plan for the month. This also aligned with a number of Winter schemes coming to a close. An evaluation of these schemes, which were enabled by SWL UEC Winter funds, was presented to the SWL UEC Board in May, to evaluate the successes and shortcomings and what would be built upon for next Winter. Trust performance ranged from 71.1% at Epsom to 81.0% at St Georges. **SWL's aggregate performance was the lowest in London, which ranged from 76.5% - 82.0%.**
- **Emergency care pressures are on the admitted non-elective pathway, due to inpatient flow; 2,276** patients waited over 12 hours from 'decision to admit' to admission in April. SWL had the second highest volume of 12-hour breaches in London, and the seventh highest nationally. To reduce the time to treatment and discharge, the system is focusing on its Continuous Flow programmes and the utilisation of virtual wards; virtual ward occupancy was reported at 85% for April.
- **Unvalidated figures show that in April, there were 188 x 12-hour breaches in emergency departments for patients awaiting a mental health bed**, one more than in March 2026. An intensive programme is underway with the national Mental Health Intensive Support Team (MHIST) and provider and ICB colleagues. Get It Right First Time (GIRFT) completed a comprehensive assessment of Mental Health UEC services across SWL, a set of High Impact Changes were identified. A SWL UEC MH joint board took place in April in line with these recommendations and to oversee implementation of these changes.
- **SWL has seen a decrease on** the 28-Day faster diagnostic cancer standard, SWL performance decreased to 81.9% compared to the previous month; **above the 77% standard and second highest ICB in London**. 31-day performance increased in March to above the 96% standard and the highest in London and performance against the 62-day increased to 81.5%, against the standard of 85% and was benchmarked at second in London. The number of patients waiting over 62 days is below the planned trajectory of 327 at 317 which has increased.
- **Long waiters on RTT pathways continue to decrease.** The volume of 52-week waits decreased by 975 pathways in March to 1,407, the lowest in London. Ear, Nose and Throat (ENT) had the greatest number of patients waiting over 52 weeks at 245, showing a decrease of 80 in-month. . Kingston and Richmond (KRFT) had the highest cohort with 177 followed by Croydon Hospital (CHS) with 66. All trusts met their March ambition of reducing their 52-week waits to <1% of their overall waiting list as a result of participating in the National Q4 performance sprint.. **Performance against the 18-week standard for SWL providers remains relatively stable at 68% and is the highest in London.**
- **In Quarter 4, 66% of Severe Mental Illness patients received all six annual health checks.** Place-based systems continue to work towards meeting the 75% national standard, all boroughs exceeded the minimum 60% requirement. Operationally, work in Primary Care continues to proactively contact patients for their annual health checks. **SWL continues to meet the current target for Dementia Diagnosis Rate**, and **Learning Disability annual health checks. Talking therapies – Access** increased for the month and **Talking Therapies – Reliable Recovery Rate standard increased to above the 48% target with performance at 51% in March.**

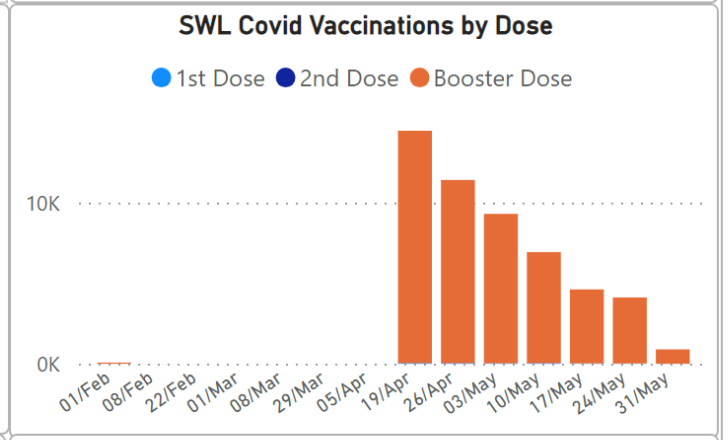
Domain: Primary Care

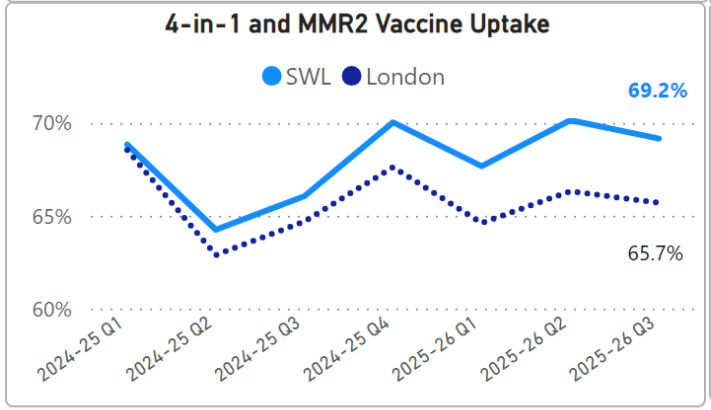
NHS South West London
Integrated Care Board

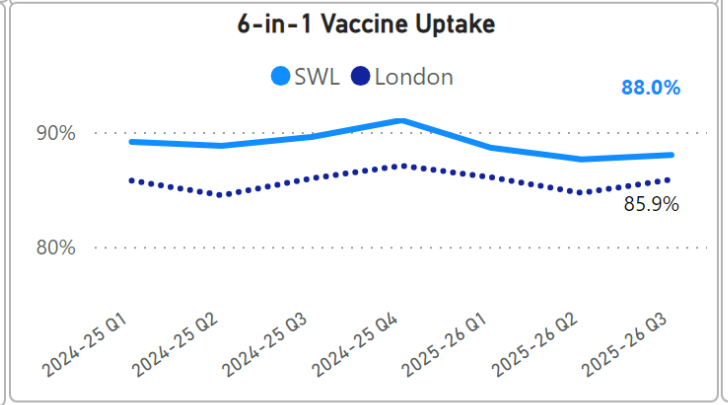












GP Appointments
801,568 GP appointments were delivered in March 2026, of which 46% were virtual with the remainder being a mix of face to face, home visit and other appointments. Overall, 46% of all appointments were delivered the same day. The GP appointments within 2 weeks metric looks at eight nationally defined categories, including home visits and care home visits. March performance for South West London (SWL) met the standard at 92%, a small decrease from the 93% reported in February.

COVID Vaccinations
The Spring vaccination season started on 13th April. On 17th May SWL had the highest uptake in London at 29.4% compared to the London uptake of 23.5%. Over 45,000 vaccinations have been provided against the original forecast of 64,000. Uptake is lower than forecasted and this position is reflected across all regions nationally.

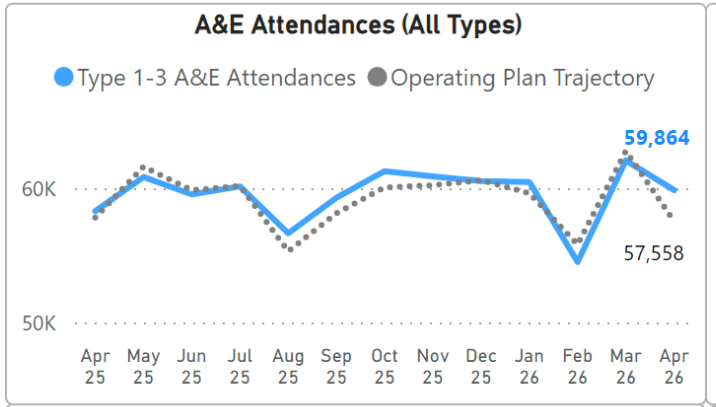
The South London Immunisation team continues to provide an outreach service at sites across the ICB footprint, in collaboration with voluntary sector organisations. Over 75 community clinics and attendance at voluntary sector events have been confirmed for Spring and this number continues to grow.

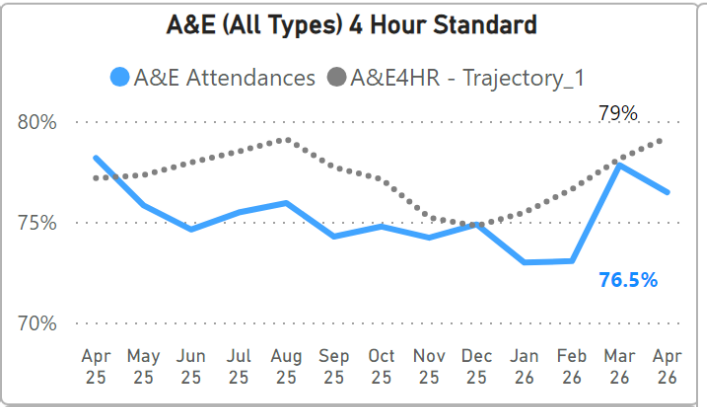
Childhood Immunisations
The 6-in-1 vaccine protects against illnesses like polio and whooping cough and is given to babies under 16 weeks old. The 4-in-1 pre-school booster helps protect against polio and tetanus, given to children aged 3 years and 4 years, before starting school.

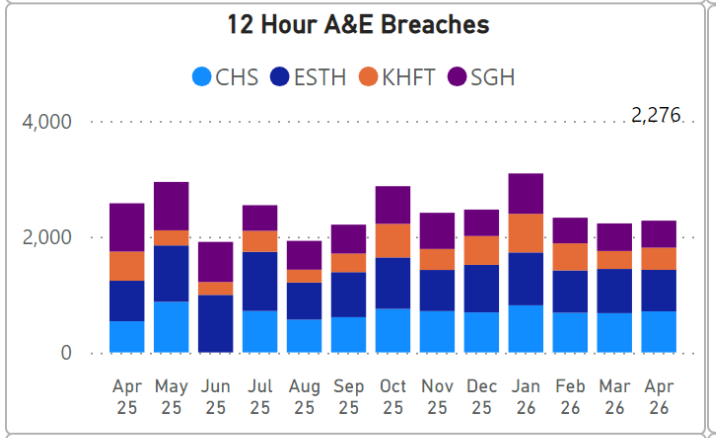
SWL uptake remains above the London average for both, but early evidence suggests there has been a decline in the Rotavirus (2 doses) uptake for Quarter 3.

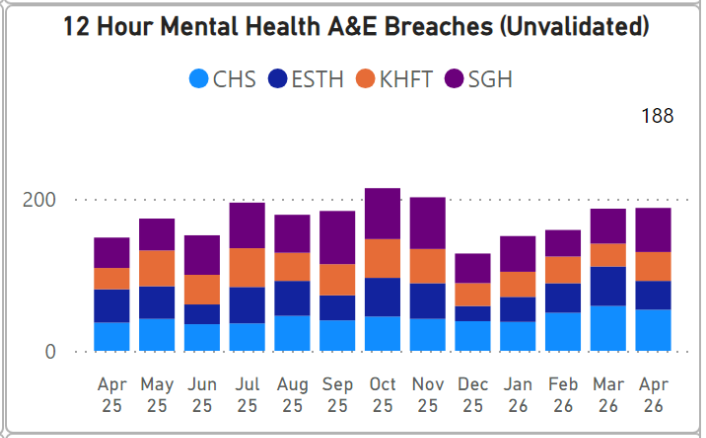
Domain: Urgent and Emergency Care

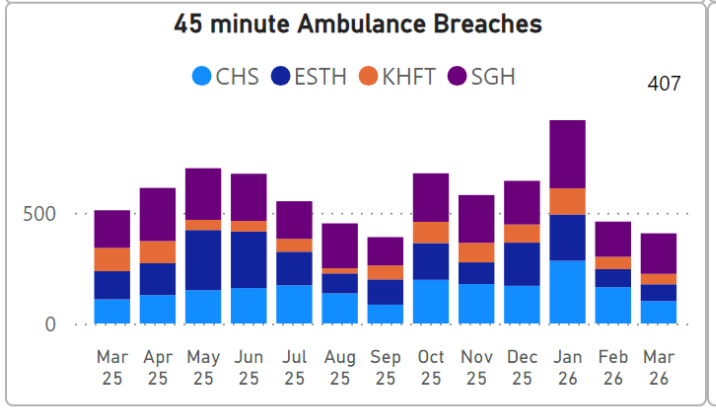
NHS South West London
Integrated Care Board

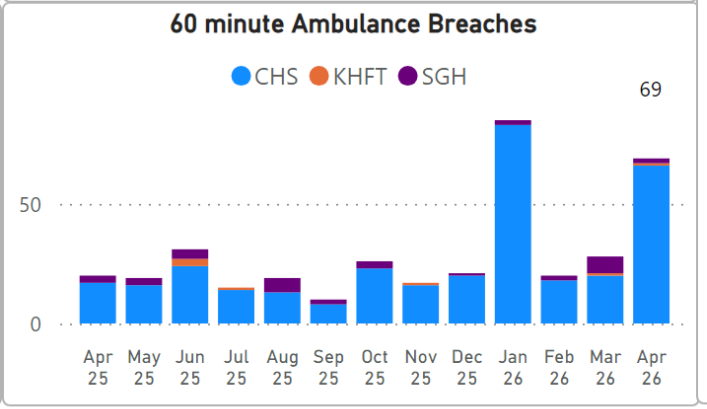












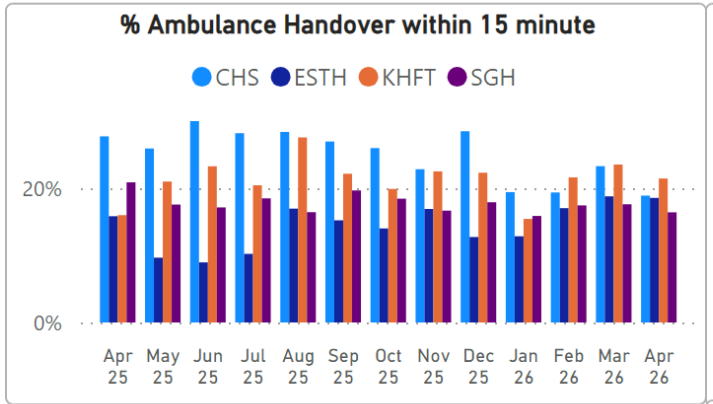
Accident & Emergency (A&E) attendances and performance
Following the additional effort to raise performance to meet the national 4-hour A&E ambition of 78% in March, performance declined slightly in April to 76.5% despite a decrease in attendance. This also aligned with a number of Winter schemes coming to a close. An evaluation of these schemes, which were enabled by SWL UEC Winter funds, was presented to the SWL UEC Board on 22 May. Successes and shortcomings will be evaluated to inform next Winter's schemes. Key focus areas were on reducing demand, improving flow and reducing harm to patients due to long waits and being looked after clinically inappropriate areas.

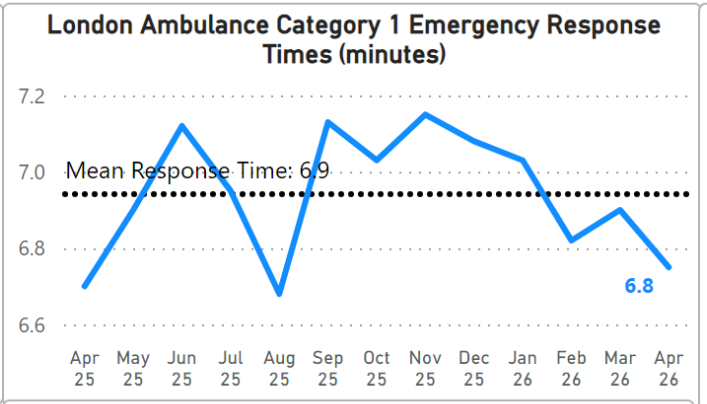
12-hour breaches
The number of 12-hour breaches increased slightly in April despite lower attendances. Mental Health (MH) breaches remained at a similar level to March.. Following the completion of a comprehensive assessment of SWL Mental Health UEC services, by the Get It Right First Time (GIRFT) team a set of High Impact Changes were identified which are being considered for implementation. A key change was to establish a SWL UEC MH joint board to oversee implementation of these changes which met for the first time on 30 April and is in the process of agreeing priorities and a workplan for the year ahead.

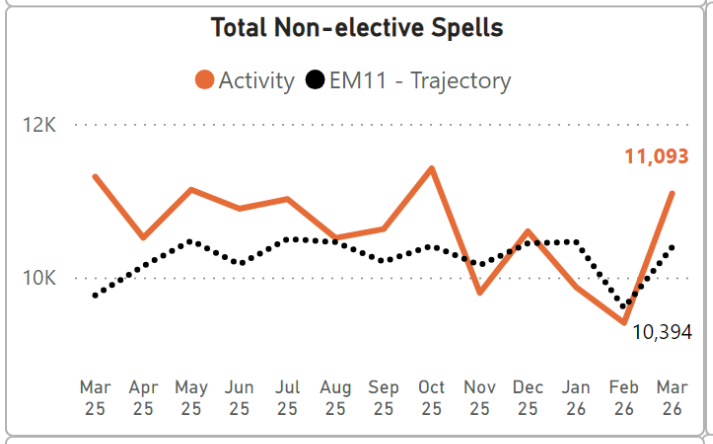
Ambulance handovers
Ambulance demand remained high correlating with an increase in 45-minute (431 for April 2026) and 60-minute handovers. The average handover time rose to 24 minutes in April. The Integrated Care Co-ordination (ICC) hub pilot continues to develop its operating model based on Emergency Department (ED) consultants supporting London Ambulance Service (LAS) crews and staff to manage patients that could be safely cared for in the community, or to access acute alternatives to A&E. This has been progressing well with Urgent Community Response (UCR) nurses a core part of the Multidisciplinary Team (MDT), GPs onboarded and a move to seven day working. This model has been shown to significantly reduce conveyances to A&E over time and is starting to have a positive impact in SWL. 654 cases were managed by the ICC in April.

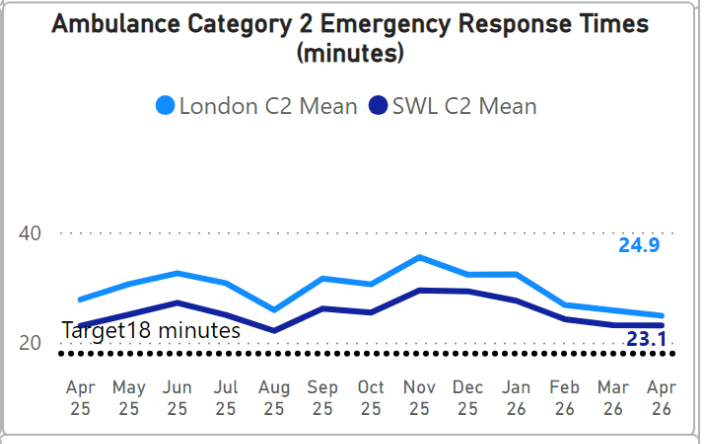
Domain: Urgent and Emergency Care

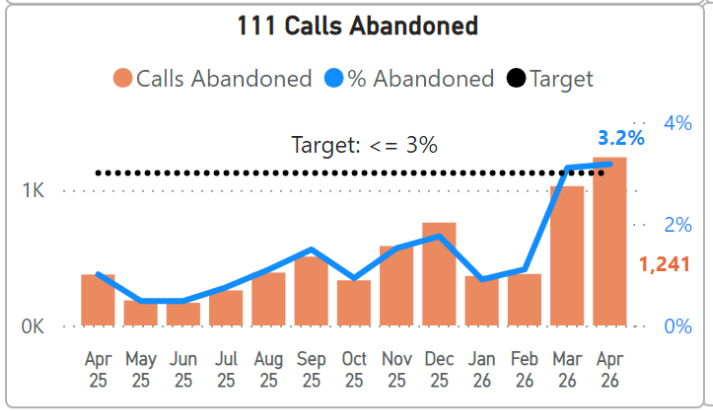
NHS South West London
Integrated Care Board

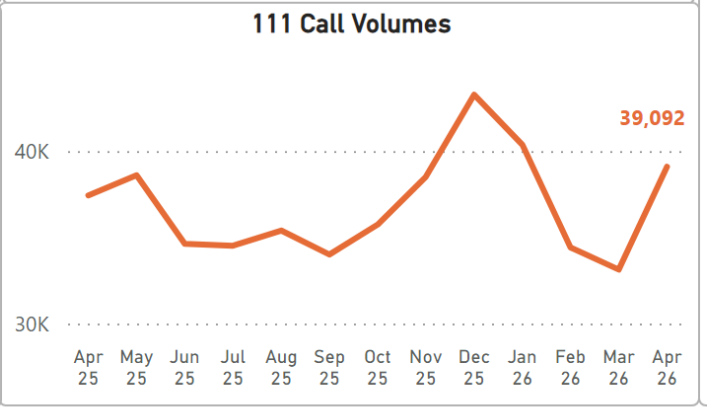












Ambulance Response Times
Ambulance conveyance numbers decreased in SWL during April, slightly less than the same time last year.

At a London level, the mean response time for Category 1 decreased slightly from 6.9 minutes in March to 6.8 minutes in April, still however within the 7- minute standard. SWL Category 1 ambulance response time also remained below the 7-minute target at 6.51 minutes.

The mean Category 2 response for London improved from 25.9 minutes in March to 24.9 minutes. SWL's mean Category 2 response was again the best performance in London improving from 23.04 minutes in April, compliant with the 30-minute average national target.

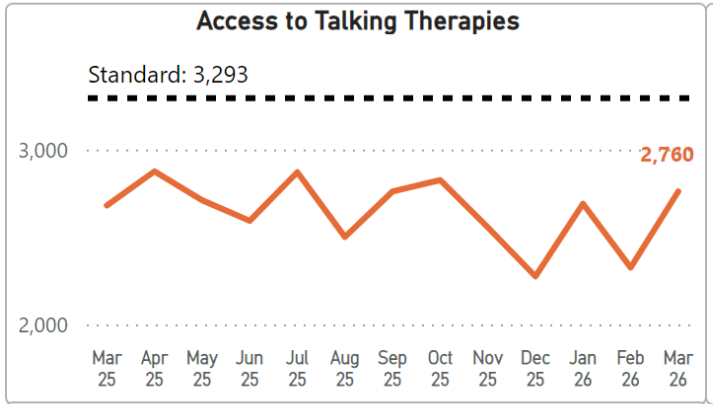
Non-elective spells
The volume of non-elective spells increased in March, tracking below the same month the previous year, and below the forecast trajectory.

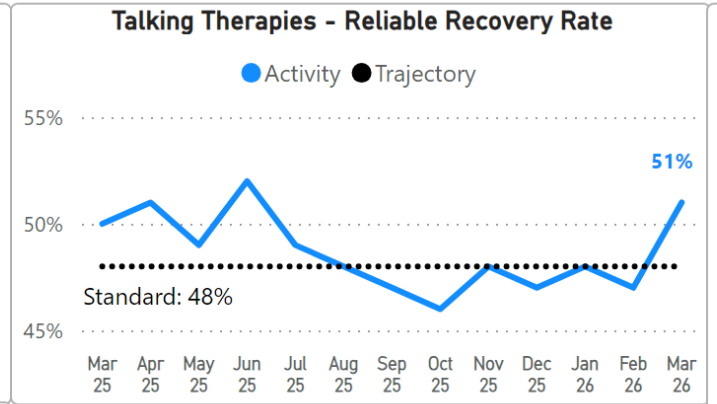
111 Calls
The number of calls (39,092) saw a significant increase in April, compared to March. The call abandonment rate also increased and was just above the 3% standard for the first time this financial year. The service has been impacted by staff vacancies and sickness there is a plan to recover the performance soon.

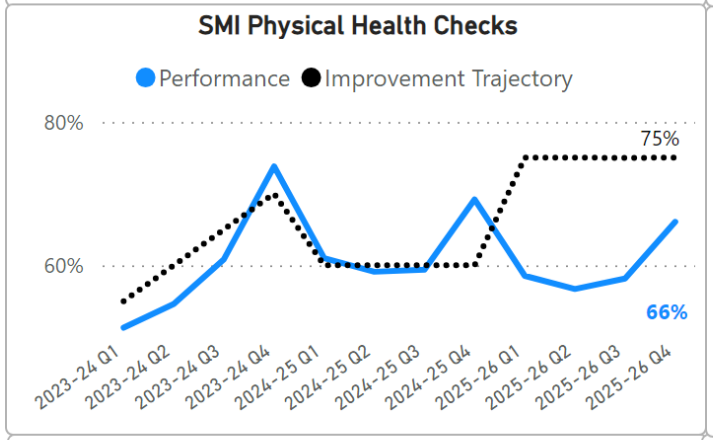
The Clinical Assessment Service (CAS) continues to manage a large volume of high acuity cases. There continues to be a strong focus on revalidating ambulance (Category 3 and 4) and A&E dispositions, all of which help reduce pressure on A&E and other UEC services.

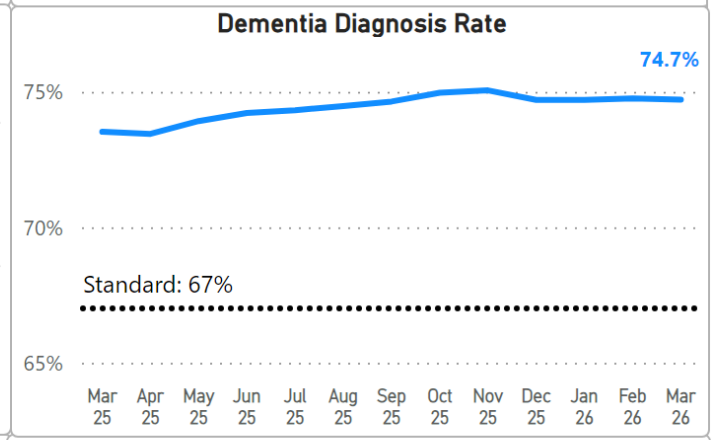
Domain: Mental Health and Learning Disabilities

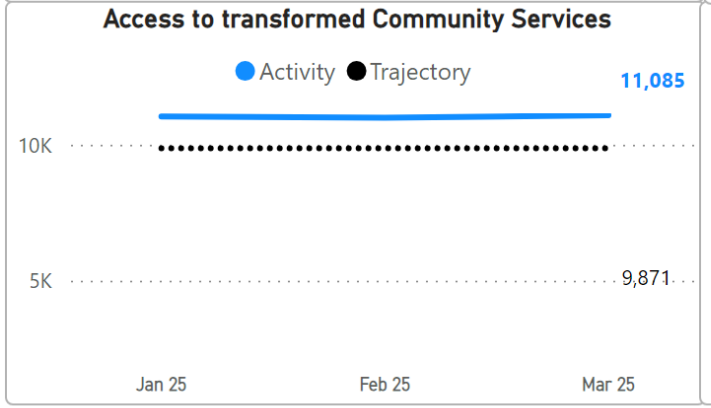
NHS South West London Integrated Care Board

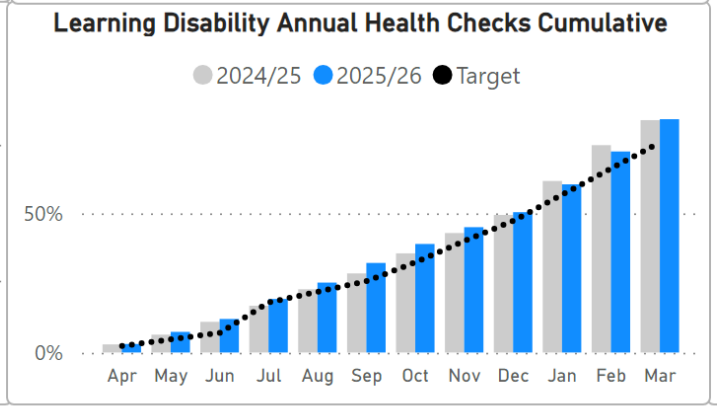












Talking Therapies (TT) – Access
Reduced referral levels during 2025/26 impacted access levels, resulting in an annual decrease of 18%. However, this reduction has been overstated due to in-year data submission related issues, when these are taken into account and adjusted the actual reduction is estimated to be 13%.
SWL have the greatest annual variance regionally, driven in part by a pause of marketing campaigns to prioritise reducing patient waiting lists and wait times for treatments. Marketing campaigns recommenced during Quarter 2 2025/26.

Talking Therapies (TT) – Reliable Recovery Rate
Performance improved in March and annually SWL achieved 48.2%, this annual position places SWL ICB with the best regional performance position for 2025/26. Audits identified some common issues between SWL localities, which included patient discharges that may have benefited from additional sessions as well as data recording issues. These issues continue to be addressed through an improvement plan, staff communications, and ensuring best practice that supports patient recovery.

Severe Mental Illness (SMI) Physical Health Checks
In Quarter 4, 66.1% of SMI patients received all six annual health checks. This was above the 60% minimum NHSE requirement, but below the 75% national standard. All SWL boroughs met and exceeded the 60% expectation and place-based systems continue to work towards increasing physical health checks for this vulnerable population.

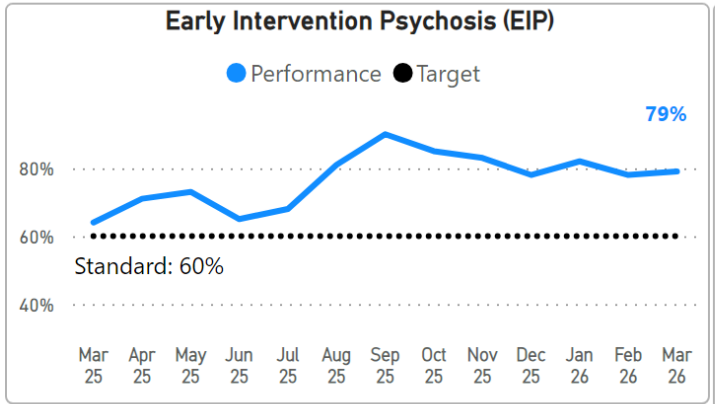
Dementia Diagnosis rate
South West London ICB continues to maintain good performance levels with the March position at 74.7%, exceeding both the national target of 66.7% and the London ambition of 70%. SWL remain the highest performing system in London.

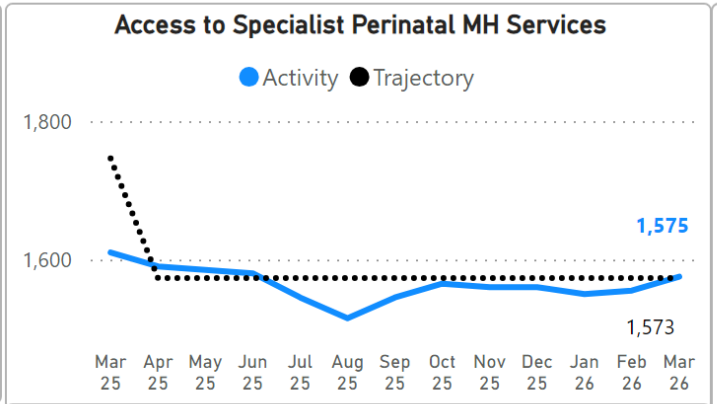
Access to transformed Community services
This national metric has been retired for 2025/26, ongoing monitoring will now focus solely on community mental health access.

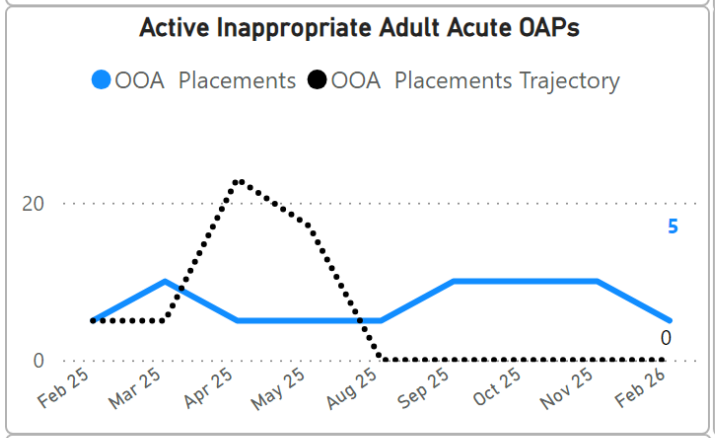
Learning Disability Annual Health Checks Cumulative
Performance is good across SWL and above plan.

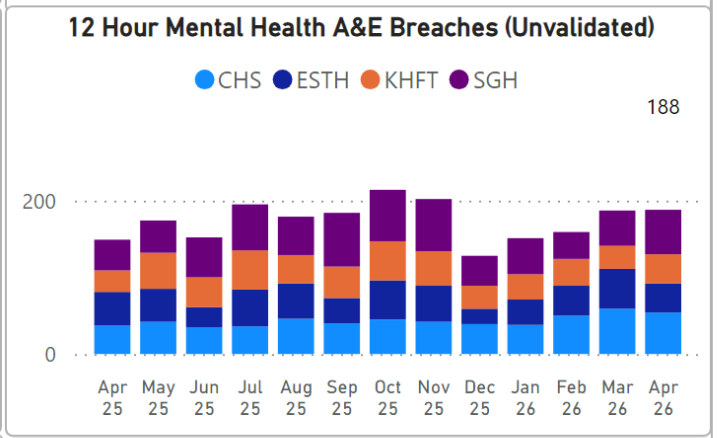
Domain: Mental Health Services

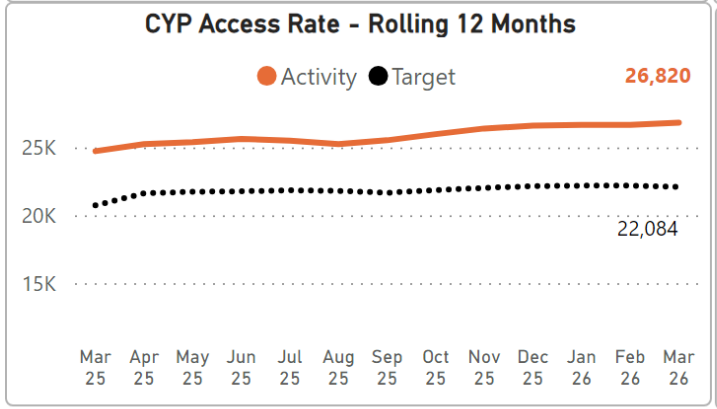
NHS South West London
Integrated Care Board

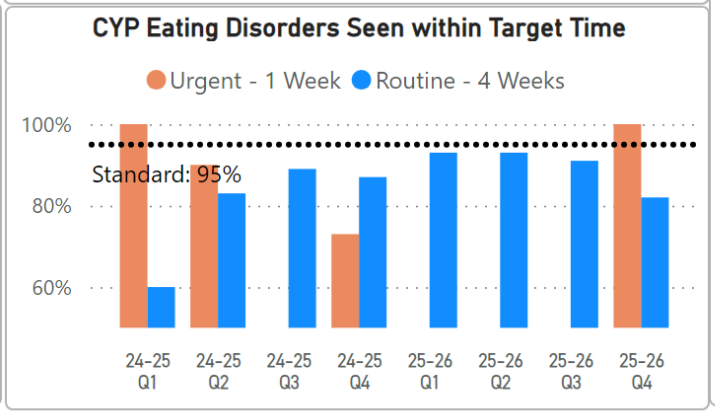












Early Intervention Psychosis (EIP)
South West London (SWL) continues to exceed both the 60% national standard and the London Region position of 78%, achieving 79%.

Access to Specialist Perinatal Mental Health (MH) Services
SWL ICB performance improved in March to just above trajectory. Improvement workstreams remain in place which include; dashboard enhancement with increased oversight on borough referrals; review of options for resuming pre-conception clinics; administrative processes improvements for booking 1st appointments and short notice cancellation waiting list utilization to better promote attendance at the 1st appointment with the service.

Inappropriate Out of Area Placements (OAP)
Published data for March has been suppressed due to low patient numbers, implying less than 5 patients were reported for this period. Work remains ongoing to address delayed discharges to ensure improved patient flow.

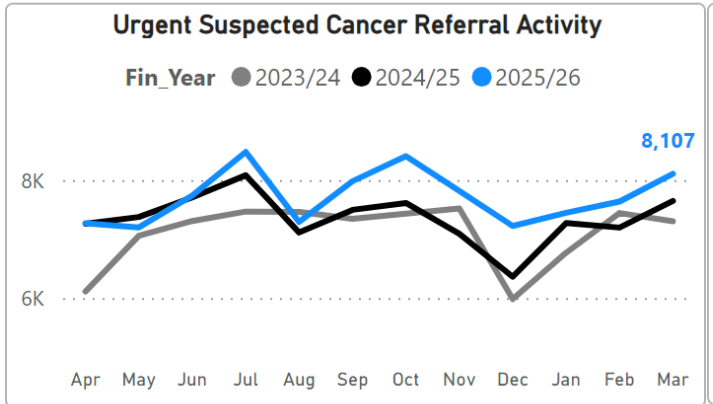
12 Hour mental health A&E Breaches (unvalidated)
The number of 12-hour breaches have increased since December 2025. Improvement work focused on the MH crisis pathway continues, supported by the London Section 136 hub, a network of health-based places of safety. Staff can review service user history; crisis plans and ensuring individuals are directed to a suitable place of safety. The 111 MH pathway helps patients to access MH professionals earlier. A trajectory to reduce MH breaches by 10% has been set. A SWL UEC MH joint board, to oversee improvements, met for the first time on 30 April. This group will process of agreeing priorities and a workplan for the year ahead.

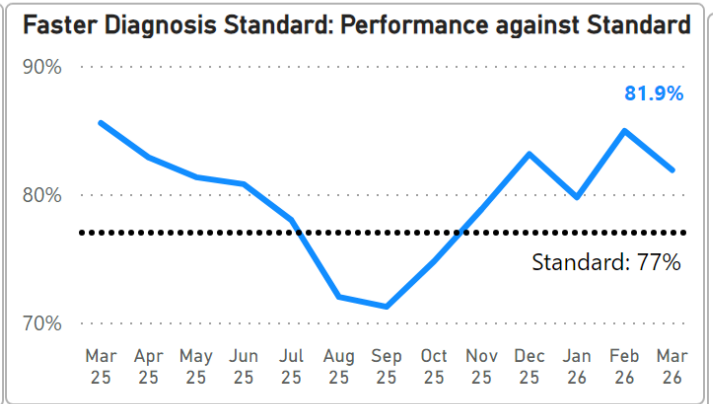
Children and Young People (CYP) Access Rate – Rolling 12 Months
Good performance levels continue to be achieved in March which remain above plan.

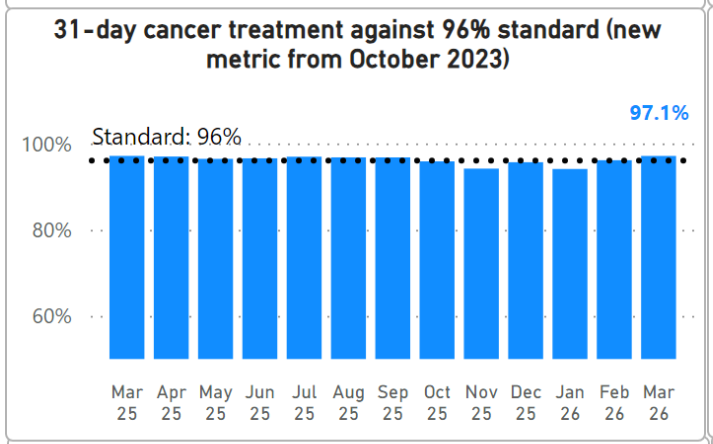
CYP eating Disorders Access
Routine case performance achieved 92% for Quarter 4, placing SWL as the highest performing system in London. For urgent cases, all patients (100%) were seen within the 1-week timeframe standard.

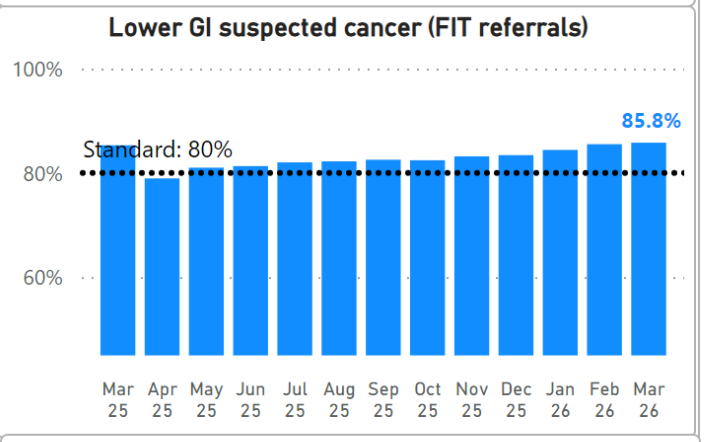
Domain: Cancer

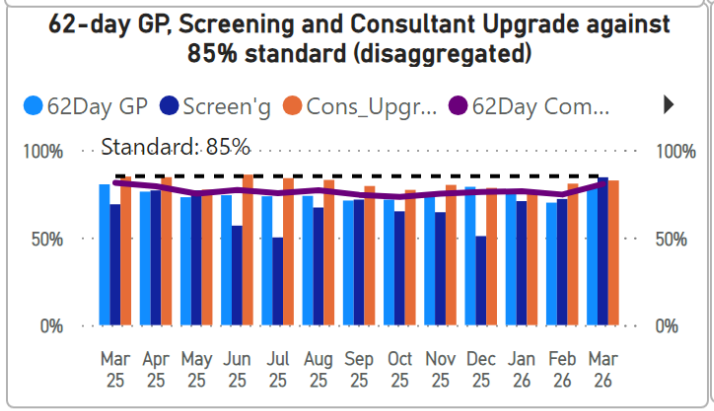
NHS South West London
Integrated Care Board

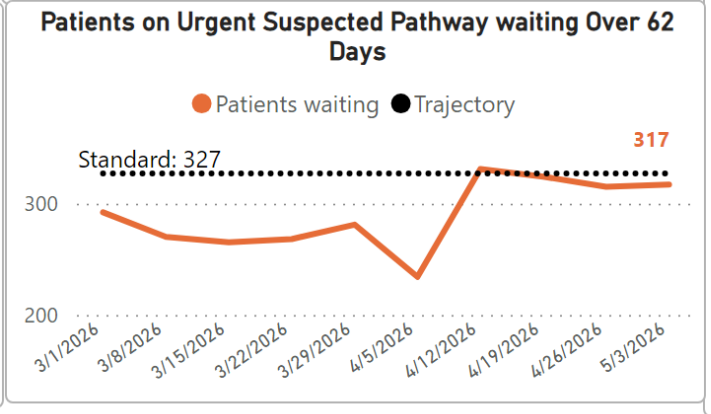












Urgent Suspected Cancer (USC) Referral Activity
Cancer referrals remain higher than in previous years. Lower GI referrals had greatly increased due to a Faecal Immunochemical Testing (FIT) score processing issue in December 2025 which resolved in early March 2026. Royal Marsden Partners (RMP) Cancer Alliance have supported with additional funding for extra diagnostic tests and clinical reviews.

Faster Diagnosis Standard
Performance in March exceeded the 80% NHSE end of year target. Each Trust individually met the target for the month, also. There does, however, continue to be impacts to Lower GI performance as per the FIT issue mentioned above.

31-day cancer treatment against 96% standard
In March, SWL performed at 97%, with all 5 Trusts above the standard. Although compliant, SGH have continued pressures in Gynaecology, Lung and Urology pathways. Financial constraints have prohibited weekend surgical lists, some of which is being mitigated using RMP funding.

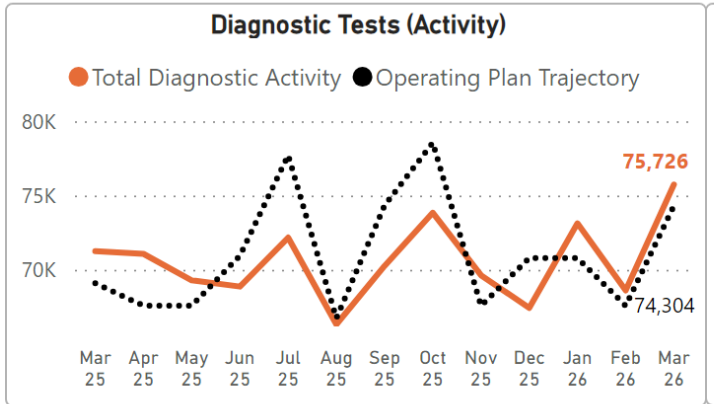
Lower GI Urgent Referrals with Faecal Immunochemical Testing (FIT)
The percentage of Lower GI USC referrals accompanied with a FIT is a 2025/26 operating plan metric. For March, the SWL aggregated position was compliant at 85.8%.

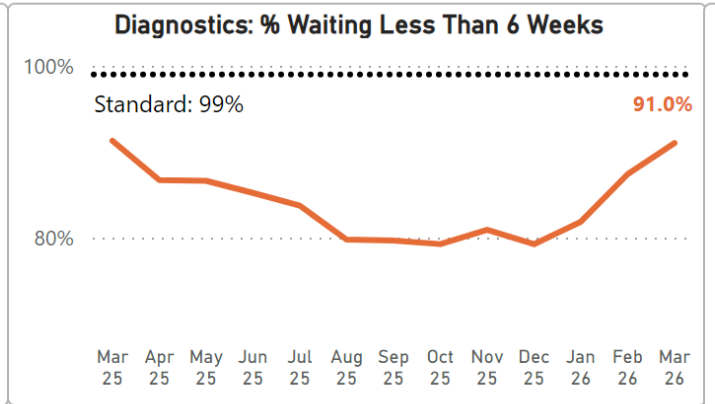
62-day GP, Screening, Consultant Upgrade against 85% standard
SWL March performance increased by over 5% to 80.4% from the previous month – the highest performance since the previous March. All Trusts met the 75% NHSE minimum requirement which resulted in SWL being one of the best performing ICBs nationally.

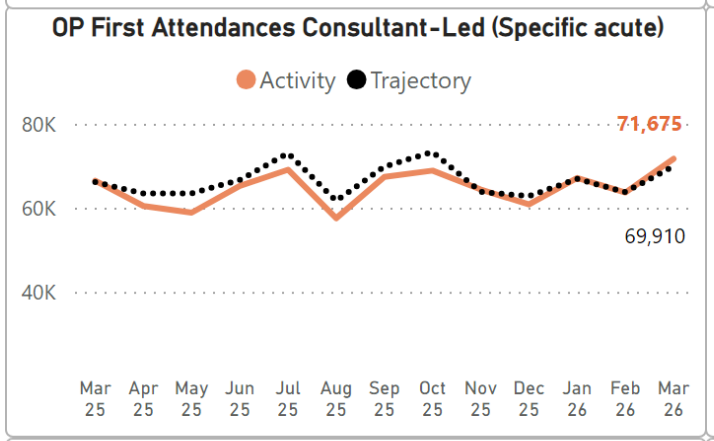
Patients on an Urgent Suspected Pathway waiting over 62 days
The number of patients waiting over 62 days increased to 317 patients, although this is still below the 327 target.

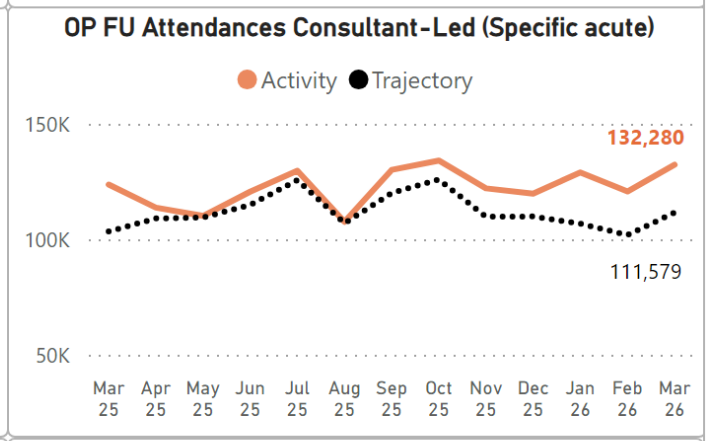
Domain: Outpatients and Diagnostics

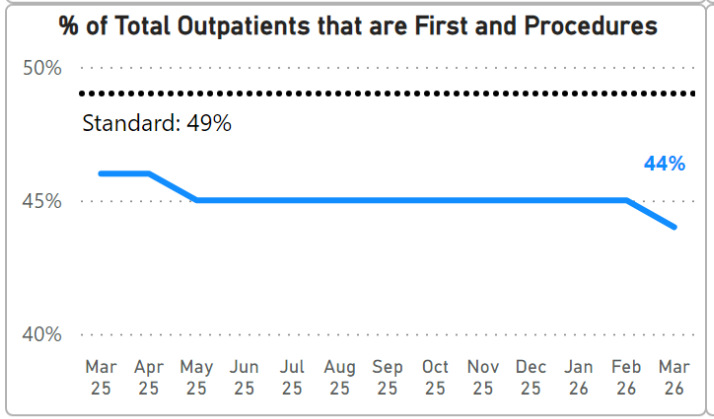
NHS South West London
Integrated Care Board

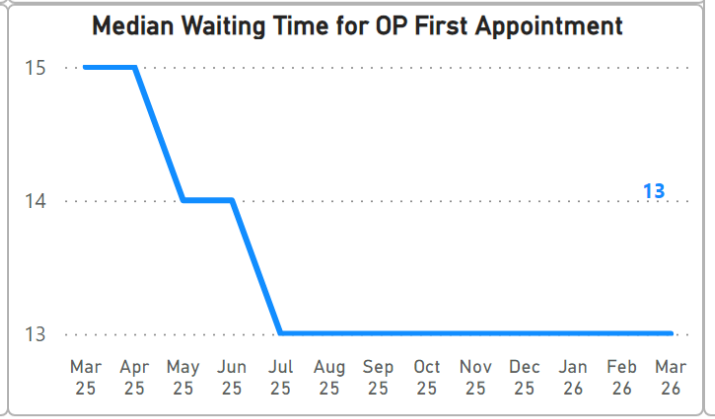












Diagnostic Activity (9 tests)
Activity increased to above plan in March. All SWL trusts, with the exception of St George's Hospital (SGH), exceeded their in-month plans.

% waiting less than 6 weeks (All tests)
Performance increased across South West London (SWL) providers in March, to 91%; the highest in London. Improvements continue to be seen at Croydon Hospital (CHS) and Kingston Hospital (KRFT) after carrying out their recovery plans. Backlog reductions of 51% at CHS and 31% at KRFT have supported performance improvement. Further work continues at CHS to reduce Non-Obstetric Ultrasound (NOUS) backlogs as they currently CHS have the largest numbers waiting over 6 weeks, in SWL.

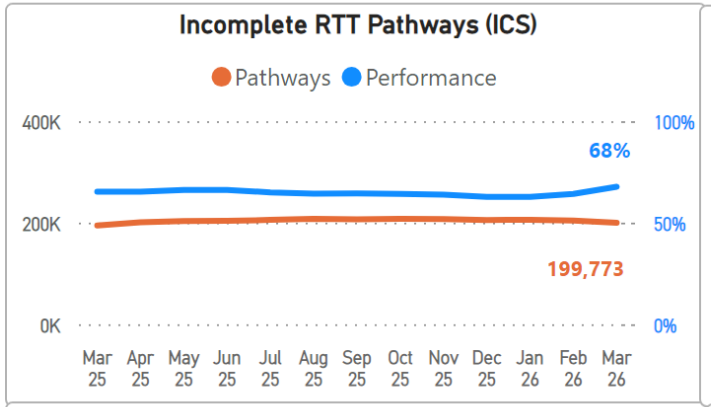
Consultant-led first and follow up outpatient attendances (Specific Acute)
Outpatient Firsts track slightly above plan in March. At provider level, ESTH were the only Trust to not meet their activity levels for their in-month plan. Follow-ups were above plan and continuing to performing above the year-to-date trajectory.

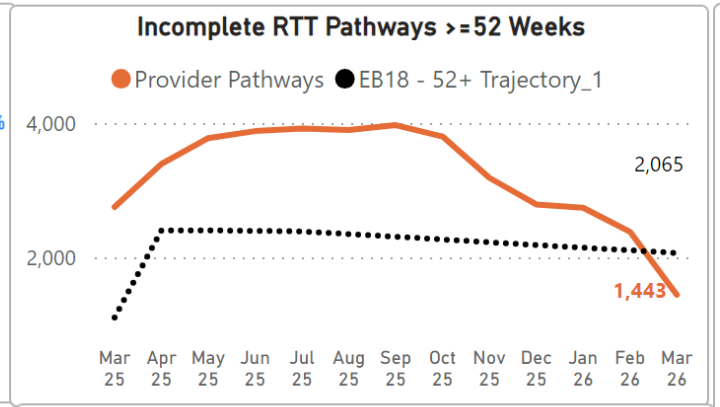
% of outpatients as firsts and procedures
SWL is reporting an aggregate achievement of 44% this month; just below the previous ten months and below the 49% standard. RMH performance is low due to the nature of Cancer pathways, which require a sequence of follow ups.

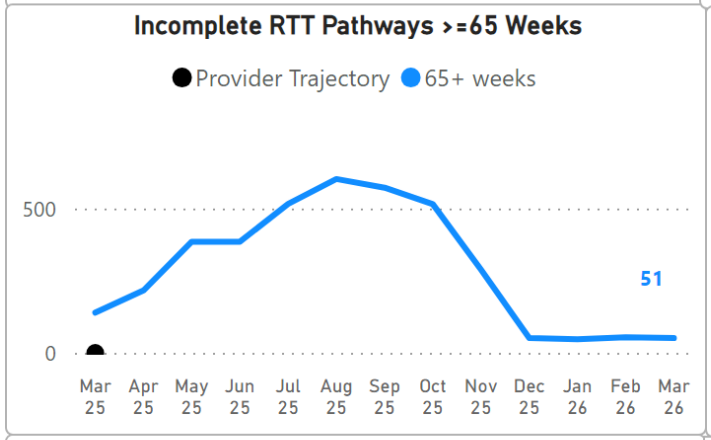
Median waiting time for outpatient (OP) first appointments
The median waiting time for high volume low complexity (HVLC) specialties remains flat at 13 weeks, having improved consistently in the past year. The Outpatient Transformation Programme oversees key improvements, including re-purposing follow-up slots for first appointments, reducing 'did not attend' (DNA) rates, increasing patient-initiated follow-up (PIFU) and implementing best practice at the front end of the elective pathway per Getting It Right First Time (GIRFT) guidelines.

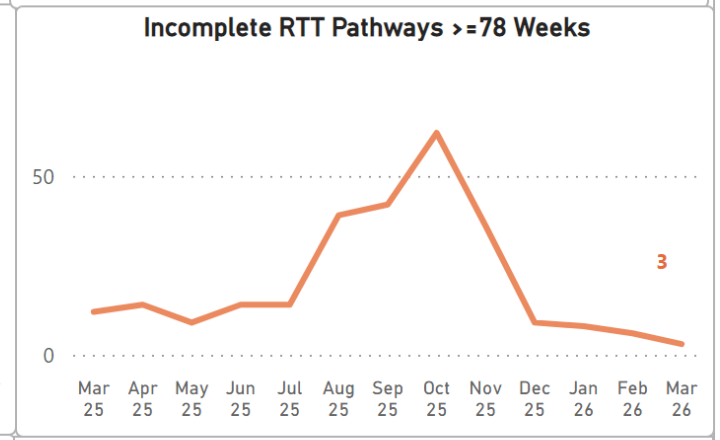
Domain: Planned Care

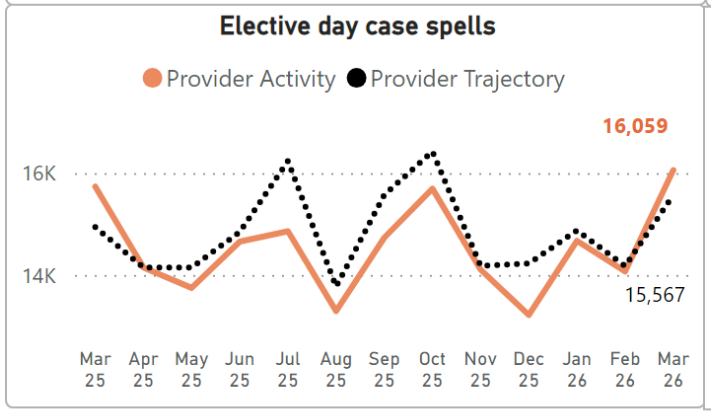
NHS South West London
Integrated Care Board

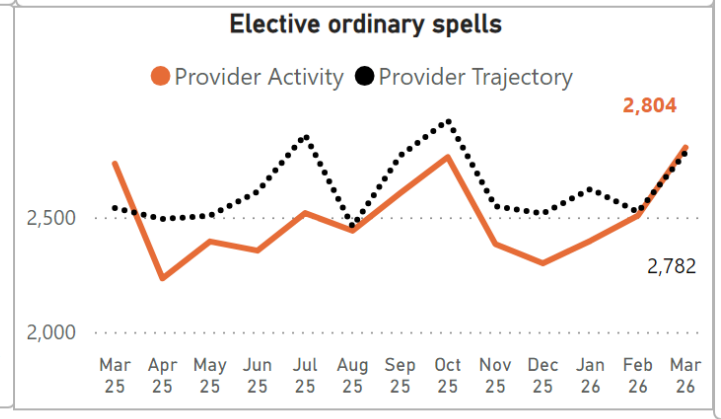












Planned care data relates to the year to March 2026; data is not yet available for 2026/27.

Incomplete waiting list pathways
March saw South West London (SWL) with 199,773 patients on an incomplete pathway awaiting treatment at hospital within or outside of the local geography. This represents a 2.2% growth since April 2025. Across SWL providers, 68% of patients were waiting less than 18 weeks, improving by 4% compared to the previous month. This is the highest position in London and higher than the national position (66.9%). Performance improved following the national Q4 performance sprint initiative. All SWL providers saw an improving position in their RTT performance as a result.

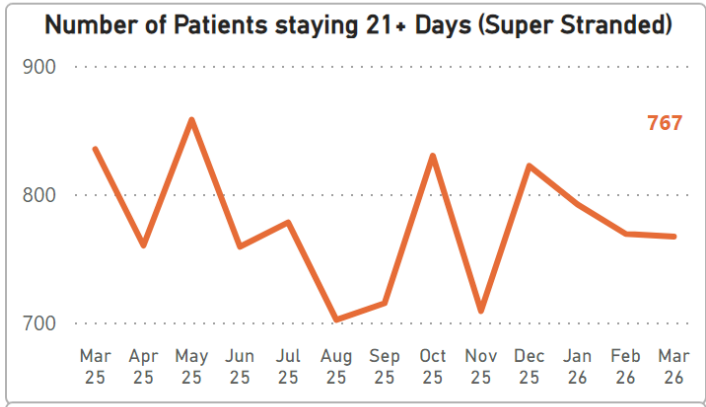
Long waiters – patients waiting over 52 weeks for treatment
SWL providers have the fewest patients waiting over 52 weeks compared to other London systems with 1,407 pathways in March, a reduction of 975 on the previous month. Ear, Nose and Throat (ENT) had the greatest number of patients waiting over 52 weeks at 245, showing a decrease of 80 in-month. Kingston and Richmond (KRFT) had the highest cohort with 177 followed by Croydon Hospital (CHS) with 66. All SWL providers delivered their plans to reduce 52- week waiters to less than 1%, as part of the National quarter 4 performance sprint.

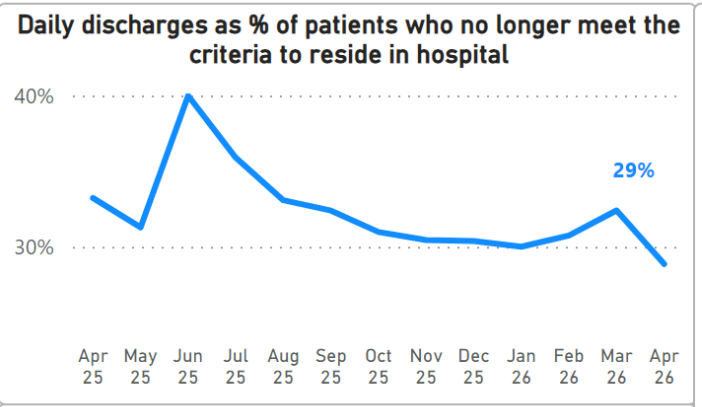
Long waiters – patients waiting over 65 weeks for treatment
The number of 65 week waits decreased slightly by 3 to 51 in March. All trusts aimed for zero 65-week waits by the end of December, some with the help of additional national funding. This metric is not expected to feature significantly in 2026/27 as performance continues toward recovery of the 92% target by March 2029.

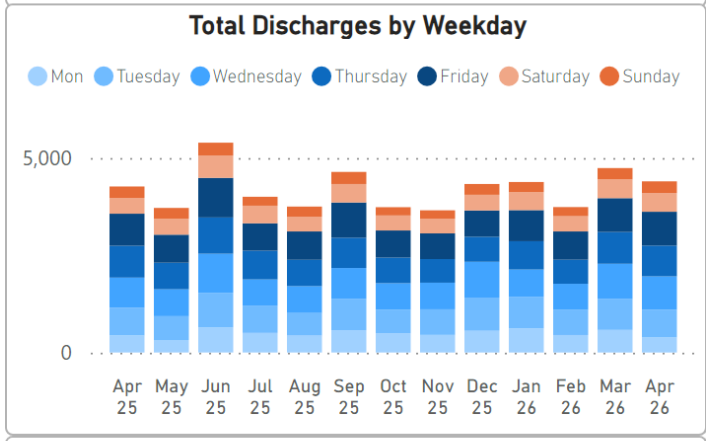
Elective day case spells & Elective ordinary spells
Activity increased in ordinary spells to above plan, elective day case also increased in line with the plan overall, elective activity is below the in-month trajectory.

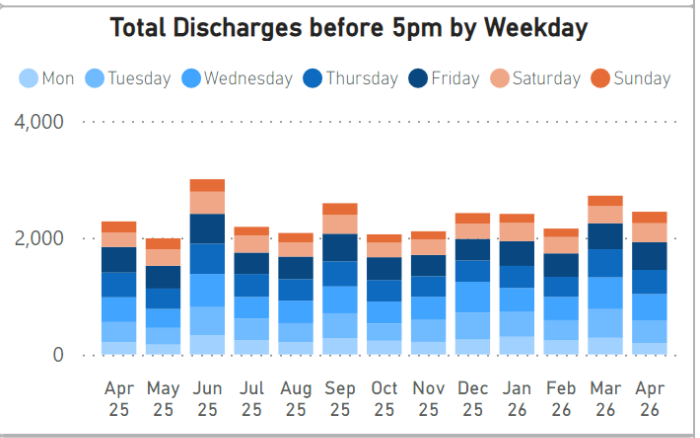
Domain: Integrated Care

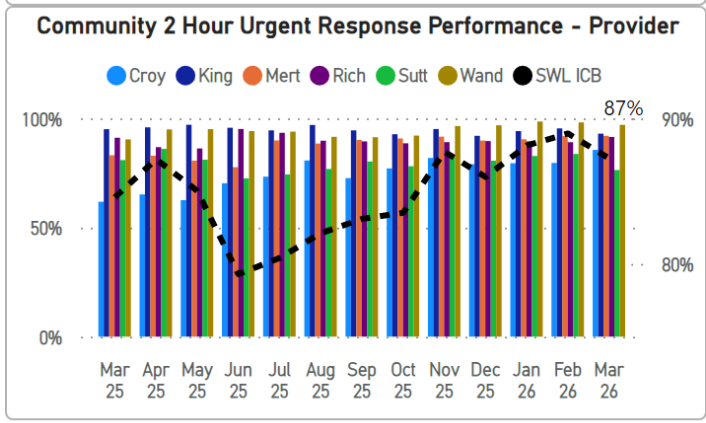
NHS South West London
Integrated Care Board

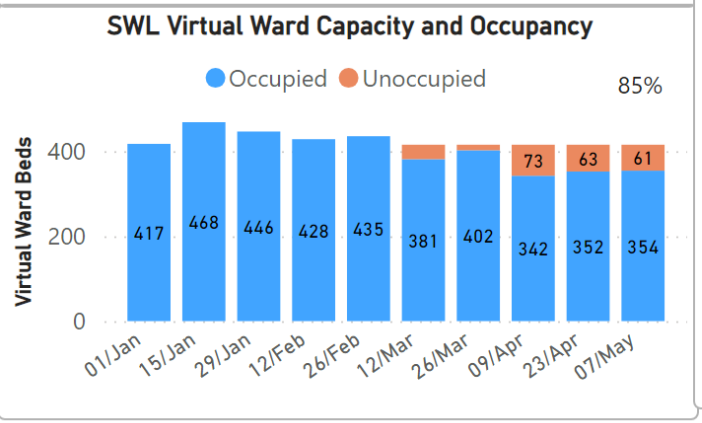












2 Hour Urgent Community Response (UCR)
At 85% for April, SWL continues to perform above the national target of 70%. Complexity of patients remains high and additional system pressures are experienced across SWL. SWL's referral rate is amongst the highest in England, and work continues on providing support to admission avoidance in SWL.

Virtual Wards (VW)
Occupancy in SWL is reported at 85% in April, which is above the target and within expected activity. Wards are optimising patient cohorts and ensuring best value for money. The Central Remote Monitoring Hub has started running 12 hours in April, which we can see has had some impact on utilisation. Systems are asked to review locally how to optimise using available resource.

Patients with a length of stay over 21 days
A significant amount of work is underway across SWL to address patient length of stay, which remains higher than the regional average. Short term plans include commissioning of additional capacity within frailty virtual wards in SWL, as part of the frailty model of care business case. This supports earlier discharges for frail patients. Work to improve relationships with LA's for closer working and faster decision making on complex patients continues.

Proportion of patients discharged who no longer meet the criteria to reside
Bed days lost to patients who do not meet the criteria to reside (CTR) remains an issue across SWL. A snap-shot audit (1 day) within one of the Trusts showed significant bed day saving opportunities particularly on Pathways 1 and 2, linking to improved discharges for older adults (frailty). Data quality issues have been noted in some Trusts. The relevant Trusts have been made aware and are working to improve recording.

Total discharges by weekday and before 5.00pm
Trends remain consistent with all Trusts showing a lower discharge profile on the weekends than during the week. Data from winter schemes such as additional GP appointments, discharge to assess / home first, show they have operated slightly extended operating hours. Where possible, service provision into the weekends are indicating positive impacts with potential opportunities for future models of care which improve discharge and flow over a 7-day period.

Data and sources

Category	Metric Name	Local/ national data source?	Data source (link)
Primary Care	GP appointments within two weeks	National: NHS Digital	https://digital.nhs.uk/dashboards/gp-appointments-data-dashboard
Primary Care	% of GP appointments that are virtual	National: NHS Digital	https://digital.nhs.uk/dashboards/gp-appointments-data-dashboard
Primary Care	Covid vaccinations by age group	National: Gov.uk	https://www.gov.uk/government/collections/vaccine-uptake#covid-19-vaccine-monitoring-reports
Primary Care	Covid vaccinations by dose	National: Gov.uk	https://www.gov.uk/government/collections/vaccine-uptake#covid-19-vaccine-monitoring-reports
Primary Care	6-in-1 vaccine by 12 months	National: Gov.uk	https://www.gov.uk/government/collections/vaccine-uptake
Primary Care	4-in-1 vaccine by 3-5 years	National: Gov.uk	https://www.gov.uk/government/collections/vaccine-uptake
UEC slide 1	A&E attendances (all types)	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2024-25/
UEC slide 1	A&E (all types) 4hr performance	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2024-25/
UEC slide 1	12hr A&E breaches	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2024-25/
UEC slide 1	12hr MH breaches	Local: Providers	Acute providers
UEC slide 1	45min ambulance handover breaches	Regional: London Ambulance Service	LAS scorecard
UEC slide 1	60min ambulance handover breaches	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2024-25/
UEC slide 2	% ambulance handovers within 15mins	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2024-25/
UEC slide 2	LAS category 1 emergency response times	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2024-25/
UEC slide 2	LAS category 2 emergency response times	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2024-25/
UEC slide 2	Non-elective spells	National: NHS Digital	SUS+
UEC slide 2	111 call volumes	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/iucadc-new-from-april-2021/
UEC slide 2	111 calls abandoned	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/iucadc-new-from-april-2021/
Mental Health	Talking Therapies access	National: NHS Digital	https://susi.sharepoint.com/sites/CentralPerformanceAnalytics/SitePages/Mental%20Health.aspx#nhs-talking-therapies
Mental Health	Talking Therapies reliable recovery rate plus target	National: NHS Digital	https://susi.sharepoint.com/sites/CentralPerformanceAnalytics/SitePages/Mental%20Health.aspx#nhs-talking-therapies
Mental Health	SMI health checks from primary care	National: NHS Digital	Physical Health Checks for People with Severe Mental Illness, Q1 2024-25 - NHS England Digital
Mental Health	Dementia diagnosis rate	National: NHS Digital	https://susi.sharepoint.com/sites/CentralPerformanceAnalytics/SitePages/Mental%20Health.aspx#primary-care-dementia
Mental Health	Access to transformed community services	National: NHS Digital	https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics
MH and LD	Learning Disability and Autism health checks	National: NHS Digital	Learning Disabilities Health Check Scheme - NHS England Digital
Mental Health	Early intervention in psychosis	National: NHS Digital	https://susi.sharepoint.com/sites/CentralPerformanceAnalytics/SitePages/Mental%20Health.aspx#mental-health-services-monthly-statistics
Mental Health	Access to specialist perinatal MH services	National: NHS Digital	https://susi.sharepoint.com/sites/CentralPerformanceAnalytics/SitePages/Mental%20Health.aspx#mental-health-services-monthly-statistics
Mental Health	Out of area placements	National: NHS Digital	Mental Health (sharepoint.com)
Mental Health	CYP access rate	National: NHS Digital	https://susi.sharepoint.com/sites/CentralPerformanceAnalytics/SitePages/Mental%20Health.aspx#mental-health-services-monthly-statistics
Mental Health	CYP eating disorders	National: NHS Digital	https://susi.sharepoint.com/sites/CentralPerformanceAnalytics/SitePages/Mental%20Health.aspx#mental-health-services-monthly-statistics
Cancer	Urgent suspected cancer referrals	National: NHS England	Cancer (sharepoint.com)
Cancer	Faster diagnosis standard (FDS)	National: NHS England	Cancer (sharepoint.com)
Cancer	31-day cancer treatment	National: NHS England	Cancer (sharepoint.com)
Cancer	Lower GI suspected cancer (FIT referrals)	National: NHS Futures	https://future.nhs.uk/connect.ti/canc/view?objectId=16647600
Cancer	62-day GP, screening and consultant upgrade	National: NHS England	Cancer (sharepoint.com)
Cancer	62-day patients waiting	National: NHS England	NHS England Cancer_PTL_Analysis Week Ending 25 Aug 2024.xlsm (sharepoint.com)
OP and diagnostics	Diagnostic tests (Activity)	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/monthly-diagnostics-data-2024-25/
OP and diagnostics	Diagnostics: % waiting less than 6 weeks	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/monthly-diagnostics-data-2024-25/
OP and diagnostics	OP first attendances consultant led (Specific Acute)	National: NHS Digital	SUS+
OP and diagnostics	OP FU attendances consultant led (Specific Acute)	National: NHS Digital	SUS+
OP and diagnostics	% of total outpatients that are first and procedure	National: NHS Digital	SUS+
OP and diagnostics	Median waiting time for OP first appointment	National: NHS Digital	SUS+
Planned care	Incomplete RTT pathways (ICS)	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
Planned care	Incomplete RTT pathways >=52 Weeks	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
Planned care	Incomplete RTT pathways >=65 Weeks	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
Planned care	Incomplete RTT pathways >=78 Weeks	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
Planned care	Elective day case spells	National: NHS Digital	SUS+
Planned care	Elective ordinary spells	National: NHS Digital	SUS+
Integrated care	21+ day super stranded patients	National: NHS Digital	SUS+
Integrated care	% discharges of patients no longer meeting CTR (daily avge)	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/acute-discharge-situation-report/
Integrated care	Total discharges by weekday	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/acute-discharge-situation-report/
Integrated care	Total discharges before 5pm	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/acute-discharge-situation-report/
Integrated care	Community urgent 2hr response	National: NHS England	https://www.england.nhs.uk/statistics/statistical-work-areas/2-hour-urgent-community-response/
Integrated care	VW occupancy and capacity	National: FDP	https://england.federateddataplatform.nhs.uk/workspace/carbon/ri.carbon.main.workspace.61768b8f-2cff-47cf-be86-b9bf8cabbf20/home

NHS South West London
Integrated Care Board

Audit and Risk Committee Update

Agenda item: 6.6

Report by: Bob Alexander, Non-Executive Member

Paper type: Information

Date of meeting: Wednesday, 15 July 2026

Date published: Wednesday, 8 July 2026

Purpose

To provide the Board with an update on the discussions, decisions and actions arising from the Audit and Risk Committee meeting held on 9 June 2026.

Executive summary

The Committee reviewed key statutory reporting documents, received positive assurance from both internal and external audit, and considered a range of annual assurance reports.

Overall, the Committee concluded that the ICB maintains a strong control environment, with no material audit concerns identified. However, members emphasised the need to remain vigilant and adaptive in light of organisational transition, particularly in relation to evolving risks, governance arrangements, and resource pressures.

Key Issues for the Board to be aware of

The Committee met on 9 June 2026. The following items were discussed:

- **Annual Report and Accounts 2025/26**
  The Committee reviewed the Annual Report and Accounts, focusing on clarity, consistency, and overall presentation. Minor amendments were identified and delegated for correction. A technical accounting issue was noted as a national matter with no impact on the underlying financial position. The Committee approved submission to NHS England.
- **Internal Audit Annual Report and Opinion**
  A positive Head of Internal Audit Opinion was noted, reflecting a strong control environment. The Committee highlighted the importance of maintaining a flexible and responsive audit approach during organisational transition and strengthening alignment between audit findings and the Board Assurance Framework.
- **External Audit Findings Report**
  The Committee welcomed the absence of material audit adjustments and noted strong overall findings. Value for Money recommendations were considered proportionate and focused on ensuring governance, financial strategy, and risk frameworks evolve in line with organisational change.
- **Letter of Representation**
  The Committee reviewed and approved the Letter of Representation, confirming it appropriately reflected management responsibilities.

- **Counter Fraud Annual Report**
  The Committee noted a positive assurance rating and a comprehensive programme of proactive work. Members stressed the need to maintain vigilance, particularly regarding emerging risks in procurement, prescribing, and continuing healthcare, and in the context of reduced capacity.
- **Information Governance Annual Report**
  Key issues discussed included increasing demand pressures (e.g. subject access and FOI requests) and limited capacity. Opportunities to improve efficiency through automation and AI were recognised.
- **Declarations of Interest, Gifts and Hospitality Annual Report**
  High levels of compliance were reported. The Committee emphasised the need for continued staff awareness and communication, particularly in relation to system changes and reporting requirements.
- **Single Tender Waivers and Non-Compliant PSR Approvals**
  An increase in waivers was noted, largely linked to planned mental health commissioning changes. While the rationale was recognised, concerns were raised regarding reliance on extensions. The Committee emphasised the importance of a clear and transparent forward commissioning pipeline and robust oversight.
- **Governance, Risk and Transition**
  Transition was identified as a central theme. The Committee agreed that future work should include a detailed deep dive into transition risks and governance arrangements. It also requested that assurance reports explicitly reference transition-related risks to support more integrated oversight.

Recommendation

The Board is asked to:

- Note the key points discussed at the Audit & Risk Committee meeting.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest

No conflicts of interest were declared in relation to agenda items.

Corporate objectives

The Committee's work supports delivery of the ICB's overall objectives through oversight of governance, risk management and internal control.

Risks

Key risks relate to organisational transition, including evolving governance arrangements, increased demand on assurance functions, and procurement-related risks

Mitigations

Mitigating actions include maintaining strong audit and assurance processes, enhancing alignment to the Board Assurance Framework, improving commissioning pipeline oversight, and exploring efficiency opportunities through automation.

Financial/resource implications

No material financial concerns were identified, though resource pressures (e.g. information governance workload) were noted.

Green/Sustainability Implications

Not Applicable

Is an Equality Impact Assessment (EIA) necessary and has it been completed?

Not Applicable

Patient and public engagement and communication

Not discussed

Previous committees/groups

Committee name	Date	Outcome
Not Applicable		

Final date for approval

Not Applicable

Supporting documents

Not Applicable

Lead director

Dinah McLannahan, Chief Finance and Compliance Officer

NHS South West London
Integrated Care Board

Author

Dinah McLannahan, Chief Finance and Compliance Officer

NHS South West London
Integrated Care Board

Remuneration Committee Update

Agenda item: 6.7

Report by: Jamal Butt, Non Executive Member

Paper type: Information

Date of meeting: Wednesday, 15 July 2026

Date Published: Wednesday, 8 July 2026

Purpose

To provide the Board with an update from the Remuneration Committee, as a Committee of the Board.

Executive summary

The update reflects the discussion, agreement and actions taken by the Remuneration Committee and is brought to the Board to provide an update on the progress and work of the Committee.

Key Issues for the Board to be aware of

The Committee met on the following dates and discussed:

17 April 2026

- Approval for the outcomes of the SWL ICB Voluntary Redundancy (VR) Scheme following completion of the Moderation Panel held on 10 April 2026.

14 May 2026

- Approval of Chief Finance and Compliance Officer and Chief Nurse and Quality Officer remuneration.
- Approval of the outcomes of the SWL ICB Voluntary Redundancy (VR) Scheme following completion of the Moderation Panel held on 10 April and further moderation via email concluded on 11 May.

21 May 2026

- Approval of the Chief Commissioning Officer Remuneration.

The following decisions were made outside of Committee:

11 June 2026

Approval of remuneration for Medical Director.

NHS South West London
Integrated Care Board

Recommendation

The Board is asked to:

- Note the update from the Committee.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
N/A

Corporate objectives
This document will impact on the following Board objective:

- Overall delivery of the ICB's objectives.

Risks
N/A.

Mitigations
N/A.

Financial/resource implications
N/A.

Green/Sustainability Implications
N/A.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
N/A.

What are the implications of the EIA and what, if any are the mitigations?
N/A.

Patient and public engagement and communication
N/A.

Previous committees/groups

Committee name	Date	Outcome

Final date for approval
N/A.

Supporting documents
N/A.

Lead director
Jamal Butt, Non Executive Member.

Author
Maureen Glover, Corporate Governance Manager

NHS South West London
Integrated Care Board

Organisation Report

Agenda Item: 7

Report by: Andrew Bland, CEO SWL ICB

Paper type: Information

Date of meeting: Wednesday, 15 July 2026

Date published: Wednesday, 8 July 2026

Purpose

To provide an overview and update to the Board on specific issues.

Executive summary

This report provides an operational update from the South West London Integrated Care Board (SWL ICB), regarding matters of interest to members of the Board that are not noted in other papers.

Key Issues for the Board to be aware of:

1. National Reports

The **Ockenden (Nottingham) Report (24 June 2026)** and the **Amos Report (30 June 2026)** together provide a strong, system-wide assessment of maternity and neonatal services in England.

Ockenden (Nottingham) Report

The Ockenden Review is the largest maternity inquiry in NHS history, examined over 2,500 cases at Nottingham University Hospitals and identified longstanding, systemic failures in leadership, staffing, culture, and clinical practice. It found hundreds of cases of potentially avoidable harm, driven by poor risk recognition, inadequate training, failure to listen to women and families, and weak governance**,** with repeated missed opportunities to learn and improve.

Amos Report

The Amos Report builds on these findings at a national level, it provides a comprehensive national assessment of maternity and neonatal services, drawing on evidence from families, staff and 12 NHS trusts. It identifies persistent, system-wide challenges including women not being listened to, workforce pressures, fragmented care pathways, and inequalities affecting outcomes and experience.

The report sets out eight strategic recommendations to deliver long-term transformation. These include establishing a statutory Maternity and Neonatal Commissioner to strengthen leadership and accountability; embedding systematic listening to women and families as a core safety requirement; and improving responses when harm occurs through better investigation, transparency, and learning.

It also calls for a modern national service framework, action to address racism and inequality, strengthened governance and team culture, and investment in workforce, estates, and digital infrastructure.

Overall, the report emphasises urgent, coordinated action to improve safety, consistency, and compassion in care**,** supported by clear national leadership and sustained system reform.

The ICB will ensure a robust maternity and neonatal governance framework with strong leadership, working in partnership with all providers to deliver safe, high-quality care in which every woman's voice is consistently heard, respected, and responded to.

Lord Mann review of antisemitism and other forms of racism in the NHS

On 4 June, Lord Mann published his review into tackling racism and antisemitism within the NHS, along with recommendations to support the NHS's shared goal of making its services safe for all patients, communities and colleagues.

In the review Lord Mann sets out recommendations to tackle "routine ostracism" of Jewish people in the NHS, including stronger accountability and mandatory training. The report emphasises the role of NHS employers as first line of defence against racism and discrimination for patients and staff. NHS employers will be required to meet new staff standards and complete mandatory anti-racism training to tackle antisemitism. The Government are clear that all racism in the NHS is abhorrent and reforms will protect Muslim, Black and minority ethnic and Jewish staff and patients alike.

South West London SEND Reforms (Special Educational Needs and Disability)

The UK Government's Schools White Paper, *Every Child Achieving and Thriving* (published on 23 February 2026), sets out long-term reforms to create a high-quality, inclusive education system for children and young people, with a strengthened role for health services in supporting SEND. As part of these reforms, Integrated Care Boards (ICBs) are required to act as full strategic partners with local authorities, education providers and social care, supported by stronger leadership, joint planning and appropriate health investment. Local areas have completed maturity assessments across seven SEND pillars and submitted Local Area SEND Reform Plans (LARPs) to the Department for Education and NHS England by the 19 June 2026 deadline, with these plans forming the basis for local authorities to access High Needs Support Grant funding. The Board is asked to note that SWL ICB's submission was completed and approved as planned, that local areas have identified varying levels of SEND maturity and improvement opportunities, and that formal feedback on the submitted plans is expected in September 2026, when a further update will be provided."

2. NHS Change

Management Response to Staff Consultation

Since the Board last met, the organisation has published the management response to consultation. The document sets out the management response to the staff consultation on the proposed future structure of NHS South West London Integrated Care Board (SWL ICB). This forms part of the wider change and transformation programme that has been put in place to ensure the organisation can deliver its statutory obligations and the requirements of the model ICB blueprint and deliver the NHS

Ten Year Plan. The organisation is now entering into the filling of posts process which will run until quarter 3 of this year.

3. Appointments

We are pleased to confirm the following appointments:

- Dinah McLannahan has been appointed as Chief Finance and Compliance Officer across both South East London and South West London ICBs. Dinah joined South West London ICB in December 2025 on a 12month secondment, bringing more than 25 years' experience in NHS finance across acute, mental health, community and system settings.
- Ed Waller has been appointed as Chief Commissioning Officer and Deputy Chief Executive appointed across South East and South West London ICBs. Ed joins the ICB from Kent and Medway ICB where he is currently the Deputy Chief Executive and Chief Commissioning Officer. Ed will join the ICB in early September.
- In April we announced the appointment of Elaine Clancy as Chief Nurse and Quality Officer across both SEL and SWL. We can now confirm that Elaine will also commence in post in early September.

4. Staff Awards/recognition

Alison Stwewart appointed to national panel shaping the future of Special Educational Neds and Disabilities (SEND) support

Alison Stewart, Deputy Director for Children's Services at SWL ICB has been appointed by the Department for Education to a new national expert panel that will help shape the future of support for children and young people with Special Educational Needs and Disabilities. The panel brings together experts from education, health, academia and parental engagement to oversee the development of National Inclusion Standards and Specialist Provision Packages. Her appointment to the panel comes as the government begins the rollout of a new Experts at Hand service designed to improve local access to specialist support and ensure children receive help earlier and closer to home.

Croydon Place selected as the Women's Health Group Clinic Regional Centre of Excellence for the London Region

Croydon has been selected as London's Women's Health Group Clinic Regional Centre of Excellence, recognising its innovative work to improve women's health, tackle inequalities and develop community-based models of care through group clinics. This is a significant achievement for Croydon Place and reflects strong partnership working across health services, the local authority and community organisations.

5. Other

South West London Mental Health and Health Inequalities Conference

On Wednesday 20 May, more than 200 mental health leaders, clinicians, community organisations and people with lived experience of mental ill health gathered at the Everyday Church in Wimbledon

for the annual South West London Mental Health and Health Inequalities Conference. The conference focused on tackling health inequalities in access, experience and outcomes across the mental health system.

Chief Nurse visits Sutton Care Home for Nurses Day

Ahead of International Nurses Day, Chief Nursing Officer for England, Duncan Barton visited Sutton Court Care Centre where he met care home manager and spent time talking to nurses, carers and residents. During the visit he also recorded a message thanking nurses and midwives across the country, who are at the heart of health and care delivery.

Recommendation

The Board is asked to:

- **Note** the contents of the report.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
N/A

Corporate objectives
This document will impact on the following Board objectives:

- Overall delivery of the ICB's objectives.

Risks
N/A

Mitigations
N/A

Financial/resource implications
N/A

Green/Sustainability Implications
N/A

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
N/A

Patient and public engagement and communication
N/A

Previous committees/groups
N/A

Committee name	Date	Outcome

Final date for approval
N/A

Supporting documents
N/A

NHS South West London
Integrated Care Board

Lead director

Andrew Bland, Chief Executive Officer

Author

Maureen Glover, Corporate Governance Manager