SWL Integrated Care Board Meeting

Wednesday 25 November 2026, 14:00 - 16:30

Rooms 2.1/2.2, 120 The Broadway, Wimbledon, SW19 1RH

NHS South West London
Integrated Care Board

Agenda

14:00 - 14:05
5 min

1. Welcome and introductions

Information *Chair*

1.1. Apologies for absence

Information *Chair*

1.2. Declarations of Interest

Information *Chair*

SWL ICB Board DOI November 2026.pdf (4 pages)

1.3. Approval of minutes of the last Board Meeting held in public

Decision *Chair*

To approve the minutes of the Board meeting held on 15 July 2026.

Item 01.3 - Draft ICB Minutes 15 July BL.pdf (5 pages)

1.4. Action Log

Information *Chair*

Item 01.4 - Action Log Part 1 Board.pdf (1 pages)

14:05 - 14:15
10 min

2. Governance Report

Decision *Ben Luscombe*

To provide Board members with an update on Governance matters, including any decisions required by the Board.

Item 2 - Governance Update.pdf (3 pages)
Item 2A - SORD revised Nov 2026.pdf (39 pages)
Item 2B - Neighbourhood ToR SWL post Board approval.pdf (10 pages)
Item 2C - SCC ToR SWL post Board approval.pdf (12 pages)

14:15 - 15:10
55 min

3. Committee Updates

Discussion

3.1. Strategic Commissioning Committee Update

Discussion *Anne Rainsberry*

To provide an update to the Board on the activities and decisions of the Strategic Commissioning Committee, together with reports on Month 6 financial position, SWL ICB Performance, SWL ICB commissioning priorities for 2027/28 and SWL Medium Term Financial Strategy.

Item 3.1 Committee update - SWL SCC.pdf (2 pages)

3.1.1. M6 Finance Report

Discussion *Dinah McLannahan*

- Item 3.1.1 - M6 Finance Report cover sheet.pdf (2 pages)
- Item 3.1.1 - M6 Finance Report.pdf (20 pages)

3.1.2. SWL ICB Performance Report

Discussion *Ed Waller*

- Item 3.1.2 - SWL Performance Report cover sheet.pdf (3 pages)
- Item 3.1.2 - SWL Performance Report.pdf (14 pages)

3.1.3. SWL ICB Commissioning priorities for 2027/28

Discussion *Ed Waller*

- Item 3.1.3 - Commissioning Intentions cover sheet.pdf (4 pages)
- Item 3.1.3 - SWL commissioning intentions 27-28.pdf (26 pages)

3.2. Audit Risk and Assurance Committee Update

Discussion *Bob Alexander*

To provide an update to the Board on the activities and decisions of the Audit, Risk and Assurance Committee.

- Item 3.2 - Committee update - SWL ARAC.pdf (3 pages)

3.3. Patient Safety Committee Update

Discussion *Masood Ahmed*

To provide an update to the Board on the activities and decisions of the Patient Safety Committee, including discussion on the Thirlwall Inquiry outcomes.

- Item 3.3 - Committee update - SWL PSC.pdf (2 pages)

3.4. Neighbourhood Strategic Delivery Committee Update

Discussion *Jamal Butt*

To provide an update to the Board on the activities and decisions of the Neighbourhood Strategic Delivery Committee.

- Item 3.4 - Committee update - SWL NSDC.pdf (2 pages)

3.5. Joint Transition Committee Update

Discussion *Bob Alexander*

To provide an update to the Board on the activities and decisions of the Joint Transition Committee.

- Item 3.5 - Committee update - Joint Transition Comm.pdf (4 pages)

3.6. Remuneration Committee Update

Discussion *Jamal Butt*

To provide an update to the Board on the activities and decisions of the Remuneration Committee.

- Item 3.6 - Committee update - SWL RC.pdf (2 pages)

15:10 - 15:30
20 min

4. Medium Term Financial Strategy

Decision *Dinah McLannahan*

- Item 4 - MTFS cover sheet.pdf (4 pages)
- Item 4 - MTFS Report.pdf (12 pages)

Borough Spotlight

15:30 - 16:00
30 min

5. Sutton Neighbourhood Development

Presentation *Michelle Rahman*

16:00 - 16:10
10 min

6. Board Assurance Framework

Discussion *Ben Luscombe*

To note the current SWL BAF position.

- Item 6 - SWL BAF cover sheet.pdf (2 pages)
- Item 6 - SWL ICB BAF Report.pdf (20 pages)

16:10 - 16:15
5 min

7. Organisation Report

Information *Andrew Bland*

To provide an overview and update on specific issues in South West London.

- Item 7 - Organisation Update.pdf (12 pages)

16:15 - 16:20
5 min

8. Any Other Business/Meeting Close

Information *All/Chair*

16:20 - 16:30
10 min

9. Public Questions

Discussion *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.

Date of next meeting: Wednesday 17 February 2027

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		
Ed Waller	Deputy CE and Chief Commissioning Officer	Declaration of Interest - Other	Indirect	Spouse is employed by King's College Hospital FT as a consultant.	King's College Hospital FT	07/09/2026		
Ed Waller	Deputy CE and Chief Commissioning Officer	Declaration of Interest - Other	Non Financial Personal	Life member of Diabetes UK	Diabetes UK	07/09/2026		
Elaine Clancy	Chief Nursing and Quality Officer	Declarations of Interest – Other	Non-Financial Personal	Clustered role Joint Chief Nursing and Quality Ofrficer for SEL and SWL ICBs	SEL and SWL ICBs	7.9.26		
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
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

Jo Farrar	Chief Executive of Kingston Hospital and Hounslow and Richmond Community Healthcare NHS Trust, Kingston and Richmond Place Executive Lead	Declarations of Interest – Other	Non-Financial Personal	My girlfriend is a Programme Manager for the Local Authorities' Transforming Adult Social Care Programme.	Wandsworth and Richmond Local Authorities	23/10/2024		15/04/2025
Jo Farrar	Chief Executive of Kingston Hospital and Hounslow and Richmond Community Healthcare NHS Trust, Kingston and Richmond Place Executive Lead	Declarations of Interest – Other	Financial	CEO of Kingston and Richmond NHS Foundation Trust	Kingston and Richmond NHS Foundation Trust	01/11/2024		15/04/2025
Masood Ahmed	SWLNEN03 Non- Executive Member	Outside Employment		Non-Executive Director	Coventry and Warwickshire Partnership NHS Trust	01/04/2024		24/04/2025
Masood Ahmed	SWLNEN03 Non- Executive Member	Outside Employment		Director	Amadeus Health and Medical Ltd	01/04/2024		24/04/2025
Masood Ahmed	SWLNEN03 Non- Executive Member	Outside Employment		Charity Trustee	Great Ormond Street Hospital Charity	01/04/2024		24/04/2025
Masood Ahmed	SWLNEN03 Non- Executive Member	Outside Employment		Trustee, Chair, Medology - Supports students from underrepresented communities, including firstgeneration applicants whose parents have never attended university, to access medicine and dentistry at University	Great Ormond Street Hospital Charity	01/04/2026		
Masood Ahmed	SWLNEN03 Non- Executive Member	Outside Employment		Board Advisor	Vitvio	01/04/2024		24/04/2025
Masood Ahmed	SWLNEN03 Non- Executive Member	Outside Employment		Editorial Board Member	Integrated Care Journal	01/04/2024		24/04/2025
Nicola Jones	SWLWSCL01 Clinical Director Primary Care	Declarations of Interest – Other	Financial	My practices are part of Wandsworth GP Federation (previously BHCiC)	Battersea Healthcare	17/12/2021		25/04/2025

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	01/11/2026	
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	01/11/2026	
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 15 July 2026 at 10.30 in the Trafalgar Suite, Hotel Antoinette, The Broadway, Wimbledon SW19 1SD

Members

Chair
Richard Douglas

Non-Executive Members
Dr Masood Ahmed, Non Executive Member, SWL ICB
Bob Alexander, Non Executive Member, SWL ICB

Executive Members
Andrew Bland, Chief Executive 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
Vanessa Ford, Partner Member, Mental Health Services

In attendance
Ben Luscombe, Director of Corporate Affairs
Maureen Glover, Corporate Governance Manager
Neil McDowell, Deputy Director of Finance
Mark Creelman, Place Executive – Merton and Wandsworth (for agenda item 3)
David Gentles, Head of Sports and Leisure, LBM (for agenda item 3)

Apologies
Cllr Andreas Kirsch, Partner Member, Local Authorities
Anne Rainsberry, Non Executive Member, SWL ICB
Jamal Butt, Non Executive Member, SWL ICB
Dinah McLannahan, Chief Finance Officer, SWL ICB
Jo Farrar, Partner Member, Community Services
Omar Daniel, Associate Non Executive Member

1 Welcome and Apologies

1.1 Richard Douglas (RD) welcomed everyone to the meeting. Apologies were noted as above and the meeting was quorate.

1.1 Declaration of Interests

1.1.1 A register of declared interests was included in the meeting pack, and no additional declarations were made.

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

Minutes

1.2.1 The Board **approved** the minutes of the meeting held on 29 April 2026.

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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 during the period April to June 2026.

3 Merton Place

3.1 Mark Creelman (MC) and David Gentles (DG) gave a presentation on the first in a series of place-focused presentations intended to strengthen understanding of the distinct needs, strengths and challenges of communities across South West London.

3.2 The presentation highlighted the significant health inequalities within Merton, particularly between the East and West of the borough, and described the borough's prevention-focused approach through the themes of Start Well, Live Well and Age Well. Members noted the strong emphasis on physical activity, community engagement and wider determinants of health, recognising the contribution these make to preventing ill health and supporting wellbeing.

3.3 The Board discussed the Borough of Sport programme and welcomed evidence of strong partnership working between the Local Authority, health partners, voluntary and community organisations and major sporting institutions. The programme's role in promoting physical activity, addressing social isolation and supporting population health outcomes was noted.

3.4 Discussion focused on the relationship between physical activity and mental health, with members highlighting the importance of belonging, social connectedness and participation in tackling anxiety, depression and loneliness. The Board also explored how interventions could be tailored to different communities, including older adults and ethnically diverse populations, to ensure equitable access and engagement.

3.5 Board members welcomed the development of Integrated Neighbourhood Teams and noted plans to begin implementation in September 2026, recognising this as an important step in delivering more integrated local services and addressing health inequalities.

3.6 The Board commended the strength of local partnerships and noted the opportunity to learn from Merton's approach as neighbourhood development progresses across South West London.

The Board **received** and **discussed** the presentation on Merton Place.

4 Approval of the revised SWL ICB Governance Framework

4.1 BL presented the report, and the Board considered the proposed Governance Framework and supporting governance documentation developed to support the future operating model of the ICB and the emerging cluster arrangements with South East London ICB.

4.2 Members noted that the framework reflected the transition of the ICB towards a strategic commissioning role and had been developed following engagement with Board members, Committee chairs and executive leads. The Board recognised that the framework would provide a basis for clear decision-making, accountability and organisational effectiveness whilst remaining subject to ongoing review and refinement.

4.3 Discussion focused on ensuring that future governance arrangements supported effective partnership working, place-based delivery and strategic oversight. Members recognised the

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importance of ensuring that governance changes were considered alongside wider work on organisational development, target operating models and future ways of working.

4.4 Particular discussion centred on the representation of mental health within future committee structures and Board members agreed that mental health representation should be appropriately reflected within the Neighbourhood Strategic Delivery Committee. Assurance was sought regarding how mental health considerations would be reflected within the work of the Strategic Commissioning Committee. Members were advised that mental health would be embedded within commissioning priorities and agenda planning, ensuring appropriate consideration alongside broader strategic commissioning responsibilities.

Action BL: Mental health representation within the Neighbourhood Strategic Delivery Committee to be reviewed and incorporated into final Committee arrangements.

4.5 The Board also noted arrangements for establishing a Transition Committee to oversee organisational change activity and ensuring that learning, risks and assurance from existing committee structures were appropriately carried forward. The ToR for the Committee were developed with the Chair and members of the Committee, and the final draft, will be circulated out of committee for approval and will then be noted at the SWL ICB Board in October.

Action: BL to circulate the Transition Committee Terms of Reference to the Transition Committee for approval.

The Board **approved** the revised Governance Framework and supporting governance documentation, subject to approval of the constitutional amendments by NHS England.

5. Annual Report and Accounts 2025/26

5.1 BL presented the Annual Report and Accounts for 2025/26.

5.2 Board members noted that the documents had been approved by the Audit and Risk Committee, prior to submission. It was noted that the Annual Report had been written to reflect the new direction of travel for the NHS and the ICB related to the 10-year plan as well as the ICB's future role as a strategic commissioner. Board members noted that NHSE use the report as a principal source of evidence for a statutory assessment of the ICB each year and the report includes detailed responses to a number of key lines of inquiry that NHSE will require.

5.3 The Board noted that all statutory financial duties and financial targets had been achieved during 2025/26. Members were advised that the accounts had received an unqualified audit opinion, no material adjustments had been required following external audit review and no new audit recommendations had been issued.

5.4 The Chair of the Audit and Risk Committee reported that both internal and external auditors had provided positive assurance regarding the quality, accuracy and governance arrangements supporting the Annual Report and Accounts.

5.5 Board members recognised the significant work undertaken by finance, governance and supporting teams in delivering the accounts during a period of considerable organisational change and formally recorded its thanks to the finance and governance teams for their work in preparing the accounts and supporting documentation.

The Board **approved** the Annual Report and Accounts for 2025/26.

6 Board Committee Updates and Reports

Finance & Planning Committee Update

6.1 Neil McDowell (NMD) presented the Finance & Planning Committee update and gave an overview of the key issues discussed at its meeting on 27 May 2026.

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Month 2 Finance Report

6.2 NMD presented the M2 Finance Report noting that acute contracts had now been agreed and that delivery of the £33 million efficiency programme remained on track. The discussion focused on financial forecasting and the importance of timely financial intelligence to support effective financial management.

6.3 A risk was identified in relation to expenditure for Right to Choose activity and assurance was provided that management actions and revised pathways were being implemented to improve control and oversight.

6.4 The Board also discussed wider challenges associated with delayed financial information flows, including prescribing data and highlighted the importance of robust forecasting methodologies to support decision making.

Quality & Performance Oversight Committee Update

6.5 Dr Masood Ahmed (MA) presented the report and gave an overview of the key issues discussed at the Quality & Performance Oversight Committee meeting on 10 June 2026.

Quality Report

6.6 Elaine Clancy (EC) presented the report, noting the continuing operational pressures across urgent and emergency care, mental health and cardiac services. Board members also noted ongoing work relating to pathology incidents, safeguarding concerns and maternity services following publication of recent national review reports.

6.7 An update was provided on the emerging NHS England Oversight Framework, which would introduce a new assessment methodology focused on a broad range of population health measures. There was a discussion about the potential implications of the framework and the importance of understanding its impact on future performance assessment and regulatory oversight was recognised. A dedicated Board development session would be arranged on the NHS England Oversight Framework following publication of the first assessment outcomes.

Performance Report

6.8 Jonathan Bates (JBa) presented the report, highlighting strong improvement in planned care and diagnostics, with SWL remaining one of the strongest performing systems in London. Board members also noted that urgent and emergency care pathways continued to experience significant pressure.

Audit & Risk Committee Update

6.9 Bob Alexander (BA) presented the report and gave an overview of the key issues discussed at the Audit & Risk Committee on 9 June 2026, highlighting the ongoing oversight of organisation transition risks and the arrangements being established through the Transition Committee.

6.10 Board members noted that there might be opportunities to align internal and external audit activity across South East and South West London clustering arrangements, whilst maintaining the statutory independence of each organisation.

Remuneration Committee Update

6.11 MA presented the report which provided an overview of the decisions made by the Committee between April and June 2026, in relation to consideration of senior appointments, organisational change and voluntary redundancy.

The Board **noted** the reports.

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7 Organisation Report

7.1 AB presented the report, and Board members discussed the impact of the ongoing organisational change programme, recognising the significant effort being undertaken by staff and leaders to implement the new organisational structure in a respectful and supportive manner. The Board noted that formal outcomes had been communicated to staff, providing increased clarity, whilst also creating understandable uncertainty for some individuals.

7.2 The Board welcomed progress in filling executive leadership roles and noted that the executive team would move towards full establishment during the autumn.

7.3 The Board noted the requirement for commissioners as well as providers to respond to the recommendations in the national maternity reports; the emerging issues relating to women's health estate challenges at Epsom and St Helier, receiving assurance that the ICB would continue to monitor developments, support providers and assess wider system impacts; and the success of the recent Mental Health and Health Inequalities Conference, recognising the strong system commitment to reducing inequalities and improving parity of esteem.

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 The Board received a written question from Mr Jeffrey Barber, regarding funding arrangements for neighbourhood health services. It was noted that investment was already being directed towards components of neighbourhood services, including virtual wards, care coordination and locally commissioned services. The Board heard that a medium-term financial strategy was being developed to support the shift of resources from acute settings into community and neighbourhood-based care and to ensure funding better reflected population need.

9.2 A second question was received from the Wandsworth Patient Forum regarding water safety governance arrangements within provider organisations. Assurance was given that provider organisations continued to operate in accordance with statutory requirements and established water safety governance processes, including regular audit and monitoring arrangements.

Next meeting in public: Wednesday 21 October 2026

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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

Governance Report

Agenda item: 2

Executive Lead: Dinah McLannahan, Chief Finance and Compliance Officer

Report by: Ben Luscombe, Director of Corporate Services

Paper type: Decision

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to update the Board on progress with the ICB's governance arrangements over the last quarter and seek approval for any proposed changes.

The Board is asked to:

- **Note** the approval of the revised Constitution by NHS England
- **Note** the ongoing work on the risk management framework
- **Note** the decisions made in other meetings
- **Approve** the revisions to the Scheme of Reservation and Delegation
- **Approve** the amendments to the Terms of Reference for the Neighbourhood Strategic Delivery Committee
- **Approve** the amendments to the Terms of Reference for the Strategic Commissioning Committee

2. Background and context

Following approval of the ICB's new governance arrangements by the Board at its last meeting of 24 July 2026, the governance and risk and assurance teams have been working with the ICB executives to implement the arrangements. This has focused on the implementation of committee meetings, and the development of a risk management framework proposal.

As a consequence, some further changes have been proposed to some Terms of Reference, and the Scheme of Reservation and Delegation (SoRD), which are detailed below for the Boards consideration.

In addition, the revised Constitution which was discussed at the last meeting of the Board and reflected changes to its composition, was approved by NHS England in October 2026.

3. Activity undertaken

All Committees of the Board have held their first meeting, where Terms of Reference were discussed and acknowledged. Where changes were proposed the Terms of Reference have been brought to the

Board within this paper for re-approval. Committees will operate on an individual ICB basis, but agendas will be aligned across the same committees within the Cluster for consistency.

A risk management framework proposal was presented to the Audit, Risk and Assurance Committee and was endorsed by the Committee for further work to take place with the Board on risk appetite definitions and process development.

Following publication of the suite of governance documents agreed at the last Board, some feedback has been received to clarify the status of some committees and groups, and to reflect legislative updates around procurement rules, which will require an update to be made to the Scheme of Reservation and Delegation (SoRD). These changes are detailed below.

4. Decisions and Outcomes

The below revisions to documents have already been considered and endorsed by the respective Committees, and are presented to the Board today for approval:

1) Scheme of Reservation and Delegation
   Amendments are proposed as follows:
   - Section 11 Medicines Optimisation
     - Clarify total value for SWL based on population size.
     - Expand commentary for delegated authority where estimated total yearly cost per drug is up to £25k per 100k population to explain the role of the Integrated Medicines Optimisation Committee (IMOC) as the recommending authority to the Chief Pharmacist.
     - Amend delegation of authority where estimated total yearly cost per drug is above £25k per 100k population to Senior Management Team on recommendation of IMOC.
     - Add a note on the ICBs obligations to fund and resource medicines and treatments recommended by the National Institute for Health and Care Excellence (NICE) Technology Appraisals.
   - Section 27 Quotation, Tendering and Contract Procedures
     - Add explicit guidance on Provider Selection Regime (PSR) non-compliant awards process.
     - Cross reference standard revenue limits for goods and services tendering, and amend values to reflect PSR requirements.
     - Update procurement legislation references.

2) Terms of Reference for Neighbourhood Strategic Delivery Committee
   - To include the Chief Commissioning Officer as a member of the committee.
   - Remove specific attendees and state individuals will be invited on an “as and when” basis to provide subject matter expertise as required by the agenda.

3) Terms of Reference for Strategic Commissioning Committee
   - Terms of Reference to be explicit that second non-executive member is Deputy Chair of Committee.
   - Remove specific attendees and state individuals will be invited on an “as and when” basis to provide subject matter expertise as required by the agenda.

5. Decisions made in other meetings

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. They are recorded here to ensure that all Board members are aware of decisions that have been made, by the Board, in other meetings.

15 July 2026

- Approval to proceed, as set out in the Complex Care Programme Phase 3 business case, with the transfer of the remaining cohort of complex placements from South West London ICB to the South London Partnership.

19 August 2026

- Approval of the 2026-27 Section 75 Agreements and values for the Better Care Fund and non-Better Care Fund schemes.
- Agreement of the modification to the Royal Marsden NHS Foundation Trust contract for Cancer Service Development Funding (SDF) funding for Lung Cancer screening.
- Approval of the new awards or modifications to Provider Selection Regime Direct Award A contracts 2026/27 for NHS Acute, London Ambulance Service (LAS), Mental Health and Delegated Specialised services.

30 September 2026

- Approved the recommendation to publish the intention to award new contracts through PSR Direct Award for Community Services contracts.
- Endorsed the SWL Winter Plan 2026/27 as the overarching approach to managing winter pressures; approved the submission of the Board Assurance Statement to NHS England; endorsed the ongoing monitoring and oversight arrangements; and delegated authority to the designated Winter Director, in consultation with the Director of Urgent and Emergency Care, to make any minor amendments required by NHS England following submission provided these did not materially alter the strategic intent of the plan.
- 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.

Appendices and supporting information

Appendix A – Revised Scheme of Reservation and Delegation
Appendix B – Revised Terms of Reference for Neighbourhood Strategic Delivery Committee
Appendix C – Revised Terms of Reference for Strategic Commissioning Committee

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	✓			

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
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 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	✓			

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
CLINICAL QUALITY AND PATIENT SAFETY				
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

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
CORPORATE MATTERS				
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	✓			

Decision	Reserved or delegated to Board	Chief Executive	Chief Finance and Compliance Officer	Committees and Sub-committees
Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions for promoting improvement in the quality of services and promoting the involvement of each patient, patient choice, public engagement and consultation				Strategic Commissioning Committee
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); and
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.
h.

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	NHS South East London ICB (SEL ICB) is the Corporate Trustee for NHS Greenwich Charitable Funds.
	Approval of Charity purpose, vision and strategic objectives	SEL ICB Board
	Approval of annual charitable funds budget	Chief Finance and Compliance Officer
	Approval of annual report and assuring compliance	Chief Finance and Compliance Officer
	Day to day control and management of charitable fund	Place Executive Lead (Greenwich)
	Approval of grants: a) Up to £10k b) £10k to £200k c) £200k+	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	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
	Approval of contract changes on dental system	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, £375,000 for South West London based on 1.5 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, £375,000 for South West London based on 1.5 million population)	a) ~~Chief Pharmacist~~The ICB Chief Pharmacist exercises delegated authority for decisions relating to the introduction of new and repurposed medicines, following consideration and recommendation through the Integrated Medicines Optimisation Committee (IMOC), and is responsible for ensuring that IMOC operates in accordance with approved terms of reference and delegated limits. b) Senior Management Team (SMT)~~CC~~ on the recommendation of Integrated Medicines Optimisation Committee (IMOC)~~medicines optimisation tea~~ Note: The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's Technology Appraisals. For drugs recommended within NICE Technology Appraisals and being used within NICE criteria and where the total yearly cost is above £25,000 per 100,000 population – these will be highlighted to the SMT for information only. 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.	For SEL ICB 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.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
		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:** 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

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
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
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)	a) Chief Finance and Compliance Officer b) Chief Finance and Compliance Officer

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	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	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
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.	a) Executive Director b) Executive Director c) Executive Director

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	d) Authorisation of consultants **in excess of budget.**	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	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) Authority to appoint staff to post not on the agreed establishment	b) As above for a). Chief Executive approval will be required should there be no recruitment panel in place.
	c) All requests for upgrading/re-grading to be dealt with in accordance with ICB procedures and recruitment panel approval.	c) Once approval received, finance department and workforce department to be informed of outcome for budgetary and ESR purposes.
	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	f) i) Line Manager

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	ii) Approval to carry forward annual leave	ii) Annual leave carry over will be approved in line with the annual leave policy for each respective ICB.
	iii) Payment of Annual Leave in exceptional circumstances	iii) Chief Executive
	iv) Special leave for bereavement up to 5 days	iv) Head of Service
	v) Extended Special Leave for bereavement	v) Executive Director
	vi) Special leave arrangements	vi)
	• carers leave - up to 3 days in any six-month period	• Head of Service. HR to be informed
	• carers leave - up to 5 days in any six-month period	• Executive Director. HR to be informed
	vii) Leave without pay	vii) Executive Director
	viii) Time off in lieu	viii) Line manager
	ix) Maternity and Paternity Leave – paid and unpaid	ix) Automatic approval as per guidance and ICB Policy; HR to be informed.
	g) Sick Leave (in exceptional circumstances)	g)
	i) Extension of sick leave – in line with contract of employment	i) To seek advice from the Director of HR before any extension is agreed
	ii) Extension of sick leave – any non-contractual payments	ii) Remuneration Committee
	iii) Return to work part-time on full pay to assist recovery	iii) Executive Director with advice with advice from occupational health and HR.
	h) Study Leave	h)
	i) Study leave outside the UK	i) Chief Executive in line with ICB training policy
	ii) All other study leave (UK)	ii) Executive Director in line with ICB training policy
	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	i) Executive Director, and notification to HR
	ii) Over £2,000	ii) Chief Executive and notification to HR
	j) Grievance Procedure All grievance cases must be dealt with strictly in accordance with the applicable ICB Grievance Procedure and the advice of HR	As per applicable (i.e. SEL or SWL) ICB procedure
	k) Authorised Car & Mobile Phone Users	k)
	i) Requests for new posts to be authorised as car users	i) As per applicable ICB policy
	ii) Requests for new posts to be authorised as mobile telephone users	ii) As per applicable ICB policy
	l) Redundancy	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.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	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	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.
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 Non- Compliant Awards - Formal PSR procedures may be waived or a non-compliant award approved by the Chief Executive and Chief Financial Officer in the circumstances set out in the non-healthcare section below.	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
	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 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.	Approval in line with the revenue and contract approval limits
	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)~~	Approval in line with the revenue and contract approval limits ~~a) Head of Service~~

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	~~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~~	~~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~~
	a) Goods/ services up to £24,999 – minimum of 1 written quotation b) Goods/services from £25,000 - £74,999. Request a minimum of 3 written quotations, contract can be awarded if less than 3 quotes received. c) Goods/ services from £75,000 - £207,719. Request a minimum of 5 tenders, contract can be awarded if less than 5 tenders received. d) Goods/services listed under light-touch – from £75,000 – £663,539. Request a minimum of 5 tenders, contract can be awarded if less than 5 tenders received. e) Goods/services equal to or greater than £207,720 (current goods and services threshold). Full competitive tenders as per PA2023. f) Light Touch contracts equal to or greater than £663,540 (current light touch contracts threshold). Full competitive tenders as per PA2023. g) Waiving of quotations and tenders subject to Standing Financial Instructions.	a) Approval in line with the revenue and contract approval limits. b) Approval in line with the revenue and contract approval limits. c) Approval in line with the revenue and contract approval limits. d) Approval in line with the revenue and contract approval limits. e) Approval in line with the revenue and contract approval limits. f) Approval in line with the revenue and contract approval limits. g) 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

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	~~g)~~h) Opening Tenders and Quotations ~~h)~~i) Authorisation of payments to public partnership schemes under existing contracts ~~i)~~j) 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 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 or a non-compliant award approved by the Chief Executive and Chief Finance and Compliance~~ial~~ 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;~~	Assurance Committee. Where the Chief Executive is requesting the tender waiver, approval is by the Chair and the Chief Finance and Compliance Officer. h) Sealed tenders and quotations will be opened by the procurement lead via the tendering portal. i) Chief Finance and Compliance Officer. j) i) Executive Director ii) Chief Finance and Compliance Officer

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	~~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.~~ a) In very exceptional circumstances where the Chief Executive Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate ICB record; b) Where the requirement is covered by an existing contract; c) 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; d) Where specialist expertise is required and is available from only one source; e) 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; f) Where no bids or no suitable bids were received in a compliant procurement process;	

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	g) Immediate risk to patient safety; h) Existing contract/ provider unexpectedly unable to provide services so new provider required; i) Other exceptional circumstances. 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, Risk and Assurance -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,~~	

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	~~approval must be sought from the Chief Finance and Compliance Officer together with one other executive prior to award of the contract.~~ PA23 permits direct awards under some circumstances – this would not be subject to a waiver. However the necessary procurement advice should be sought and governance approval obtained. Capital Revenue Up to £2,500,000 (if within delegated budget) Over £2,500,000 to £10~~5~~,000,000 (if within delegated budget) Over £10~~5~~,000,000 up to £25,000,000 Over £25,000,000	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

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
	Authority to approve acceptance of late tenders 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** *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	Executive director or manager Chief Finance and Compliance Officer 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.

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
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.
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

REF	DELEGATED MATTERS	AUTHORITY DELEGATED TO
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
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

Neighbourhood Strategic Delivery Committee

Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
0.1	April 2026	Initial core parts of ToRs developed by directors of Neighbourhood Delivery in SEL and SWL
0.2	15 May 2026	Initial draft in ToRs template by SEL governance team for engagement
0.3	3 June 2026	Updated to incorporate amendments proposed by SWL Director of Corporate and SEL NEM member for governance
0.4	12 June 2026	Updated to incorporate suggestions from ICB NEMs
0.5	28 June 2026	CEO review and comments.
1.0	22 July 2026	Published version following Board approval
1.1	30 October 2026	Amendments following Committee review at first meeting

Approved by

Version	Date	Committee / Group name
1.0	22 July 2026	Board approved

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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 SEL 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:

4.2 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.

4.3 Provide oversight of the development of key neighbourhood strategies and resources including the model of care.

4.4 Approve plans with integrator partnerships for the development of integrated neighbourhood health and care.

4.5 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.

4.6 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.

4.7 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.

4.8 Assures the work of ICB executives as part of other groups across London and within South East London to facilitate the development to the tools and infrastructure required to enable integrated neighbourhood health and care.

4.9 Through the committee's executive membership links to system partnership groups in SEL on system sustainability, workforce, digital and estates, and also the London Neighbourhood Board.

5. Membership and attendance

Membership

5.1 The Neighbourhood Strategic Delivery Committee membership is as follows:

- Non-Executive Director – Co-Chair
- Local Authority representative (executive member representing the local authority sector) – Co-Chair
- ICB Partner Member (Primary Care)
- Chief Commissioning Officer
- Seven Place representatives (comprisincluding three representatives from ICB place leadership and four provider integrators).
- Director of Delivery for Neighbourhoods and Population Health
- Director of Strategic Commissioning
- Director of Public Health (representing the local authority sector)
- Representative of mental health sector
- VCSE Alliance Representative
- 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 f 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 Director – Co-Chair or local authority representative – Co-Chair (proposed)
- Four Place representatives (including at least one PEL)
- ~~Place representatives (including representatives from ICB place leadership and provider integrators)~~
- SEL Director of Delivery for Neighbourhoods and Population Health.

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.

Date of approval: 22 July 2026

Date of next review: June 2027

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

Document Management

Revision history

Version	Date	Summary of changes
0.1	April 2026	Initial core parts of ToRs developed by Directors of Commissioning in SEL ICB
0.2	15 May 2026	Initial draft in ToRs template by SEL governance team for engagement
0.3	28 May 2026	To reflect SWL F&P Committee inputs on future committee functions
0.4	3 June 2026	Updated to incorporate amendments proposed by SWL Director of Corporate and SEL NEM member for governance
0.5	10 June 2026	Updated to incorporate amendments proposed by SWL and SEL NEMs
0.6	28 June 2026	CEO review and comments
0.7	7 July 2026	Added 2 x PELs as committee members
1.1	30 October 2026	Amendments following initial meeting of Committee

Approved by

Version	Date	Committee / Group name
1.0	22 July 2026	ICB Board

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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.

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 Non Executive Lead – Chair
- 5.1.2 Non Executive Director – Deputy Chair
- 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 Executive Leads x 2 (representing all place PELs)
- 5.1.8 Chief Nurse
- 5.1.9 Medical Director.

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

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 Deputy~~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 Deputy~~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 Deputy~~Vice~~ Chair, if present, shall preside. If the Chair or Deputy~~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 Executive Leads~~
- ~~Director of Public Health.~~

5.9 The Committee Chair will invite additional individuals to attend a meeting to provide subject matter expertise and advice as required by the agenda.

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~~5.11 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~~5.12 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~~5.13 The Strategic Commissioning Committee Chair may ask any or all of those in attendance ~~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 six weeks~~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 Executive Lead

6.4.5 Medical Director or Chief Nurse

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.

Date of approval: 22 July 2026

Date of next review: June 2027

NHS South West London
Integrated Care Board

Committee Update – Strategic Commissioning Committee

Agenda item: 3.1

Executive Lead: Ed Waller, Chief Commissioning Officer

Report by: Dr Anne Rainsberry CBE, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Strategic Commissioning Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the items of discussion
- **Note** the outcomes of the Committee discussions
- **Note** the amendments to the Committee Terms of Reference, which are included for Board approval in the Governance Update under a separate part of the agenda.

2. Background and context

Since the last meeting of the Board on 15 July 2026, the Strategic Commissioning Committee (SCC) has met once. This was the first meeting of the Committee.

Membership comprises two non-executive members as Committee chair and deputy chair, together with the Chief Executive, Chief Commissioning Officer, Chief Finance and Compliance Officer, ICB Medical Director, ICB Chief Nursing and Quality Officer, two Place Executive Leads and the Director of Strategic Commissioning.

The Chairs of the respective SCCs in South East London and South West London ICB's are working closely together to ensure agendas between the two committees are aligned, whilst remaining flexible to respond to any emerging issues affecting one or other ICB uniquely.

3. Activity undertaken

The October 2026 meeting covered the following items:

<u>Governance and ways of working</u>

Chair: Richard Douglas CB CEO: Andrew Bland

The Committee reviewed the Terms of Reference approved at the last Board with some amendments proposed to clarify membership roles, and an acknowledgement of the Committees' purpose.

Ways of working for the Committee were discussed, with a recognition of the breadth of the Committee's remit and a proposal that, as the Committee was in its early days of formation, a short reflection will be included at the end of forthcoming meetings to consider quality and volume of information received, and whether the committee was focusing on the right issues.

Commissioning activity
Draft Commissioning Intentions were discussed, including planning timeframes and the Medium Term Financial Strategy (MTFS). The members supported the principle that a smaller number of priorities should be protected, with prioritisation that was evidence based, deliverable and accompanied by clear measures of intended outcomes and benefits. Consideration of patient experience alongside quality, performance financial outcomes was emphasised, with the MTFS welcomed as the framework for aligning financial resources with strategic commissioning priorities. Alignment between SWL and SEL where possible was welcomed.

Performance Oversight
October performance across the system was discussed by the Committee, noting the ambition to develop more integrated reporting across performance, finance and quality objectives in the near future. The Committee discussed what information they felt was needed to deliver on their objectives and how this could be achieved, noting a move towards a self-service environment was planned.

The Board Assurance Framework and corporate risks were discussed with the Committee recognising the responsibility of the Committee to obtain assurance against the strategic risks relating to commissioning. Members emphasised the need to maintain clear risk ownership and management during organisational transition.

Financial performance at month 5 was also presented and discussed, noting the ICB remained on target to break even, with work underway to address immediate cost pressures.

4. Decisions and Outcomes

The following outcomes were agreed by the Committee within their own scope of responsibility:

- Committee responsibilities as laid out in the Terms of Reference were **noted.**
- A change was requested to the Terms of Reference to enable greater flexibility around the attendance of non-members of the Committee.

Decisions made by the Committee were within the scope of its delegated authority stated in the Scheme of Reservation and Delegation.

NHS South West London
Integrated Care Board

Month 6 Finance Report 2026/27

Agenda item: 3.1.1

Executive Lead: Dinah McLannahan, Chief Finance and Compliance Officer

Report by: Dinah McLannahan, Chief Finance and Compliance Officer

Paper type: Assurance / standing finance report

Conflicts of Interest: None – no contract award or commissioning decision is sought.

1. Purpose and recommendation

To update the Board on South West London Integrated Care Board's (ICB) financial position at 30 September 2026, efficiency delivery and forecast for 2026/27. This paper is for assurance; no new spending approval is sought.

The Board is asked to:

- Note and discuss.

2. Background and context

The ICB reports a £0.7m underspend at 30 September 2026, £1.9m better than plan, and forecasts breakeven. The £33.3m efficiency programme is broadly on track. However, service pressures remain and balance depends on savings and other offsets, including corporate vacancy savings and restructuring costs returning to plan. Non-recurrent efficiencies total £6.9m. The provisional underlying deficit is £2.1m, in line with plan, subject to review of recurring investments. In-year delivery is on track, but long-term sustainable balance requires further work.

3. Implications, impacts and risks

- **Service pressures:** Mental health forecasts a £4.1m overspend, mainly from Right to Choose assessments. Continuing healthcare is £2.5m overspent but forecasts a £0.1m underspend; acute services are £1.3m overspent but forecast breakeven. These forecasts depend on improvement during the second half of the year.
- **Recurring savings:** The £6.9m of one-off efficiencies includes £2.5m covering planned savings while borough teams identify recurring replacements.
- **Forecast and control risks:** Continuing healthcare data cover five months, prescribing data cover July, and Mental Health Investment Standard reporting is at Month 5. Agency spending is 6% of pay against a 5% target; debt overdue by more than 30 days is £4.1m.

4. Next steps and oversight

Take assurance from delivery to date, recognising the risks and assumptions supporting forecast breakeven.

Seek further assurance through future reports on service pressures, forecast recovery, recurring savings and the underlying position.

Appendices and supporting information

Appendix 1: SWL ICB M06 Finance Report Board.pptx

NHS
South West London

SWL ICB Month 06 Finance Report

Contents

- ICB Financial Overview – Month 06
- Variance breakdown by places and areas of spend
- Overview of efficiency plan
- Key Performance Indicators (KPI)
- Allocations
- Underlying Position
- Appendix
    1. Delegated GP primary care overview
    2. Dental, Ophthalmic and Pharmacy (DOPS) overview
    3. Medicines management and prescribing overview
    4. CHC finance – run rate analysis
    5. Mental Health Investment Standard (MHIS) overview
    6. Place breakdown in detail

NHS South West London

ICB financial overview month 06

NHS South West London

Target	Measure	Month 06 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 3.26%	Achieved
Running Costs	ICB running costs not to exceed £26.6m	Forecast spend £25.2m	Achieved
Better payments practice code	Paying 95% of invoices within 30 days	95% invoice paid within 30 days	Achieved
Cash Balance	Cash in bank at month end within the 1.25% draw down limit	Cash 0.32% of drawdown limit	Achieved

Key Messages:

- At 30 September 2026, the ICB reports a £0.7m underspend, £1.9m better than the planned £1.2m deficit. The full-year forecast remains breakeven.
- The efficiency plan remains on course to deliver the £33.3m target, with savings broadly in line with the year-to-date plan.
- Acute services report a £1.3m year-to-date overspend, reflecting pressures on activity outside contracts and independent sector budgets. The full-year forecast remains breakeven.
- All Age Continuing Healthcare reports a £2.5m year-to-date overspend and a £0.1m forecast underspend. The position uses patient data for the first five months of the year.
- Mental health services report a £4.3m year-to-date overspend and a £4.1m forecast overspend, mainly reflecting increased demand for Right to Choose assessments above planned levels.
- Primary care reports a £0.7m year-to-date underspend following confirmation of lower prescribing expenditure for 2025/26 than estimated. The £2.7m forecast overspend reflects medicine availability and Category M medicine prices.
- The forecast assumes that corporate vacancy savings and restructuring costs return to plan by year end.

ICB high level budget reporting month 06

NHS South West London

Allocation and Expenditure	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Annual Budget £000s	Forecast Outturn £000s	Forecast Variance £000s	Previous Month Forecast Variance £000s	Movement from last month £000s
Total Allocation (Income)	**£2,184,082**			**£4,420,773**				
Expenditure:								
Acute Services (NHS & non-NHS)	£1,022,917	£1,024,258	-£1,340	£2,050,670	£2,050,670	£0	£0	£0
Specialist Commissioning	£265,742	£265,742	£0	£539,952	£539,952	£0	£0	£0
Community Health Services	£150,525	£149,656	£868	£317,625	£316,863	£763	£776	-£14
All Age Continuing Healthcare	£93,247	£95,774	-£2,527	£186,494	£186,355	£140	£375	-£235
Corporate & Other	£38,058	£30,744	£7,314	£91,388	£85,487	£5,901	£1,237	£4,665
Mental Health	£212,921	£217,251	-£4,329	£424,695	£428,775	-£4,081	-£2,643	-£1,438
Primary Care (Incl Prescribing & Delegated)	£401,847	£401,182	£665	£809,949	£812,667	-£2,718	£255	-£2,973
Total Expenditure:	**£2,185,258**	**£2,184,607**	**£651**	**£4,420,773**	**£4,420,769**	**£4**	**£0**	**£4**
Surplus/(Deficit)	**-£1,176**			**£0**				

ICB month 06 variances by places and areas of spend

NHS South West London

Table 1: Place Position variances (£'000) (month 06)

Borough places	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Annual Budget £000s	Forecast Outturn £000s	Forecast Variance £000s	Previous Month Forecast Variance £000s	Movement from last month £000s
CROYDON PLACE	£131,755	£129,516	£2,239	£263,954	£261,229	£2,726	£770	£1,955
KINGSTON PLACE	£41,406	£40,418	£988	£82,990	£82,553	£437	£439	-£2
MERTON PLACE	£52,744	£52,068	£676	£105,669	£105,176	£492	£846	-£354
RICHMOND PLACE	£68,814	£68,356	£458	£137,695	£136,834	£861	£574	£286
SUTTON PLACE	£52,521	£52,342	£179	£105,210	£104,382	£828	£730	£99
WANDSWORTH PLACE	£86,236	£85,838	£399	£172,750	£174,273	-£1,523	-£656	-£867
SWL PLACE	£1,751,782	£1,756,069	-£4,287	£3,552,505	£3,556,322	-£3,817	-£2,704	-£1,113
Grand Total	**£2,185,258**	**£2,184,607**	**£651**	**£4,420,773**	**£4,420,769**	**£4**	**£0**	**£4**

Narrative: (favourable/-adverse variance)

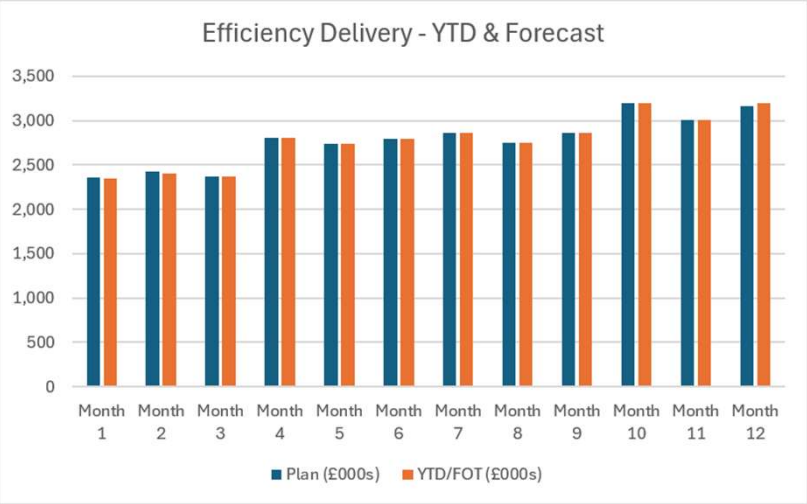
1. Table 1 gives the position by place, and table 2 the YTD variances by area of spend.
2. SWL is showing an overspend of £4.3m in Corporate, Acute and Primary Care.
3. Continuing healthcare and mental health pressures affect borough budgets. Overall year-to-date positions vary by borough, as shown in Table 1.
4. Further analysis for each place can be found in Appendix 6.

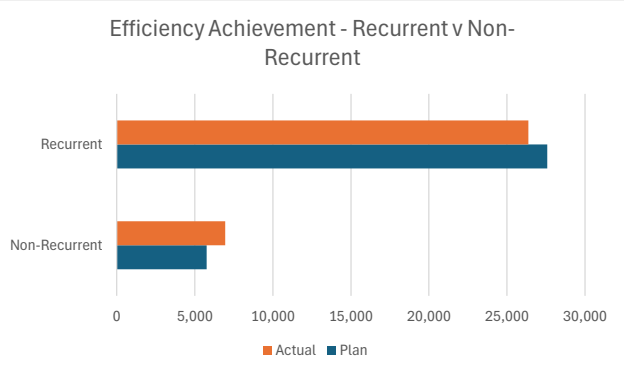
Table 2: Variances (£'000) by service area and place – year to date (month 06)

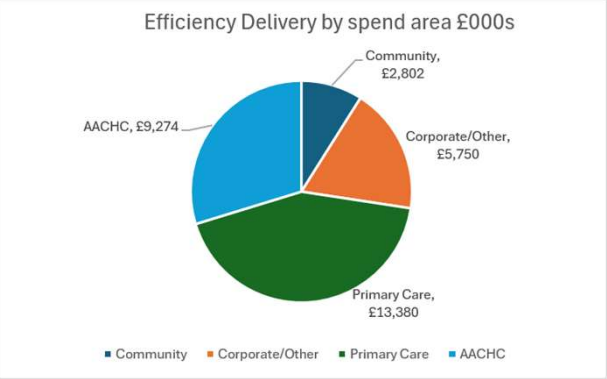
Borough places	ACUTE	SPECIALISED COMMISSIONING	COMMUNITY HEALTH SERVICES	ALL AGE CONTINUING CARE	CORPORATE & OTHER	MENTAL HEALTH	PRIMARY CARE	Grand Total
CROYDON PLACE	£0	£0	£104	£758	£3,073	-£2,372	£675	**£2,239**
KINGSTON PLACE	£0	£0	£73	-£831	£1,841	-£393	£297	**£988**
MERTON PLACE	£0	£0	£276	-£380	£757	-£153	£177	**£676**
RICHMOND PLACE	£0	£0	-£77	-£672	£1,321	-£295	£182	**£458**
SUTTON PLACE	£0	£0	£105	-£1,008	£1,085	-£231	£229	**£179**
WANDSWORTH PLACE	£0	£0	£258	-£393	£773	-£613	£373	**£399**
SWL PLACE	-£1,340	£0	£129	£0	-£1,536	-£272	-£1,268	**-£4,287**
Grand Total	**-£1,340**	**£0**	**£868**	**-£2,527**	**£7,314**	**-£4,329**	**£665**	**£651**

Overview of SWL ICB's efficiency plan

NHS South West London







Commentary

- The efficiency plan remains on course to deliver £33.3m, with savings broadly in line with the year-to-date plan.
- One-off savings account for £6.9m, mainly from business rates rebates and vacancies.
- One-off measures currently cover £2.5m of planned efficiencies while borough teams identify recurring savings. This creates a continuing requirement to secure sustainable savings.
- Priorities for November:
  - Borough and service teams will continue monthly reviews and complete the supporting plans for identified schemes.
  - Monitoring will continue throughout the year to track delivery and identify risks.

Key Performance Indicators (KPI)

NHS South West London

Financial Management	Target	Actual	Last Month	Change	Trend
Budget statements issued (working day)	15	15	15	→	
Finance Position agreed (working day)	6	6	6	→	
Budget holders seen (%)	95%	95%	95%	→	
ESR Reconciliation to Ledger WTE & £ (100%)	100%	100%	100%	→	
Agency Expenditure (% of pay)	5%	6%	6%	↑	

Financial Control	Target	Actual	Last Month	Change	Trend
Non PO Values (£m)		34.3	38.7	↑	
Non PO Numbers		3,515	3,744	↑	
AR - Debt over 30 days (£m)	0	4.1	2.7	↓	
BPPC Value	95%	99%	99%	→	
BPPC Number	95%	95%	95%	↑	
Cash Target	1.25%	0.32%	0.40%	↑	

Procurement					
PO Compliance	90%	100.0%	100.0%	→	

Payroll					
Payroll overpayments (number)	0	0	0	→	
Payroll overpayment (£k)	0	0	0	→	
Manual payments (number)	0	0	0	→	

- Agency expenditure remained at 6% of pay expenditure, above the 5% target.
- The ICB meets the Better Payment Practice Code targets for both invoice numbers and value.
- Invoices without a purchase order decreased to 3,515, compared with around 3,500 before the finance system change.
- Debt overdue by more than 30 days increased to £4.1m in September. Outstanding sales invoices raised during September total £2.2m.
- No new payroll overpayments occurred in Month 6. Outstanding historic payroll overpayments total £29k.
- **The ICB is reviewing staff leaver processes to reduce the risk of further overpayments during organisational change.**

Funding allocation as at Month 06

South West London

Month	Amount £'000	Description
Opening Allocation	£4,432,787	Allocations as per M05
New allocations:		
M06	-£14,050	2627 Efficiency Adjustment
M06	£1,096	Obesity Pathway Improvement Programme (OPIP)
M06	£474	Hybrid Closed Loop 26/27 Q1 payment
M06	£466	Other
YTD M06 total	**£4,420,773**	

The above table shows the overall allocation received up to Month 06. The most significant changes are -£14.0m for 2627 Efficiency Adjustment and £1.1m for Obesity Pathway Improvement Programme.

Underlying Position

NHS South West London

ICB Underlying Position - Month 6	
	£m
2025/26 Underlying Position Surplus/(Deficit)	**(4.0)**
Net cost pressures including inflation	(28.8)
Funding changes & NR income	(0.2)
Efficiency	33.0
26/27 Forecast Surplus/(Deficit)	**0.0**
Forecast non-recurring efficiencies	(7.0)
Full Year Effect of recurring efficiencies	2.4
Other non-recurent movements	2.5
2026/27 Underlying Position Surplus/(Deficit)	**(2.1)**

- The summary estimates the underlying financial position at the end of 2026/27, based on Month 6 reporting.
- One-off efficiencies total £6.9m, mainly from business rates rebates and vacancies.
- The full-year effect of recurring efficiencies improves the underlying position by £2.4m.
- Other one-off movements in 2026/27 improve the underlying position by £2.5m.
- The estimated underlying deficit is £2.1m, in line with the 2026/27 plan.
- This estimate remains provisional while the ICB reviews the ongoing financial impact of recurring investments.

NHS
South West London

APPENDIX

1. Delegated primary care overview

NHS South West London

Financial Summary by Service Line - Four Months to 30th September 2026						
Service Line Description	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Annual Budget £000s	Forecast Full Year spend £000s	Forecast Full Year Variance £000s
Core Payments to Practices (Including Premium)	113,130	113,130	(0)	224,463	224,463	0
Enhanced Services	794	794	(0)	1,588	1,588	0
Quality and Outcomes Framework (QOF)	7,856	7,856	(0)	15,713	15,713	0
Premises Payment	14,150	14,150	(0)	30,226	30,226	0
Other Administered Funds (Maternity etc)	2,348	2,348	(0)	4,695	4,695	0
Personally Administered Drugs	328	328	0	655	655	0
Other Medical Services	199	199	0	369	369	0
Primary Care Networks	34,281	34,281	(0)	68,563	68,563	0
GP Reimbursements	2,524	2,524	0	7,572	7,572	0
Other	0	0	0	0	0	0
Grand Total:	**175,611**	**175,611**	**(0)**	**353,843**	**353,843**	**0**

- Delegated primary care reports a breakeven position at Month 6.
- The base budget includes additional funding for the 2026/27 GP contract settlement, confirmed at Month 3. Funding also reflects expected changes in registered patient numbers following NHS England's review of patient lists. Early modelling indicates that expenditure will remain within budget, subject to continued monitoring.

2. Dental, Ophthalmic and Pharmacy (DOPS) overview

NHS South West London

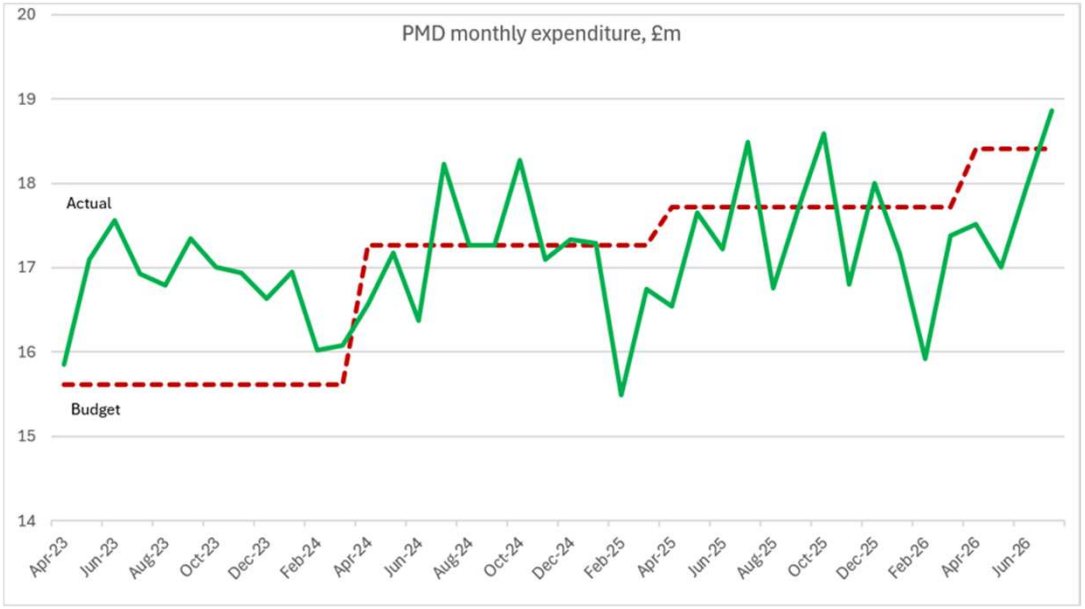
SWL ICB DOPs DELEGATION SUMMARY

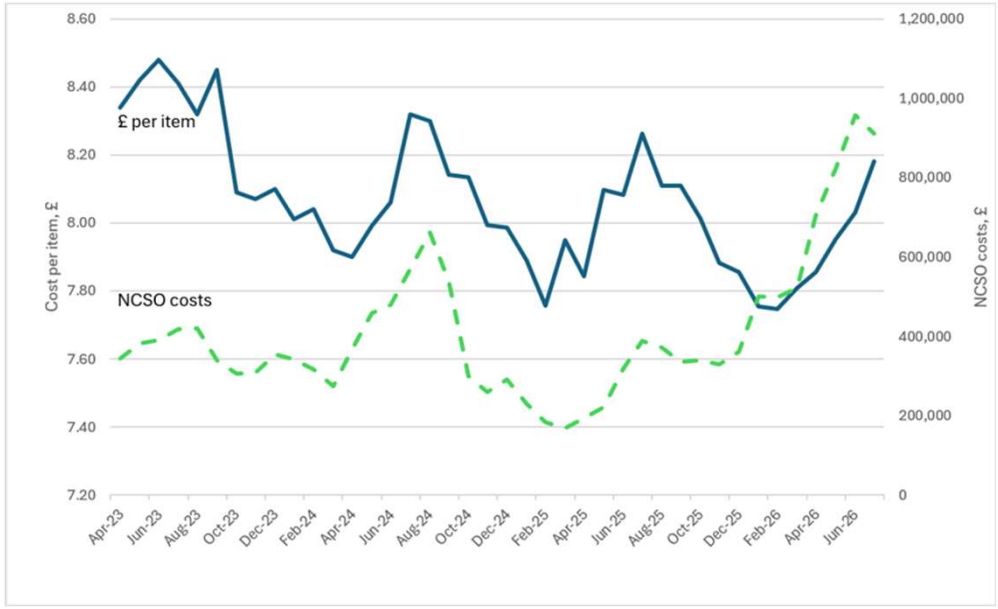
Financial Summary - 6 Months to 30th September 2026

DOPs Delegated Service	SUM of YTD Budget £000s	SUM of YTD Actual £000s	SUM of YTD Variance £000s	SUM of Annual Budget £000s	SUM of Forecast Outturn £000s	SUM of Forecast Variance £000s
ACUTE DENTAL and NCAs	16,236	16,236	0	35,012	35,012	0
COMMUNITY DENTAL	3,261	3,284	(22)	6,523	6,567	(45)
PRIMARY CARE **Dental**	38,204	38,234	(30)	76,408	76,454	(46)
DENTAL SERVICES (Ring Fenced)	**57,702**	**57,754**	**(52)**	**117,943**	**118,033**	**(90)**
PRIMARY CARE **Ophthalmic**	6,626	6,896	(269)	13,250	14,104	(853)
PRIMARY CARE **Pharmacy**	22,015	21,753	261	44,030	44,047	(18)
Delegated **Property**	0	0	0	0	0	0
TOTAL:	**86,343**	**86,403**	**(60)**	**175,223**	**176,184**	**(961)**

- Primary Care Dental has higher than expected Occupational Health costs: contract expenditure was below budget in April to September but is expected to catch up later in the year.
- Ophthalmic has a one-off prior year benefit but this year's costs have been significantly above budget.
- Pharmacy also has a one-off benefit from last year that is expected to be more than offset by increased expenditure this year.

3. Medicines management and prescribing overview

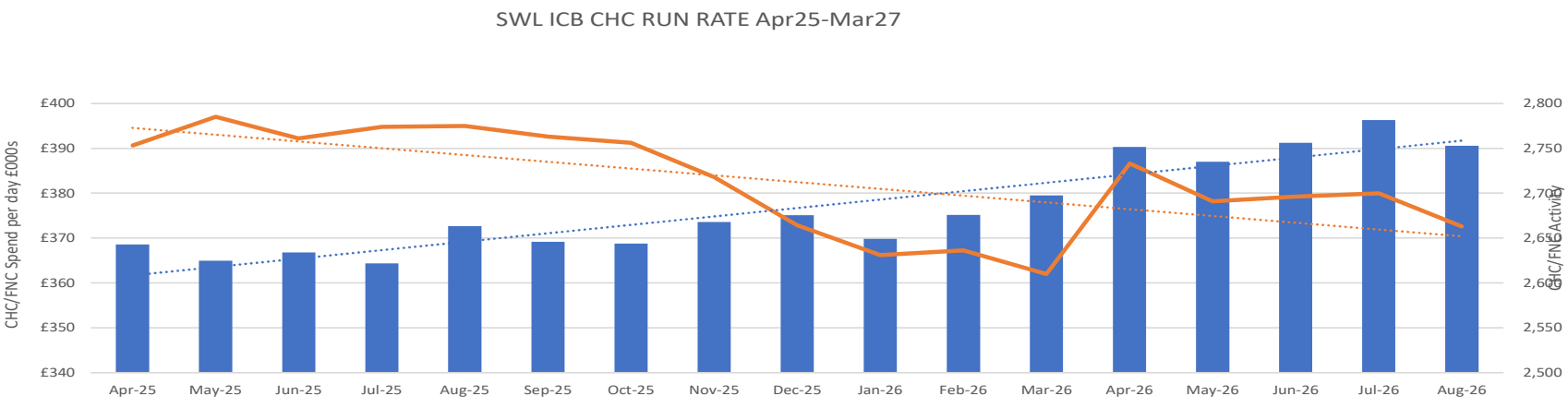




- Prescribing data are available two months in arrears. The latest figures in this report cover July 2026.
- The ICB received £8.7m of additional prescribing funding for the Community Pharmacy Contractual Framework margin increase, growth in GLP-1 medicines and the Obesity Pathway Improvement Programme.
- In July 2026, 2.30m prescription items were issued against an expected 2.12m. The average cost per item was £8.18, continuing the recent increase.
- Medicine shortages, price concessions and supply pressures continue to increase costs. Provisional estimates indicate that these pressures will remain high at least until December.

4. CHC finance – run rate analysis

South West London



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
CHC/FNC Cost per day £000k	£369	£365	£367	£364	£373	£369	£369	£374	£375	£370	£375	£380	£390	£387	£391	£396	£391
CHC/FNC Activity	2,753	2,785	2,761	2,774	2,775	2,763	2,756	2,718	2,664	2,631	2,636	2,610	2,733	2,691	2,696	2,700	2,663

Commentary

- The chart shows recurring continuing healthcare expenditure and patient numbers from April 2025 to August 2026 for the areas included in this analysis.
- Daily expenditure allows comparison between months of different lengths, as most care packages use weekly rates.
- The analysis excludes Croydon because comparable data were unavailable. The trends therefore describe the included areas only.
- The trend lines show increasing daily costs and declining patient numbers. These figures alone do not establish the reasons for the cost increase.

5. Mental Health Investment Standard (MHIS) overview

NHS South West London

Reporting context

- At Month 5, the Mental Health Investment Standard (MHIS) position was in line with plan. This is a prior-month position.
- At Month 5, the wider mental health budget forecast a £2.6m overspend (0.4%), reflecting activity above plan. The Month 6 financial overview reports a £4.1m forecast overspend.
- Commissioning and service teams are progressing measures to manage expenditure. Their effect on activity and the year-end position remains under review.

Mental Health Spend By Category	MHIS Ref	Total Mental Health (MHIS) BLOCK Actual(£000s)
Children & Young People's Mental Health (excluding LD)	1	31,593
Children & Young People's Eating Disorders	2	2,273
Perinatal Mental Health (Community)	3	4,284
NHS Talking Therapies, for anxiety and depression	4	32,849
A and E and Ward Liaison mental health services (adult and older adult)	5	13,346
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	8,064
Adult community-based mental health crisis care (adult and older adult)	7	25,994
Ambulance response services	8	551
Community A – community services that are not bed-based / not placements	9a	86,324
Community B – supported housing services that fit in the community model, that are not delivered in hosp	9b	68,216
Mental Health Act	10	2,243
SMI Physical health checks	11	0
Suicide Prevention	12	244
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	76,287
Adult and older adult acute mental health out of area placements	14	1,085
Mental health prescribing	16	8,918
Mental health in continuing care (CHC)	17	1,264
Mental Health Placements in Hospitals	20	2,675
Mental Health Support Teams in Schools	21	8,706
Sub-total - MHIS (inc CHC, Prescribing)		**374,918**
Learning Disability	18a	15,456
Autism	18b	9,893
Learning Disability & Autism - not separately identified	18c	32,269
Sub-total - LD&A (not included in MHIS)		**57,619**
Dementia	19	8,440
Sub-total - Dementia (not included in MHIS)		**1,304**
TOTAL - Mental Health, LD&A and Dementia Spend		**56,635**
Target MHIS Spend		**374,917**
Forecast MHIS Spend		**374,918**
Excess/Shortfall in 2025/26 MHIS Delivery %		**0.00%**
Excess/Shortfall in 2025/26 MHIS Delivery		**1**

6a. SWL place breakdown

NHS South West London

Area of spend	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Annual Budget £000s	Forecast Outturn £000s	Forecast Variance £000s	Previous Month Forecast Variance £000s	Movement from last month £000s
Acute Services (NHS & non NHS)	£1,022,917	£1,024,258	-£1,340	£2,050,670	£2,050,670	£0	£0	£0
Specialist Commissioning	£265,742	£265,742	£0	£539,952	£539,952	£0	£0	£0
Community Health Services	£7,342	£7,213	£129	£31,260	£31,001	£259	£259	-£0
All Age Continuing Healthcare	£0	£0	£0	£0	£0	£0	£0	£0
Corporate & Other	£32,976	£34,512	-£1,536	£81,005	£81,246	-£242	-£1,286	£1,045
Mental Health	£143,373	£143,645	-£272	£285,597	£285,920	-£322	£17	-£339
Primary Care (Incl Prescribing & Delegated)	£279,431	£280,700	-£1,268	£564,022	£567,534	-£3,512	-£1,693	-£1,819
SWL PLACE Total	**£1,751,782**	**£1,756,069**	**-£4,287**	**£3,552,505**	**£3,556,322**	**-£3,817**	**-£2,704**	**-£1,113**

Narrative -

- As at month 06, SWL place has reported an overspend of £4.3m with a forecast overspend of £3.8m for the full year.
- The corporate forecast assumes that vacancy savings and restructuring costs return to plan by year end.
- Acute services report a £1.3m year-to-date overspend, reflecting pressures on activity outside contracts and independent sector budgets. The full-year forecast remains breakeven.
- Primary Care is showing a forecast adverse variance of £3.5m, predominantly due to projected pressures against the 111 budget and the tariff impact being higher than anticipated.

6b. Croydon place breakdown

NHS South West London

Area of spend	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Annual Budget £000s	Forecast Outturn £000s	Forecast Variance £000s	Previous Month Forecast Variance £000s	Movement from last month £000s
Acute Services (NHS & non NHS)	£0	£0	£0	£0	£0	£0	£0	£0
Community Health Services	£33,727	£33,622	£104	£67,453	£67,281	£172	£165	£7
All Age Continuing Healthcare	£17,577	£16,819	£758	£35,154	£33,936	£1,218	£783	£435
Corporate & Other	£1,300	-£1,773	£3,073	£2,660	£213	£2,447	£333	£2,114
Mental Health	£49,195	£51,567	-£2,372	£98,390	£100,008	-£1,618	-£1,187	-£431
Primary Care (Incl Prescribing & Delegated)	£29,956	£29,281	£675	£60,297	£59,791	£506	£676	-£170
CROYDON PLACE Total	**£131,755**	**£129,516**	**£2,239**	**£263,954**	**£261,229**	**£2,726**	**£770**	**£1,955**

Narrative -

- As at month 06, Croydon place has reported a YTD underspend of £2.2m and a forecast underspend of £2.7m.
- All Aged Continuing Healthcare (AACHC) position is based on patient levels for the first five months of the year, and we are reporting a YTD underspend of £0.8m with a forecast underspend of £1.2m.
- Mental Health is showing a £2.4m unfavourable variance YTD with a forecast overspend of £1.6m.
- Primary Care is £0.7m under plan YTD due to a favourable variance on prescribing after receiving the final 2025/26 expenditure compared to what was estimated at year end.

6c. Merton and Wandsworth place breakdown

NHS South West London

Area of spend	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Annual Budget £000s	Forecast Outturn £000s	Forecast Variance £000s	Previous Month Forecast Variance £000s	Movement from last month £000s
Acute Services (NHS & non NHS)	£0	£0	£0	£0	£0	£0	£0	£0
Community Health Services	£19,311	£19,035	£276	£38,622	£38,253	£370	£302	£67
All Age Continuing Healthcare	£11,420	£11,800	-£380	£22,841	£23,197	-£357	-£67	-£289
Corporate & Other	£0	-£757	£757	£0	-£481	£481	£80	£401
Mental Health	£3,970	£4,123	-£153	£7,940	£7,673	£267	£362	-£95
Primary Care (Incl Prescribing & Delegated)	£18,042	£17,865	£177	£36,265	£36,534	-£268	£170	-£438
MERTON PLACE Total	**£52,744**	**£52,068**	**£676**	**£105,669**	**£105,176**	**£492**	**£846**	**-£354**
Acute Services (NHS & non NHS)	£0	£0	£0	£0	£0	£0	£0	£0
Community Health Services	£30,133	£29,875	£258	£60,266	£60,058	£208	£358	-£150
All Age Continuing Healthcare	£17,798	£18,191	-£393	£35,595	£35,480	£115	£96	£19
Corporate & Other	£1,354	£581	£773	£2,764	£2,362	£403	£233	£170
Mental Health	£8,468	£9,081	-£613	£16,936	£18,785	-£1,849	-£1,823	-£27
Primary Care (Incl Prescribing & Delegated)	£28,484	£28,111	£373	£57,188	£57,587	-£399	£480	-£879
WANDSWORTH PLACE Total	**£86,236**	**£85,838**	**£399**	**£172,750**	**£174,273**	**-£1,523**	**-£656**	**-£867**

Merton Place narrative:

- As at month 06, Merton place has reported £0.7m YTD underspend with a forecast underspend of £0.5m.
- All Aged Continuing Healthcare (AACHC) position is based on patient levels for the first five months of the year, and we are reporting a YTD overspend of £0.4m with a forecast overspend of £0.4m.
- Mental Health is reporting a YTD overspend of £0.2m with a forecast underspend of £0.3m.

Wandsworth Place narrative:

- Wandsworth reports a £0.4m year-to-date underspend and a £1.5m forecast overspend.
- Mental health reports a £0.6m year-to-date overspend and a £1.8m forecast overspend, mainly reflecting adult care placements and Right to Choose assessments outside existing contracts.
- All Aged Continuing Healthcare (AACHC) position is based on patient levels for the first five months of the year, and we are reporting a £0.4m overspend YTD with a forecast £0.1m underspend.

6d. Kingston and Richmond place breakdown

NHS South West London

Area of spend	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Annual Budget £000s	Forecast Outturn £000s	Forecast Variance £000s	Previous Month Forecast Variance £000s	Movement from last month £000s
Acute Services (NHS & non NHS)	£0	£0	£0	£0	£0	£0	£0	£0
Community Health Services	£5,418	£5,345	£73	£10,836	£10,791	£45	£45	£0
All Age Continuing Healthcare	£16,960	£17,791	-£831	£33,920	£34,765	-£845	-£641	-£204
Corporate & Other	£1,523	-£318	£1,841	£3,110	£1,658	£1,452	£1,071	£381
Mental Health	£2,594	£2,987	-£393	£5,188	£5,751	-£563	-£333	-£231
Primary Care (Incl Prescribing & Delegated)	£14,911	£14,614	£297	£29,936	£29,588	£349	£297	£51
KINGSTON PLACE Total	**£41,406**	**£40,418**	**£988**	**£82,990**	**£82,553**	**£437**	**£439**	**-£2**
Acute Services (NHS & non NHS)	£0	£0	£0	£0	£0	£0	£0	£0
Community Health Services	£36,466	£36,543	-£77	£72,933	£73,263	-£330	-£345	£15
All Age Continuing Healthcare	£15,834	£16,506	-£672	£31,667	£31,336	£331	£152	£179
Corporate & Other	£0	-£1,321	£1,321	£0	-£763	£763	£657	£106
Mental Health	£2,206	£2,502	-£295	£4,412	£4,623	-£210	-£13	-£198
Primary Care (Incl Prescribing & Delegated)	£14,307	£14,126	£182	£28,682	£28,375	£307	£123	£184
RICHMOND PLACE Total	**£68,814**	**£68,356**	**£458**	**£137,695**	**£136,834**	**£861**	**£574**	**£286**

Kingston Place narrative:

- As at month 06, Kingston place has reported £1.0m underspend YTD and a £0.4m forecast underspend.
- All Aged Continuing Healthcare (AACHC) position is based on patient levels for the first five months of the year; we are reporting a £0.8m overspend YTD.
- Mental Health is showing a £0.4m YTD overspend.
- Primary Care is £0.3m favourable YTD. This is due to a favourable variance on prescribing after receiving the final 2025/26 expenditure compared to what was estimated at year end.

Richmond Place narrative:

- Richmond place has reported £0.5m underspend YTD and a £0.9m forecast underspend.
- All Aged Continuing Healthcare (AACHC) position is based on patient levels for the first five months of the year; we are reporting a £0.7m overspend YTD.
- Primary Care is £0.2m favourable YTD. This is due to a favourable variance on prescribing after receiving the final 2025/26 expenditure compared to what was estimated at year end.

6e. Sutton place breakdown

NHS South West London

Area of spend	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Annual Budget £000s	Forecast Outturn £000s	Forecast Variance £000s	Previous Month Forecast Variance £000s	Movement from last month £000s
Acute Services (NHS & non NHS)	£0	£0	£0	£0	£0	£0	£0	£0
Community Health Services	£18,128	£18,023	£105	£36,256	£36,217	£39	-£7	£47
All Age Continuing Healthcare	£13,659	£14,667	-£1,008	£27,317	£27,640	-£323	£53	-£376
Corporate & Other	£906	-£179	£1,085	£1,850	£1,252	£598	£150	£448
Mental Health	£3,115	£3,346	-£231	£6,230	£6,015	£215	£334	-£118
Primary Care (Incl Prescribing & Delegated)	£16,714	£16,485	£229	£33,557	£33,259	£299	£201	£98
SUTTON PLACE Total	**£52,521**	**£52,342**	**£179**	**£105,210**	**£104,382**	**£828**	**£730**	**£99**

Narrative -

- At month 06, Sutton place has reported an underspend of £0.2m YTD with a £0.8m forecast underspend.
- All Aged Continuing Healthcare (AACHC) position is based on patient levels for the first five months of the year; we are reporting a YTD overspend of £1.0m and a forecast overspend of £0.3m.
- Mental health reports a £0.2m year-to-date overspend, reflecting adult care placements and Right to Choose assessments outside existing contracts.
- Primary Care is £0.2m favourable YTD. This is due to a favourable variance on prescribing after receiving the final 2025/26 expenditure compared to what was estimated at year end.

NHS South West London
Integrated Care Board

SWL ICB Performance Report

Agenda item: 3.1.2

Executive Lead: Ed Waller, Deputy Chief Executive/Chief Commissioning Officer

Report by: Jonathan Bates, Chief Operating Officer

Paper type: Information

Conflicts of Interest: No specific conflicts of interest are raised in respect of this paper.

1. Purpose and recommendation

To provide Board Members with the latest performance and financial reports and a verbal update on the development of an integrated performance report.

The Board is asked to:

- Note this paper

2. Background and context

The ICB Performance Report provides an overview of performance against constitutional standards at an ICB level and in some cases at the provider level. This report focuses on performance for July and August 2026, using nationally published and local data.

3. Analysis and evidence

Key areas where SWL has seen improvements in performance:

- **Cancer 28-day Faster Diagnosis Standard** (FDS) performance improved in July to 84.8%, with all SWL Trusts achieving compliance. SWL benchmark well against London peers for all cancer metrics.
- **Continued strong performance in planned care with RTT remaining above plan.** Nevertheless, there are challenges with individual providers and we continue to work through our contractual mechanisms to address these.
- **GP appointments within 2 weeks** saw third consecutive increase since April 2026. Whilst below the 92% standard, SWL achieved 91% in July.

Key issues of concern for the Board to be aware of:

- **A&E 4 hour wait** performance did increase in August to 74% yet remains below the 80% plan. Performance was impacted by greater demand than expected due to higher temperatures

affecting older patients and exacerbating respiratory presentations. The 4-hour national requirement is to deliver 82% by March 2027.

- **Urgent care remained under pressure in September;** an early review of data for September 2026 indicates an increase in A&E attendances and increase in 60-minute ambulance breaches, particularly in Croydon. In addition, there was continued pressure on performance for 111 calls abandoned and we are working with our 111 provider to understand actions to address this.
- **Key diagnostics carried out within 6 weeks** performance reduced in July for the fourth consecutive month as a total across SWL providers. Recovery plans are in place across many modalities with the Diagnostics Programme Board overseeing progress. SWL ICB continues to benchmark favourably against London peers.
- **The number of planned care 52 week waits** increased for the fourth month. The largest cohort remains in Gynaecology and Ears, Nose and Throat specialties. There are number of actions in place to support the increase of ENT capacity within the system, including consultant recruitment and transformation including the introduction of the single point of entry for referral, to reduce variation and increase utilisation across SWL.
- **Talking therapies access** and performance, whilst above other London ICB's, remains challenging.

The ICB is reviewing opportunities for waiting list initiatives and other non-recurrent initiatives to drive delivery for the remainder of 2026/27.

4. Options and trade-offs

There are no commissioning decisions to be taken as a result of this paper.

5. Implications, impacts and risks

Remedial actions to address performance are set out in the paper with the key areas noted above in Section 3.

6. Engagement and approvals

The Strategic Commissioning Committee discussed this paper at its October 2026 meeting.

7. Next steps and oversight

Continued oversight of performance metrics and, where required, remedial actions to address performance. Also, consideration of impact on our planning assumptions for 2027/28.

NHS South West London
Integrated Care Board

Appendices and supporting information

SWL performance dashboard

South West London Integrated Board Report

September 2026

NHS South West London

DATE REFRESHED : 14-09-2026

SRO: Jonathan Bates



Key Findings

NHS South West London
Integrated Care Board

Area	Key updates and issues to note
Primary care access	• **GP appointments seen within 2 weeks increased in July to 91%.** • **Childhood Immunisation rates for Q4, both 4-in-1 and 6-in-1 vaccinations, are above the London average**, however 6-in-1 has reduced closer to the London average in Q4.
Urgent & Emergency Care (UEC)	• Whilst there was a drop in A&E attendances in August, year to date remain above plan, largely due to the heatwaves experienced in the UK during the summer months. **A&E (all types) performance increased to 74.3%,** below the 80% plan for the month. Trust performance ranged from 68.1% at Epsom to 81.7% at St Georges. **SWL ICB's aggregate performance (74.3%) was the lowest in London, which ranged from 74% - 80%.** • **The volume of 111 decreased in August as did abandoned 111 calls, increasing to 5%.** 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; a high number of cases continue to be managed by the ICC, enabling patients to be treated outside of Emergency Departments. • **Emergency care pressures are on the admitted non-elective pathway, due to inpatient flow; 2,102** patients waited over 12 hours from 'decision to admit' to admission in August. SWL had the second highest volume of 12-hour breaches in London, and the fifth highest nationally.
Mental Health & Learning Disabilities	• **In Quarter 1, 58% of Severe Mental Illness patients received all six annual health checks.** Place-based systems continue to work towards meeting the 75% national standard, with all boroughs exceeding 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** decreased in July, and **Talking Therapies – Reliable Recovery Rate standard decreased to 49% in July, below the 2026/27 target of 51%.** • SWL ICB **Access to Specialist Perinatal Mental Health Services** improved in July to 1,595, however this is below trajectory set for 2026/27. • **Children and Young People's access rate** in June is below plan with 27,195 but continues to incrementally increase each month. • **Children and Young People's eating disorder routine access performance achieved 97% for Quarter 1, 2026/27**. For urgent cases, all patients (100%) were seen within the 1-week timeframe standard.

Key Findings

NHS South West London
Integrated Care Board

Area	Key updates and issues to note
Cancer	• Performance on the **28-Day faster diagnostic cancer standard** improved in-month and **remains above the 77% standard**. SWL ICB were the highest performing ICB in London. • **31-day performance increased further in July** and remained above the 96% standard and was the highest performing ICB in London. • **Performance against 62-day was 77.5%, above the operation plan trajectory but below** the standard of 85%. SWL benchmarked as top ICB in London. • The number of patients waiting over 62 days is below the planned trajectory of 352 with 295.
Outpatient & Diagnostics	• Diagnostic activity decreased in July, remaining below plan with the exception of Royal Marsden (RMH) and Croydon (CHS) who exceeded their planned levels in July. **Diagnostic performance decreased** in July to 86.1% however **SWL ICB continues to be the highest performing ICB in London**. • **Outpatient Firsts track just below plan in July with follow-ups above plan** and continuing to performing above the year-to-date trajectory. • SWL is reporting an aggregate outcome of 33% of % of total outpatients that are first and procedures, below the 49% standard.
Planned Care	• **Performance against the 18-week standard for SWL ICB remains relatively stable at 68.2% and is the highest in London.** • **Long waiters on RTT pathways continue to increase.** The volume of 52-week waits increased to 2,095 in July against a plan of 1,362 pathways, however this is still the lowest ICB level in London. Gynaecology (gynae) and Ear, Nose and Throat (ENT) had the greatest number of patients waiting over 52 weeks at 285 and 271, respectively. Croydon Hospital (CHS) had the highest cohort for ENT and St George's (SGH) for gyanaecology.
Integrated Care	• **Services contributing to A&E avoidance are performing well**. The latest **urgent community response (UCR) 2-hour performance** was 87%, against the national standard of 70%. SWL continues holds second-highest ranking UCR activity in London, and work continues to support providers with admission avoidance in SWL. • To reduce UEC waiting times, 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 92% for July**.

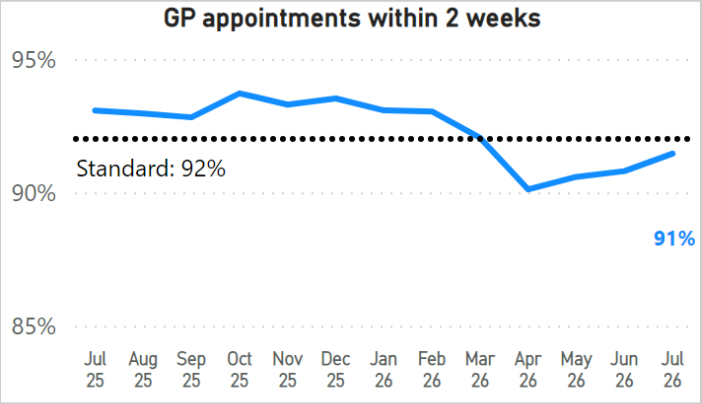
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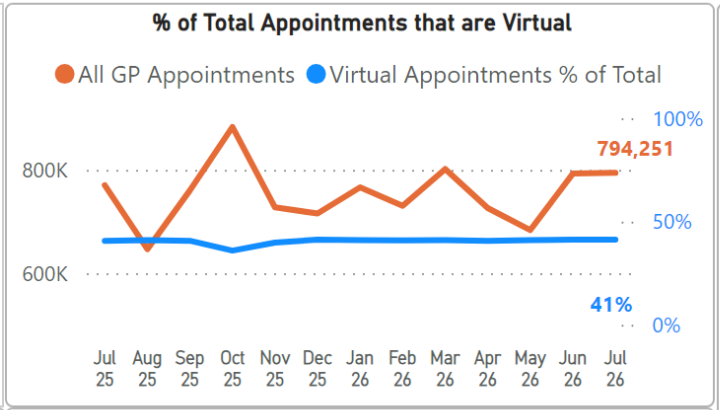
NHS South West London
Integrated Care Board

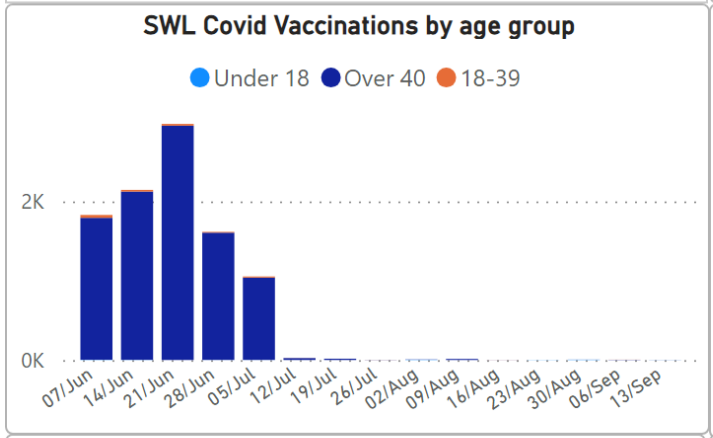
- The South West London (SWL) Integrated Board report presents the latest published and unpublished data assessing delivery against the NHS Constitutional standards and locally agreed on metrics. These metrics relate to acute, mental health, community and primary care services and other significant borough/Place 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 **indicators are being reviewed and refined as work progresses to develop reporting within the Integrated Care Board (ICB), in alignment with SEL.**
- Data Quality Issues:
    - Data on 45-minute handovers is from London Ambulance Service and has not been validated by South West London Trusts.

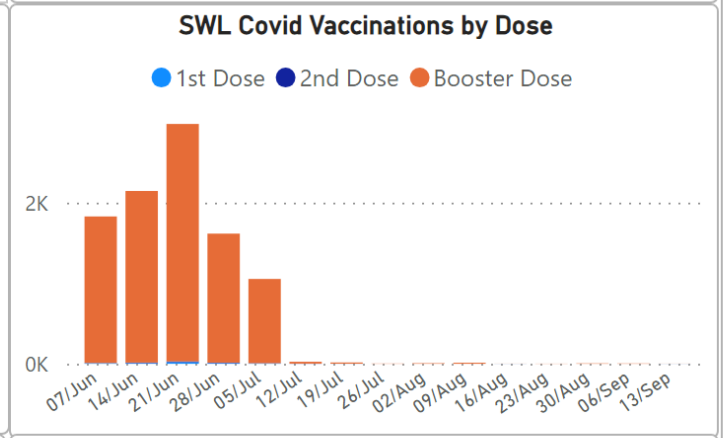
Domain: Primary Care

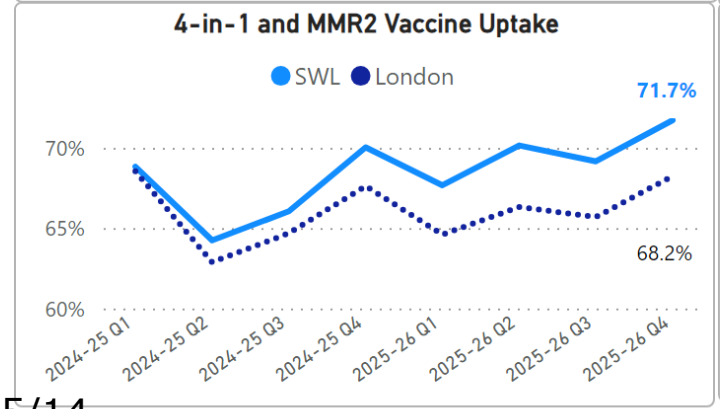
NHS South West London
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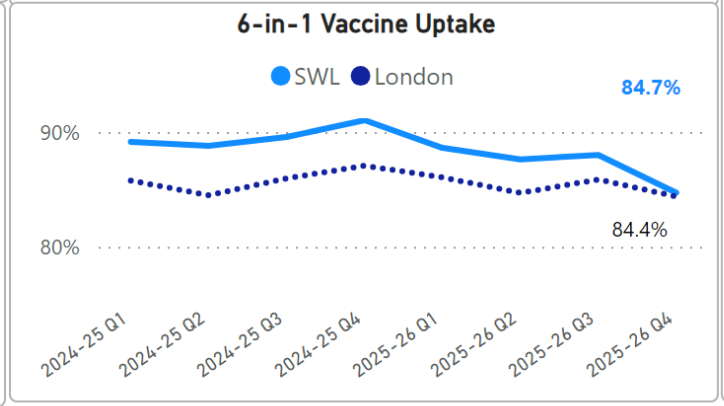












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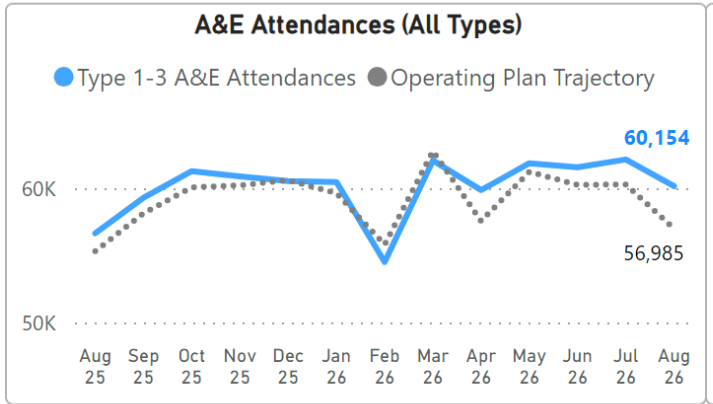
- Overall GP appointments remained at a similar level in June and July. Appointments were 2% above the plan of 778k.
- GP appointments within 2 weeks, whilst improving since April have not yet recovered the 92% target, delivering 91% for July.
- The COVID Spring programme finished on the 30th June, therefore no data to show from then. Preparations are underway for the Autumn and Winter Programme which will start in October
- Childhood immunisations for 4-in-1 remain higher than the London average. As does 6-in-1 uptake, albeit showing a decline in Q4.

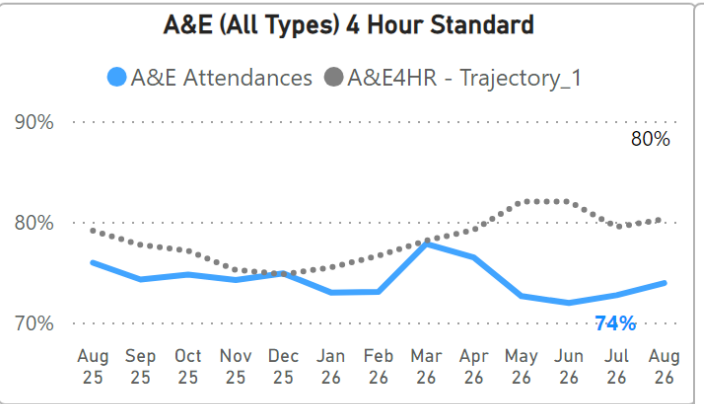
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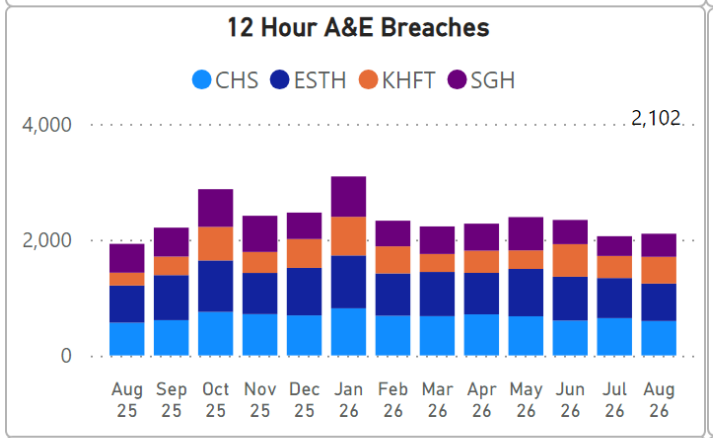
- Continue to monitor GP Appointments within 2 weeks, to ensure that we achieve over the 92% threshold. Additionally, a programme of work exists to improve coding within GP practices which is expected to improve data accuracy.
- Covid vaccination mitigations include a targeted social media campaign across postcodes with low uptake and continued outreach events. The SWL Immunisation team continues to collaborate with voluntary sector organisations. There were a number of outreach events carried out in Q1, including a Windrush event in Croydon to reach out to black Caribbean communities, to improve uptake.
- In response to the increase in measles cases, several community engagement programmes have been introduced, providing information in a variety of languages to support childhood vaccination uptake.
- Childhood Immunisation Coordinators continue to support GP practices in their efforts to increase childhood immunisation uptake.

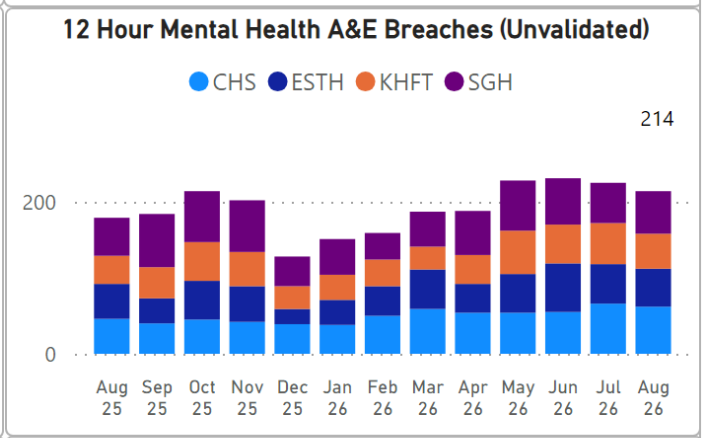
Domain: Urgent and Emergency Care

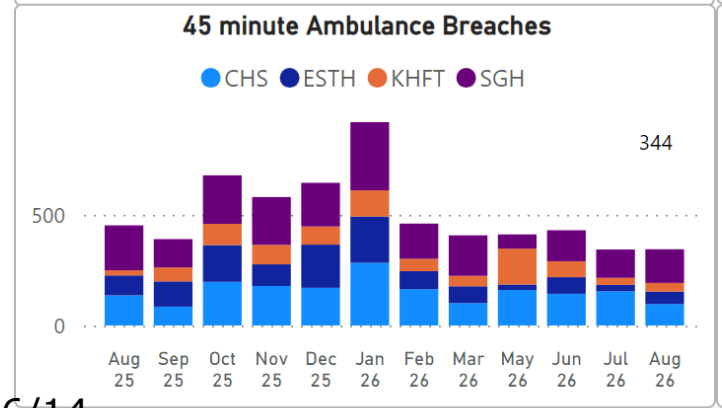
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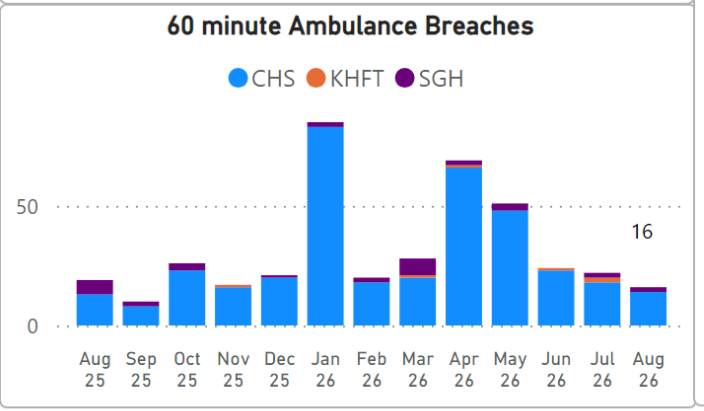












Notes & Issues

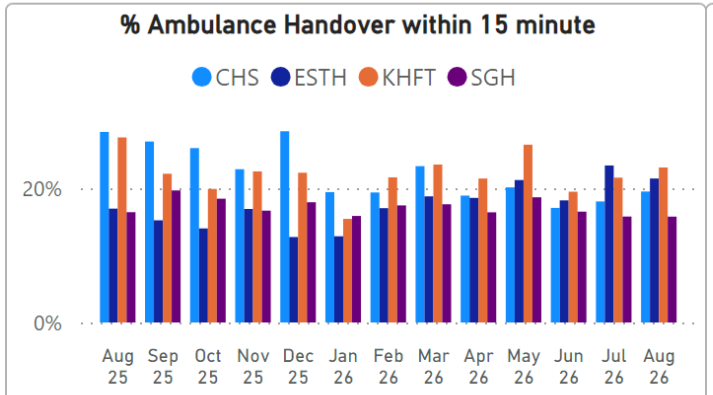
- Accident & Emergency (A&E) attendance dropped significantly in August, in line with seasonal trends but remains well above expected demand, in part driven by the heatwaves experienced during the summer months. There was an aligned, but slight improvement to 4-hour performance from 73% to 74% in August.
- Despite the drop in attendances, the number of 12- hour breaches did not reduce but remained with a slight reduction mental health cohorts.
- However, the average numbers of patients cared for in hospital corridors decreased markedly in August down to 30 at 8am which is the lowest number since March this year.
- Average ambulance handover times also remained stable at 23 minutes. Long ambulance waits were also stable and performance against the 15-minute handover breach remained high but steady.

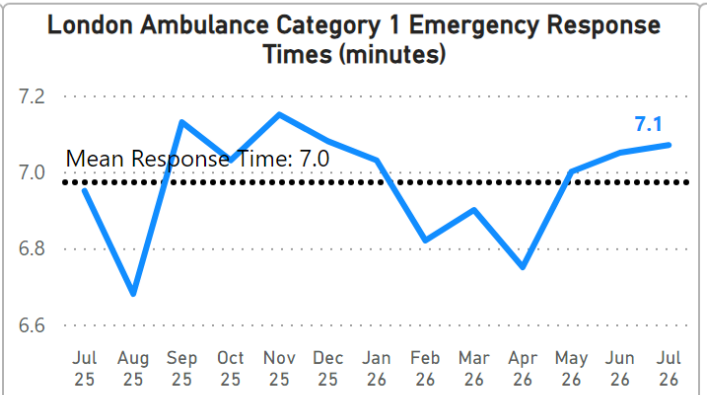
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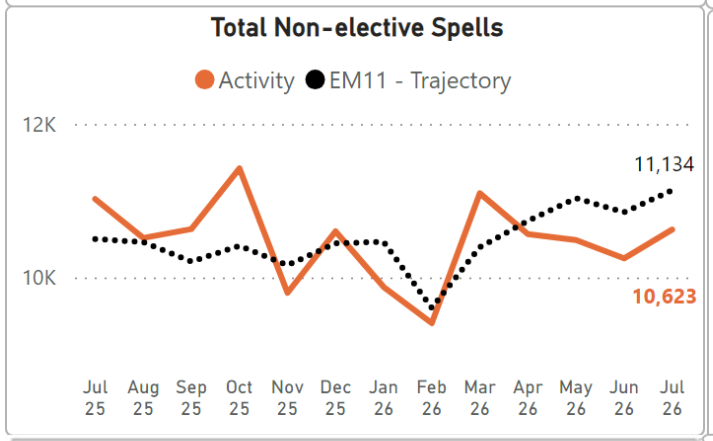
- All acute Trusts continue to focus on flow along the Urgent and Emergency Care (UEC) pathway to reduce delay and waiting times.
- The numbers of cases managed through the Integrated Care Coordination Hub (ICC) remained high in August, with positive feedback from crews and evidence of having an impact on demand to A&E. There has been a pilot focussed on Care Homes, where crews are encouraged to call the ICC before conveyance. The impacts of this are being evaluated.
- Reducing long waits and corridor care remains a high priority for all Trusts in their work to drive down waiting times.
- The SWL Mental Health (MH) UEC Board is now well established. A key focus is to oversee development of a business case to establish a dedicated MH A&E in SWL, working collaboratively to reduce delays; in particularly 12- hour breaches and pressures on existing A&Es. The groundwork for this business case is currently being developed through a series of workshops with key stakeholders completing in September.

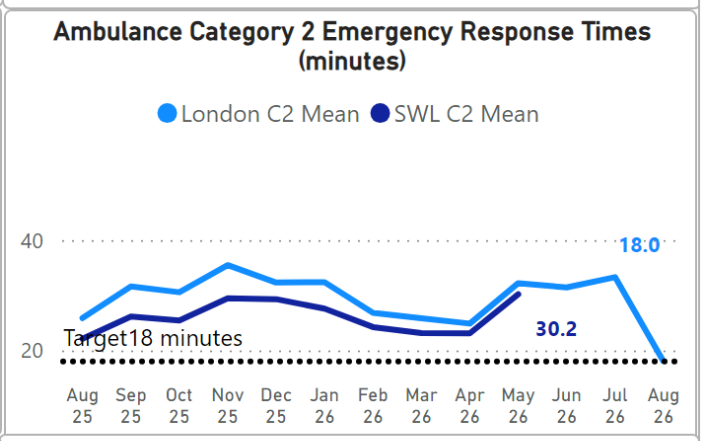
Domain: Urgent and Emergency Care

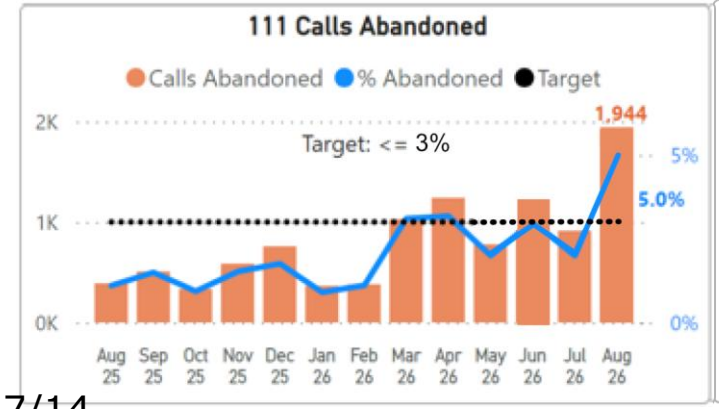
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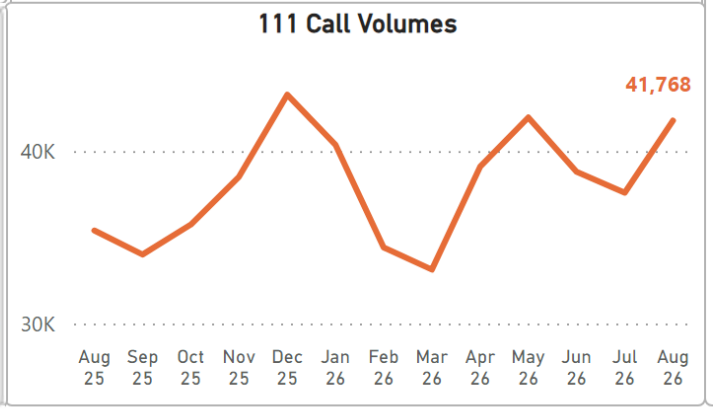












Notes & Issues

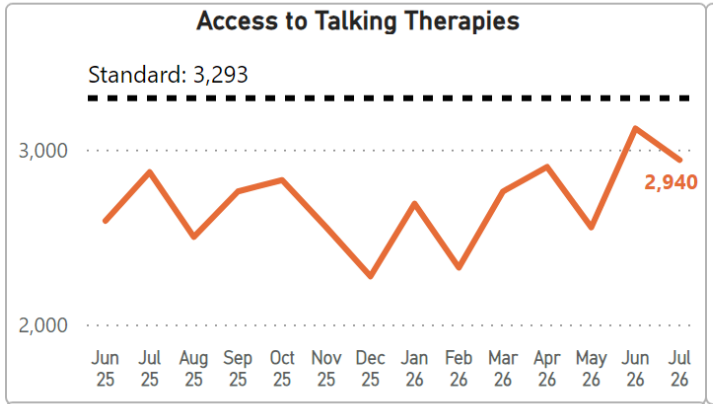
- Category 2 response performance in SWL improved to just under the 30 minute average target in August, and continuing to be lower than the London average. There is evidence that the ICC is reducing the impacts of increased demand via 999 which is helping to achieve this improvement. SWL 111 service continues to achieve key performance targets, with the proportion of abandoned calls improving to 2%,well under the 3% standard.
- There was a marked increase in 111 calls in August reflected in a particularly high abandonment rate.

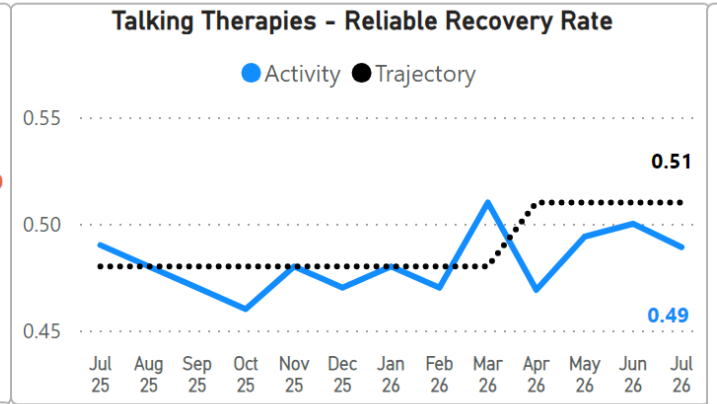
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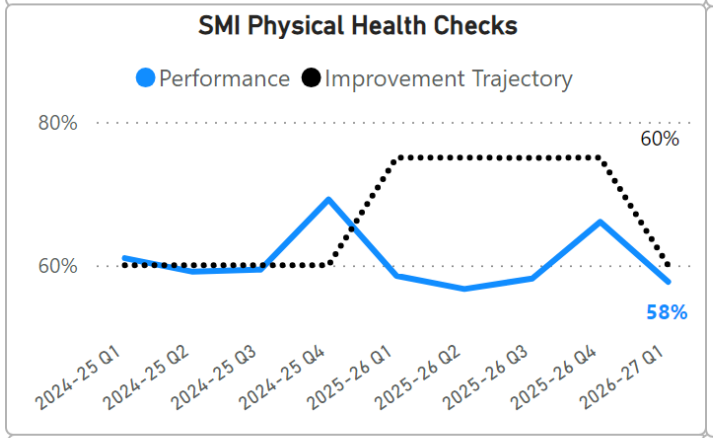
- Integrated Community Care (ICC) hub development to reduce ambulance conveyance to A&E when there is a community alternative available.
- All hospitals continue to deliver their improvement plans to reduce delays across the Urgent and Emergency Care (UEC) pathway..
- Implementation of the Frailty Plan for SWL has now commenced with the overall aim of keeping patients in the community and at home wherever possible.
- All trusts and the ICB have completed Winter Plans for submission on 30 September, following participation in a regional exercise to stress-test plans.

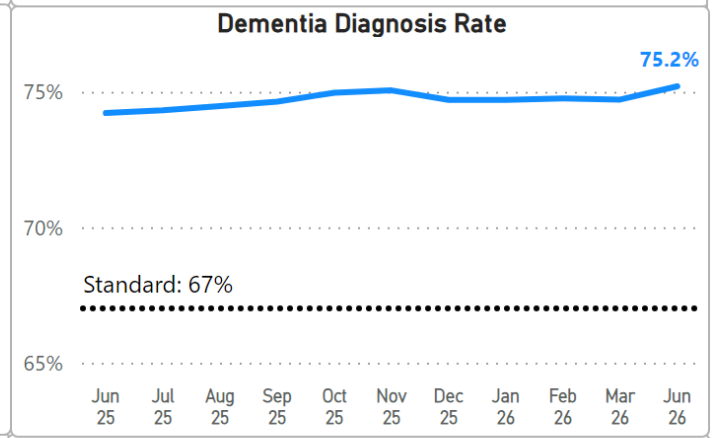
Domain: Mental Health and Learning Disabilities

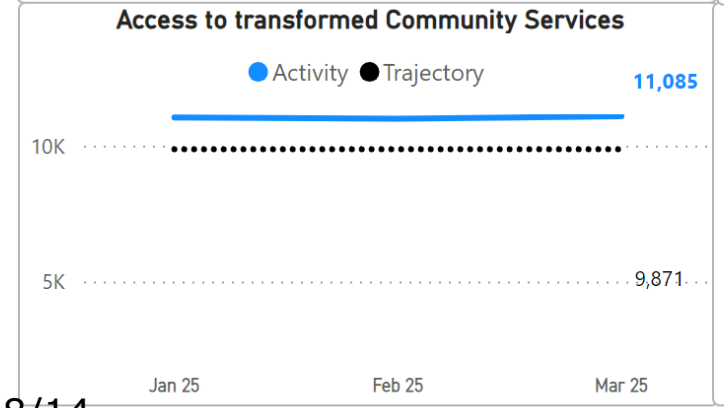
NHS South West London Integrated Care Board

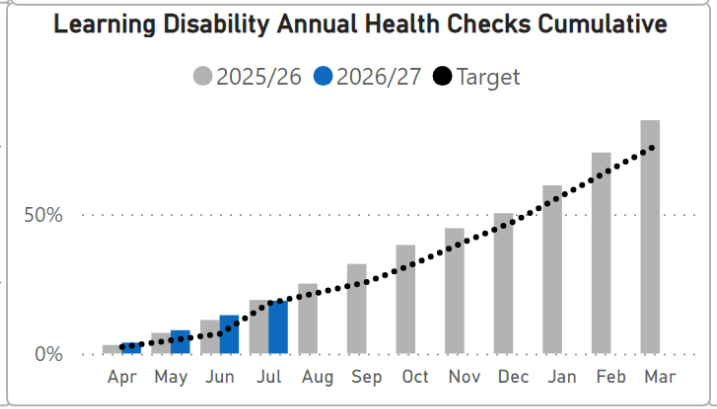












Notes & Issues

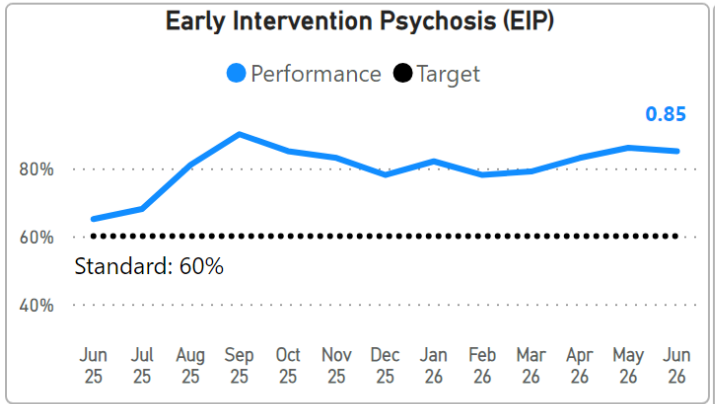
- Access levels to Talking Therapies decreased in July and were down on the previous month but continue in along a longer term trend of increase since December.
- Reliable Recovery Rate was 49% in July which was below the 2026/27 uplifted 51% standard. However, SWL performance remains best regionally. Annually SWL achieved 48.2%; the highest in London 2025/26.
- In Quarter 1, 58% of SMI patients received all six annual health checks which is inline with regional average of 60%. Note that performance has a seasonal effect which sees more checks completed from Q3 and peaks in Q4.
- South West London ICB continues to maintain good performance levels with the June position at 75.2%, exceeding both the national target of 66.7% and the London ambition of 70% for Dementia Diagnosis. SWL remain the highest performing system in London.
- Access to transformed Community services national metric has been retired for 2025/26, ongoing monitoring will now focus solely on community mental health access.
- Performance for Learning Disability Annual Health Checks is good across SWL and above plan.

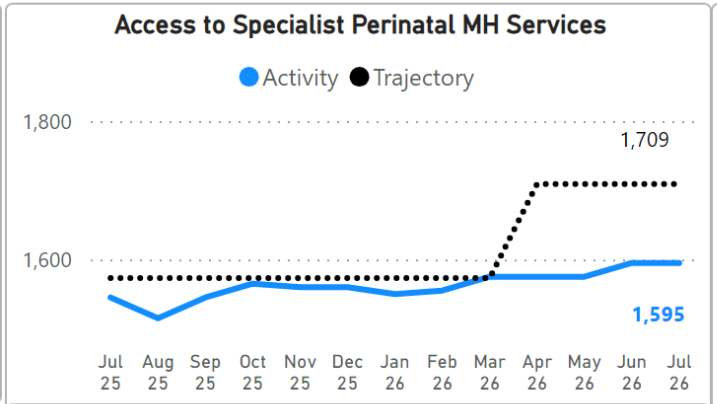
Recovery Actions

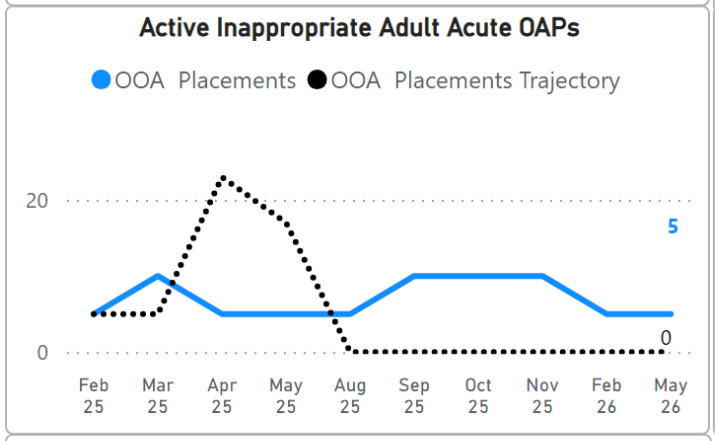
- Reliable Recovery Rate audits identified some common issues between SWL localities, which included patient discharges that may have benefited from additional sessions as well as data recording issues. These issues continue to be addressed through an improvement plan, staff communications, and ensuring best practice that supports patient recovery.
- All SWL boroughs continue to work towards increasing physical health checks for this vulnerable population.

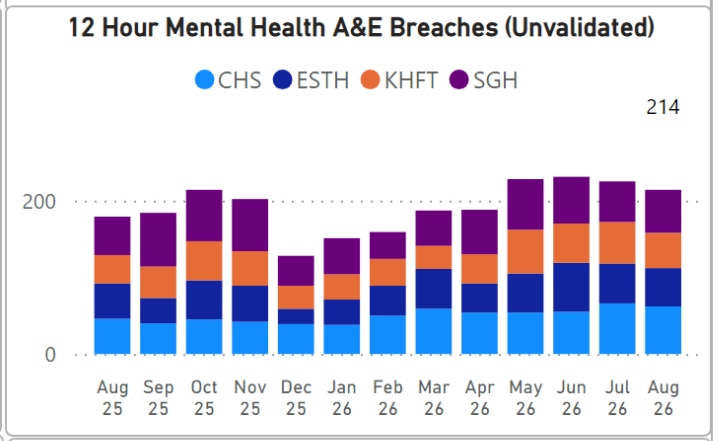
Domain: Mental Health Services

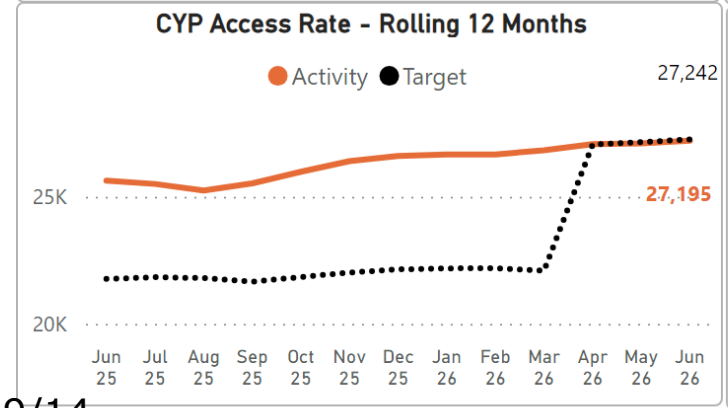
NHS South West London
Integrated Care Board

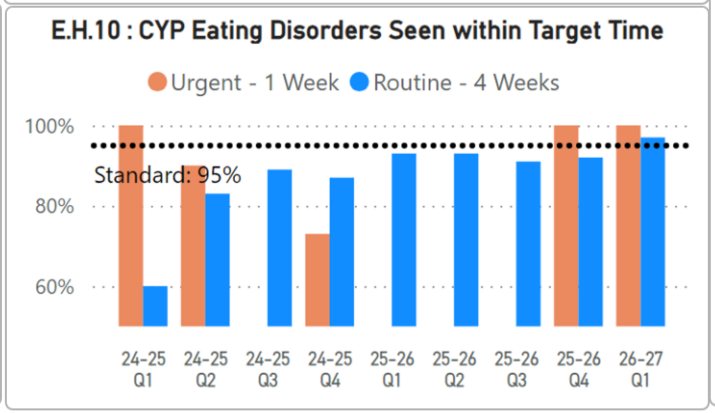












Notes & Issues

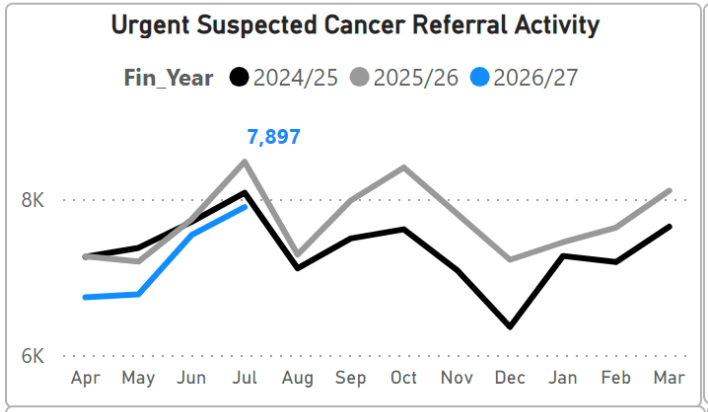
- SWL continues to exceed both the 60% national standard and the London Region position of 78%, achieving 85% in June for Early Intervention Psychosis.
- SWL ICB performance improved in July remains below the 2026/27 uplifted target for Access to Specialist Perinatal Mental Health Services.
- The number of 12-hour mental health breaches marginally reduced in August.
- Children and Young People's access in May has seen activity increase to just below plan.
- Children and Young People' eating disorder routine access 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.

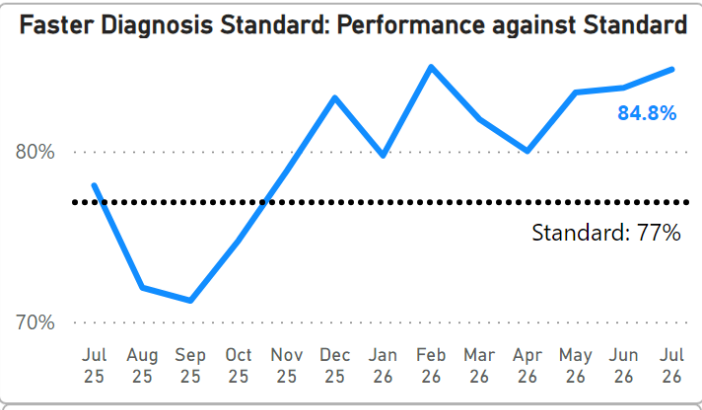
Recovery Actions

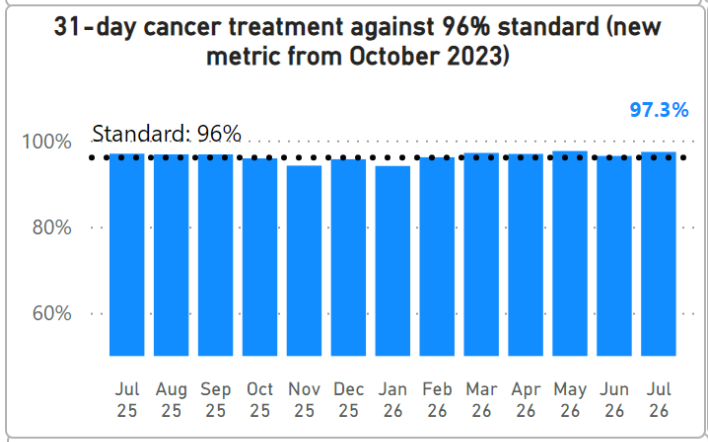
- Improvement workstreams for Perinatal access remain in place which include; dashboard enhancement with increased oversight on borough referrals; review of options for resuming pre-conception clinics; administrative processes improvements for booking 1st appointments and short notice cancellation; waiting list utilization to better promote attendance at the 1st appointment.
- For Out of Area Placements data was been suppressed due to low patient numbers, implying less than 5 patients were reported for these periods. Work remains ongoing to address delayed discharges to ensure improved patient flow.
- Improvement work to reduce the number of 12- hour mental health (MH) breaches are 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 was set up and has agreed priorities and a workplan for the year ahead.

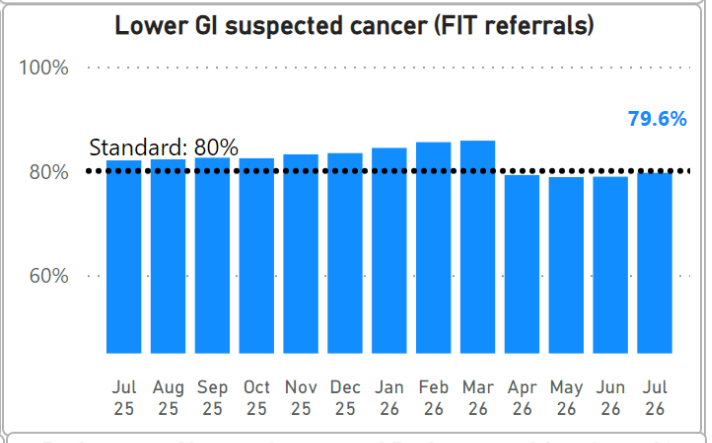
Domain: Cancer

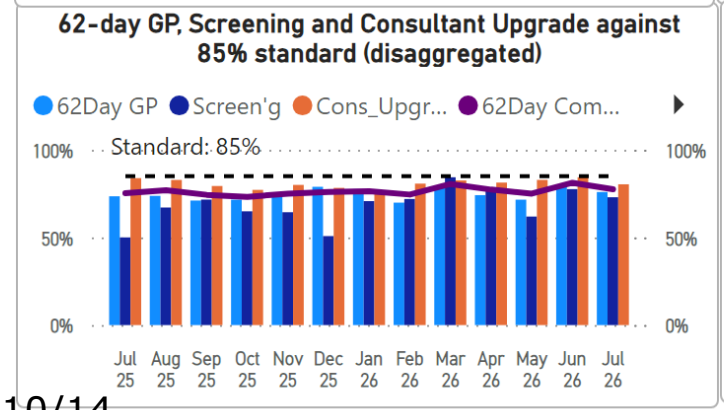
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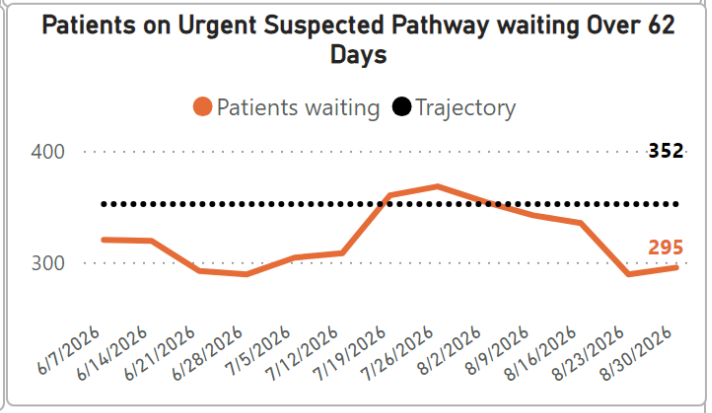












Notes & Issues

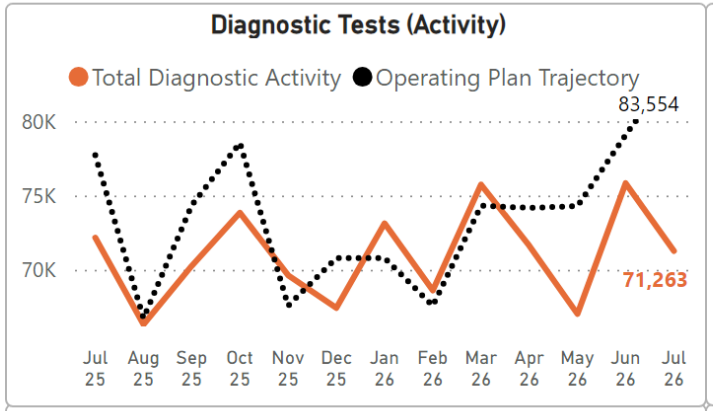
- Whilst no longer a national standard, the 14-day standard (93%) is being closely monitored at a national level for the Breast pathway as this has a strong indicator on 62- day performance. St George's (SGH) and Kingston Hospital (KRFT) continue to significantly underperform with the14 day standard in July.
- SWL met the Faster Diagnosis Standard (FDS) and 31 day standard for July with all Trusts meeting the 80% and 96% standard respectively.
- SWL achieved 77.6% against the 62-day standard of 85% (NHSE end of year target 80%); with only Epsom Hospital (ESTH) achieving above 80% in July.
- Lung 62 day performance is significantly challenged across SWL with just 43% compliance in July. There are numerous diagnostic challenges across SWL with surgical capacity issues at SGH.

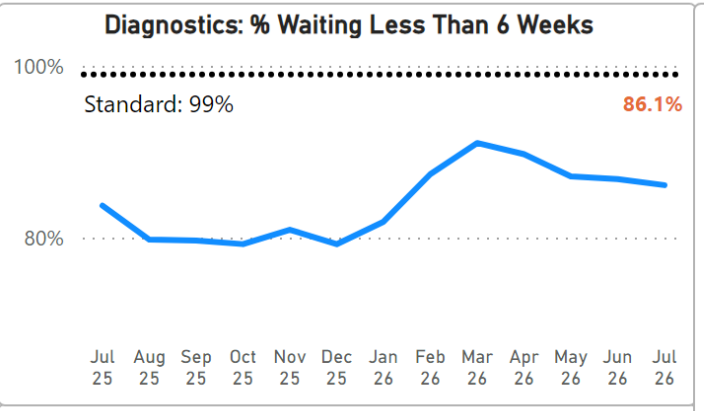
Recovery Actions

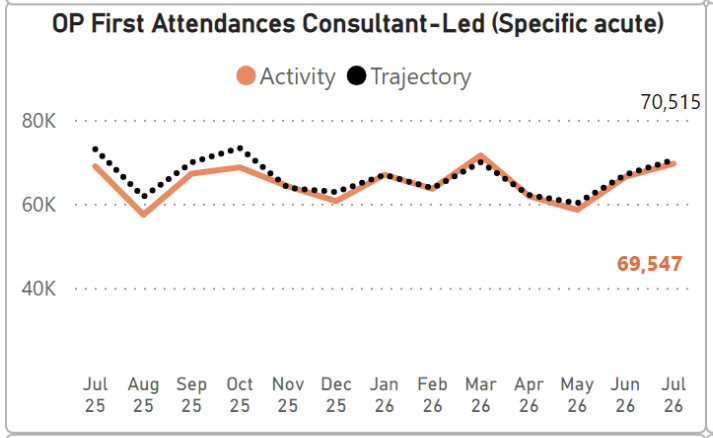
- For breast, Royal Marsden Hospital continues to support KRFT by providing mutual aid and KRFT are converting a vacancy to a clinical fellow post to improve performance and implementing short-term waiting list initiatives (WLI). SGH is developing a plan which will lead to a more efficient pathway. Whilst not compliant, both Trusts have seen waits to first OPA reduce.
- Royal Marsden Partners (RMP) main diagnostic improvement project this year is to introduce "WIDeasy" triage test into the Endometrial Gynaecology pathway. This will reduce hysteroscopies and increase compliance against the Faster Diagnosis Standard (FDS) and 62- day standards. SGH have already implemented with KRFT starting deployment now. ESTH and CHS will implement in 2027.
- A rapid improvement Lung programme has been agreed with all Trusts following an RMP facilitated clinical workshop held in May. There are a number of Trust level and sector wide actions which will aim to improve the position by Q3, notably via improved access to navigational bronchoscopy.
- Dermatology operational resilience has been agreed to accommodate summer demand, with a long- term plan of standardising the pathway and moving to a single point of access.

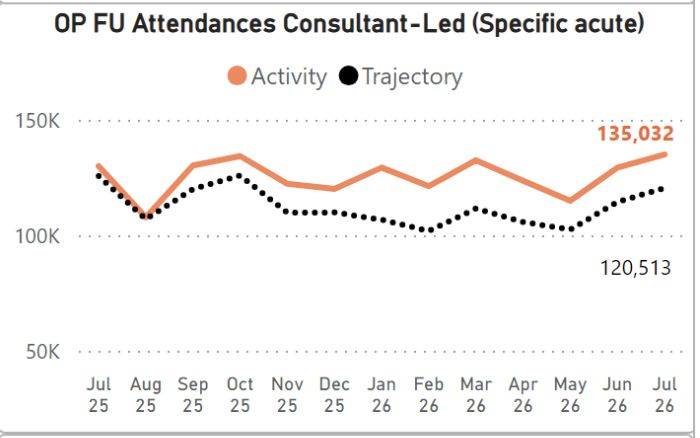
Domain: Outpatients and Diagnostics

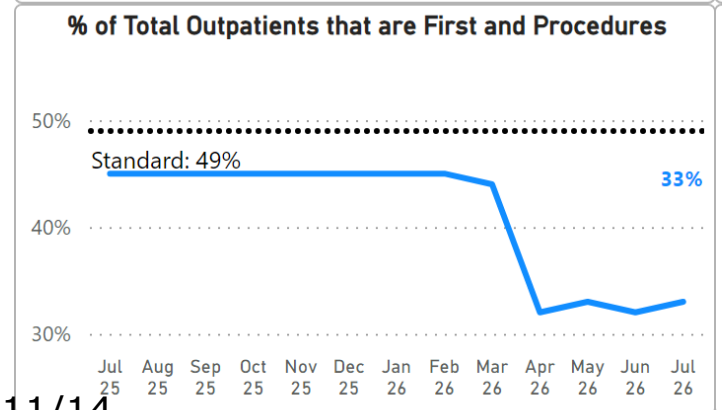
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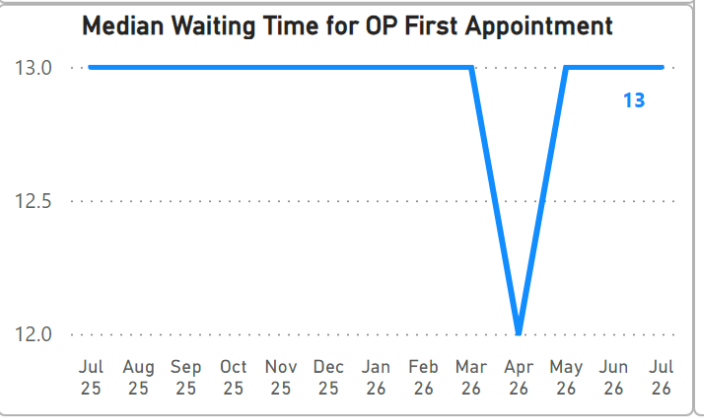












Notes & Issues

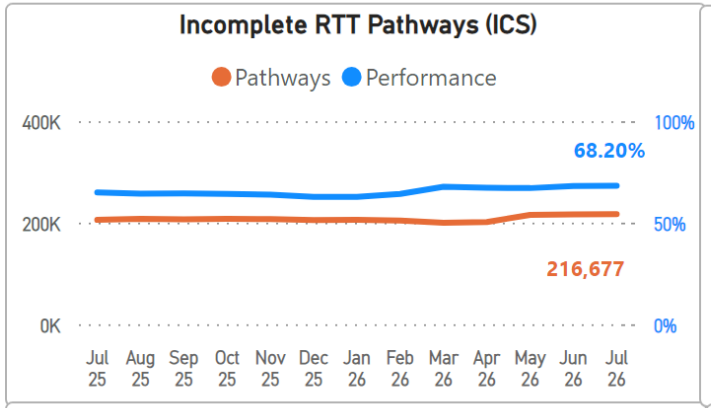
- Diagnostic activity decreased in July remaining below plan. Croydon (CHS) and Royal Marsden (RMH) exceeded their in-month plans, the others were below planned levels.
- Diagnostic performance decreased slightly in July to 86.1% however SWL ICB continues to be the highest performing ICB in London.
- The test with the largest backlog is non-obstetric ultrasound (NOUS), with SGH and KRFT holding the largest number of +6 week pathways
- Outpatient Firsts track below plan in July. Follow-ups were above plan and continuing to performing above the year-to-date trajectory.
- SWL is reporting 33% of all Outpatients as firsts or procedures this month; below the 49% standard. RMH performance is low due to the nature of Cancer pathways, which require a sequence of follow ups. ESH have noted that some of their procedures have been incorrectly coded as follow-ups.
- The median waiting time for high volume low complexity (HVLC) specialties remained at 13 weeks.

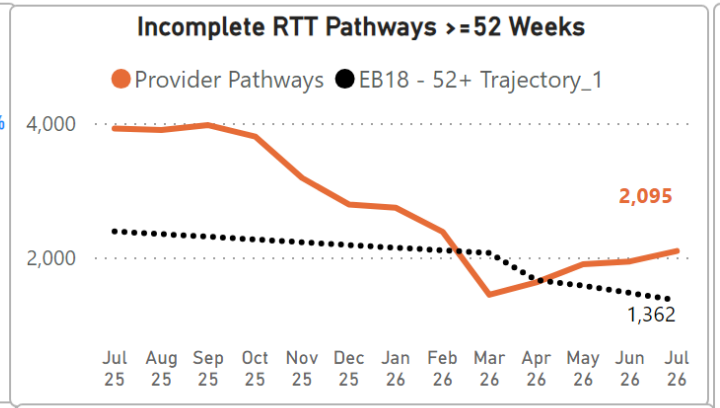
Recovery Actions

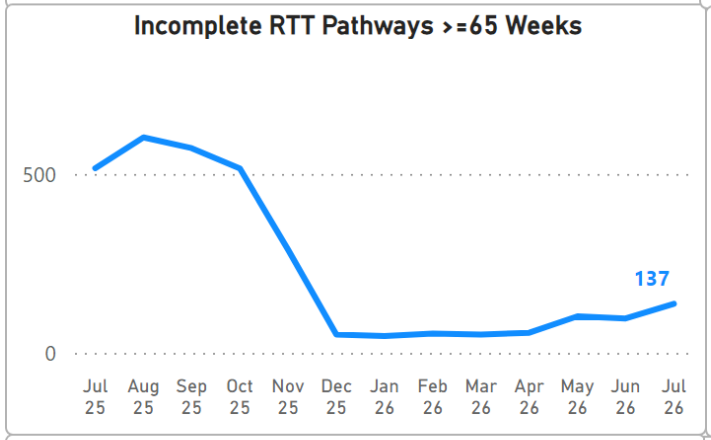
- Improvements continue to be seen at Croydon Hospital (CHS) after enacting their recovery plans, with a backlog reduction continuing in +6 week waits.
- SGH are currently using agency staff to support manage NOUS demand.
- KRFT are developing a diagnostic recovery plan inclusive of timelines and Endoscopy service redesign to address a number of issues within the service.
- ESH continue to work to improve data quality since the migration to Cerner.
- 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.

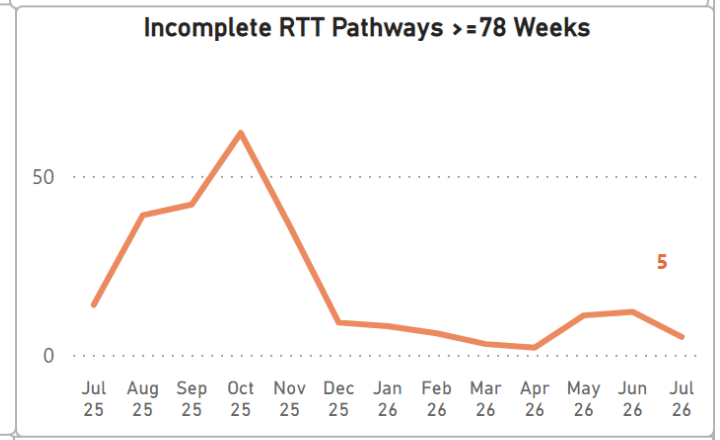
Domain: Planned Care

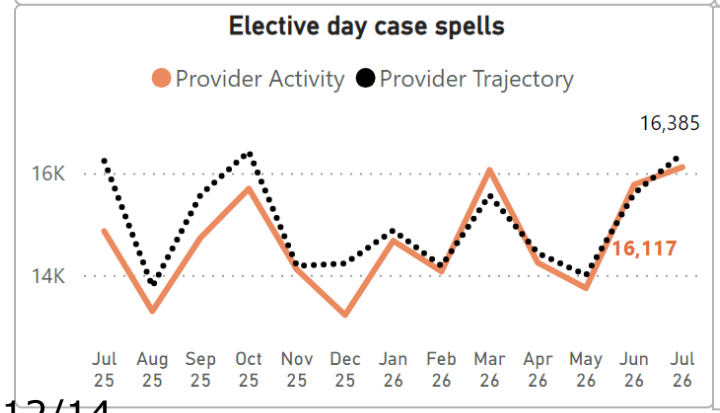
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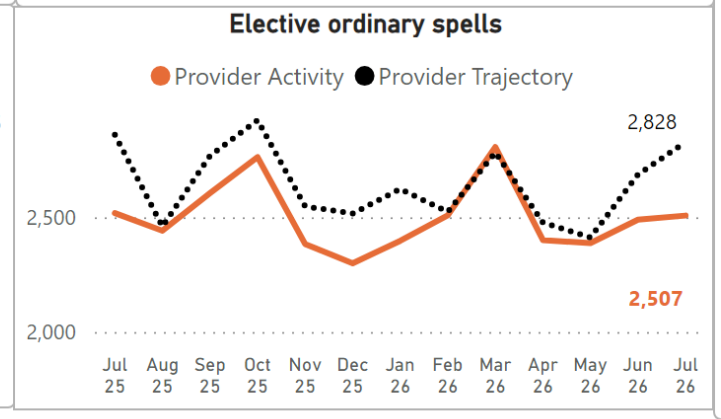












Notes & Issues

- July saw South West London (SWL) with 216,667 patients on an incomplete pathway awaiting treatment at hospital within or outside of the local geography. Across SWL providers, 68.2% of patients were waiting less than 18 weeks from Referral to Treatment (RTT); 2.6% above in-month plan. This is the highest ICB performance in London and higher than the national position (65.3%).
- SWL had the least 52 week waits, compared to other London systems, in July. SWL providers, regardless of which ICB the patient is registered with saw an increase of 156 pathways in July, resulting in 2,095 pathways against an aggregate plan of 1,362.
- At ICB level Gynaecology and , Ear, Nose and Throat (ENT) had the greatest number of patients waiting over 52 weeks at 285 and 271, respectively. St George's (SGH) holding the largest volume for Gynae and Croydon Hospital (CHS) for ENT.
- The number of 65 week waits increased to 137 in July.
- Activity increased in ordinary spells whilst still below plan, elective day case also increased in line with the plan.

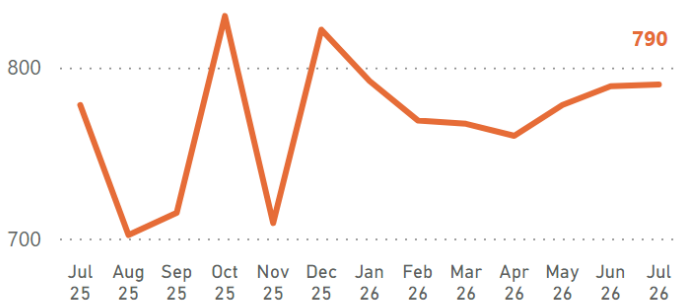
Recovery Actions

- All Provider have NHS approved plans to deliver national targets by the end of March 2027.
- There are number of actions in place to support the increase of ENT capacity within the system, including consultant recruitment and transformation including the introduction of the single point of entry for referral, to reduce variation and increase utilisation across SWL.
- Additional focus on provider delivery comes from NHS England Region, following the Model ICB blueprint guidance. Region now closely monitors providers' delivery against RTT and activity plans as well as contractual management by the ICB.

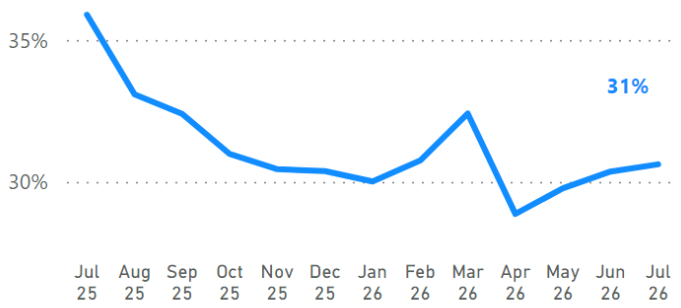
Domain: Integrated Care

NHS South West London
Integrated Care Board

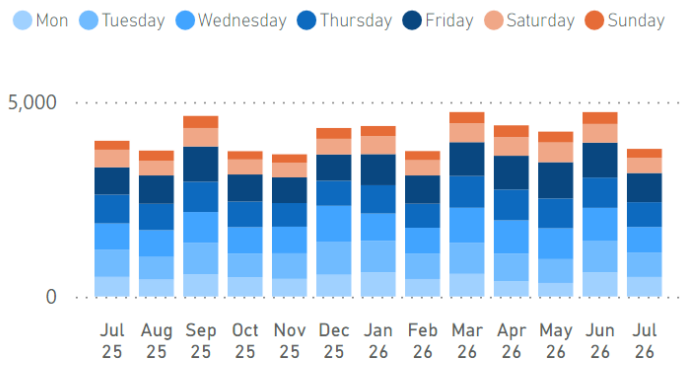
Number of Patients staying 21+ Days (Super Stranded)



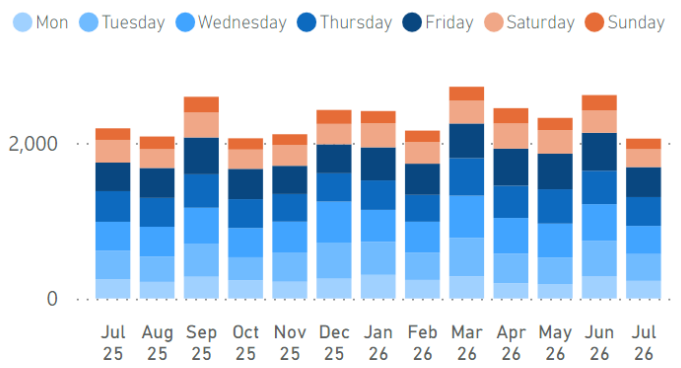
Daily discharges as % of patients who no longer meet the criteria to reside in hospital



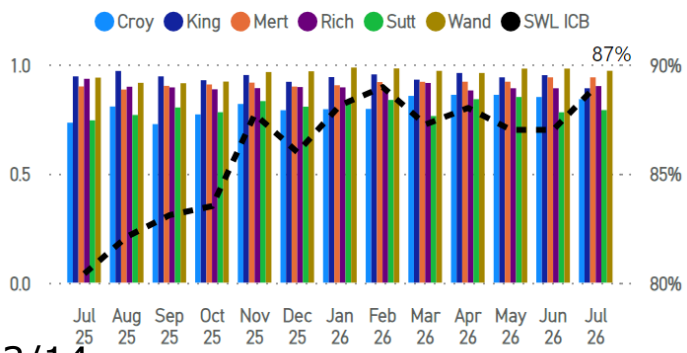
Total Discharges by Weekday



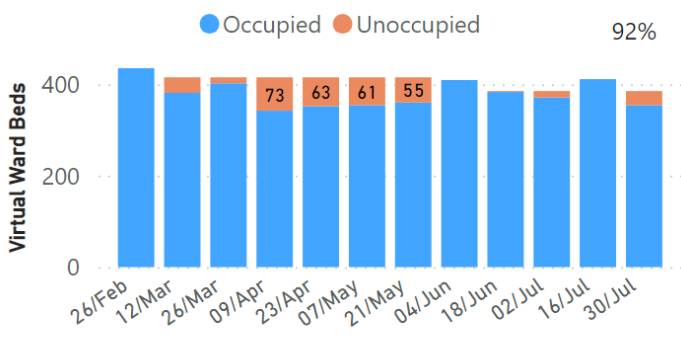
Total Discharges before 5pm by Weekday



Community 2 Hour Urgent Response Performance - Provider



SWL Virtual Ward Capacity and Occupancy



Notes & Issues

- At 87% performance for SWL's UCR services for July, SWL continues to perform above the national target of 70% for community 2- hour Urgent Community Response (UCR).
- SWL has now met the national target of UCR referrals of 200 per 100k patients, with an expectation that this will increase over winter. Complexity of patients remain high with catheters, respiratory and end-of-life conditions being top referral reasons.
- SWL continues tp hold the second-highest ranking UCR activity in England, and work continues to support providers with admission avoidance in SWL.
- Virtual Ward (VW) occupancy in SWL is reported at 92% for July, which is above the target of 80%.

Recovery Actions

- System-wide focus remains on maintaining consistency of access for UCR, strengthening referral pathways (including London Ambulance Service and care homes) and optimising pathways.
- Investment around frailty will include VWs and UCR services, with an expectation of an enhanced offer over winter / next financial year.
- VW have an aim to stay within the 100% occupancy as much as possible to ensure a good standard of care, flagged as a risk for winter months.
- Review of capacity is ongoing, and processes are in place to ensure patient safety and optimisation. The Central Remote Monitoring Hub runs 12 hours a day, with patient selection having slightly changed – the Hospital at Home / Virtual Ward component has continued running as expected.

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

SWL ICB Commissioning priorities for 2027/28

Agenda item: 3.1.3

Executive Lead: Ed Waller, Deputy Chief Executive/Chief Commissioning Officer

Report by: Kath Cawley, Director of Planning

Paper type: Discussion

Conflicts of Interest: There are no conflicts of interest as a result of this paper.

1. Purpose and recommendation

This pack is designed to support discussion on our commissioning intentions for 2027/28. The pack summarises the priorities set out in our strategic commissioning plan and our commissioning intentions as we move into 2027/28.

The Board is asked to comment on SWL's Commissioning Priorities for 2027/28 and note the next steps currently being undertaken to set out the investment requirements, the expected population health and health inequality benefits and financial return on investment and deliverability which will be shared at the SWL ICB Board for sign off.

In addition, it is anticipated that we will be required to make a submission of our draft financial and non-financial plans for 2027/28 to NHSE in mid-December. Given the timings of our Board meetings, we are asking the Board to delegate sign off of this submission to the SWL Strategic Commissioning Committee.

The Board is asked to:

- Discuss the proposed commissioning priorities for 2027/28.
- Delegate responsibility for the sign off of draft financial and non-financial plans for a national return required in mid-December 2026 to the Strategic Commissioning Committee.

2. Background and context

The NHS 10 Year Plan sets a clear ambition to change the way in which the NHS organises, delivers and funds services. In response to this ambition, all NHS organisations have been asked to shift their focus towards a rolling five-year planning horizon and to prepare integrated five-year plans which

support transformational change, deliver the three shifts set out in the NHS 10 Year Plan and demonstrate how financial sustainability will be secured over the medium term.

In May 2026 SWL ICB agreed its strategic commissioning plan, which sets out how the ICB will secure improvements for its population in line with its key responsibilities as a strategic commissioner.

The plan was developed in partnership with our system partners and incorporated the findings from previous engagement work with residents and patients on their access and experience of care. In developing the plan and determining our commissioning priorities for the next five years, we:

- Undertook a population health needs analysis to understand local need and in doing so, identified the healthcare interventions that will have the biggest impact on our population both now and in the future.
- Brought together insight and intelligence on our existing commissioned health care services to ensure we continue to focus on the delivery of consistent, equitable and high quality services.
- Reviewed our current strategy and financial sustainability plans to ensure our approach is fit for purpose for the next five years and supports delivery of our commissioning priorities.

Our strategic commissioning plan sets out our priority areas for commissioning; we are currently progressing work in 2026/27 aligned to this strategy and our commissioning intentions for 2027/28 build on this.

We have not yet received the draft national planning guidance for 2027/28, which will include a number of operational planning asks of ICBs and providers that we will need to work through when available. Our expectation, having discussed with NHSE, is that key expectations will remain aligned to those published in the Medium-Term Operating Plan which was published last year. As such, starting point for our plans is year 2 of the three-year plan that was submitted last year, updated for our commissioning intentions.

3. Analysis and evidence

South West London's (SWL) draft Commissioning Intentions for 2027/28 represent the next stage in implementing the Strategic Commissioning Plan and developing SWL's role as a strategic commissioner. Our data analysis highlighted variation, and our interventions have been designed to standardise the care offer, tackle health inequalities and ensure equity of access. They respond to a clear and pressing case for change: an ageing population, rising prevalence of long-term conditions, increasing complexity, inequalities in access and outcomes, and growing demand across primary, community and acute care. Without intervention, these pressures are forecast to create a cumulative system financial deficit of £1.5bn by 2035/36.

4. Options and trade-offs

The commissioning intentions seek to move SWL away from predominantly reactive, episodic and hospital-based care towards a model that prevents ill health, identifies and manages risk earlier, provides proactive support and delivers more care closer to home. This directly supports the NHS three shifts of hospital to community, treatment to prevention and analogue to digital, while improving outcomes, reducing inequalities and unwarranted variation, and creating a more financially sustainable health and care system.

The Strategic Commissioning Plan identifies significant opportunities from delivering care differently, in particular opportunities to change models of care to deliver more consistent proactive care to support effective population health management, making the shift from acute to community. Strategic commissioning priorities were agreed to deliver against these opportunities. The commissioning intentions begin to translate these strategic opportunities into specific service and pathway changes for 2027/28.

The commissioning priorities for SWL ICB for 2027/28 are:

- Expansion of the frailty model of care including stronger links with mental health, dementia and end of life care
- Establishment of integrated community hubs for babies and children and young people
- Develop and expand Women's Integrated Networks to provide joined up care across the life course
- Redesign and integration of pathways for cardiovascular, renal and metabolic conditions
- Integrated model of care for adults with severe mental illness
- Core mental health offer for children and young people
- Improving access to assessment, diagnosis and support for people with ADHD
- Commissioning of an improved end-to-end adult weight management pathway
- Revision of our maternity contract specifications to reflect outputs and recommendations of national maternity reviews

The ICB will also be reviewing wider performance investment that may be required as well as reviewing other commissioning and provider intentions that sit outside the main priorities.

5. Implications, impacts and risks

As set out in the Medium-Term Financial Strategy document, we will maintain affordability by prioritising investment within available financial envelopes, improving productivity across existing services and testing whether investments deliver their expected benefits.

6. Engagement and approvals

To inform the development of this five-year commissioning plan, we undertook a structured review of relevant existing engagement insight to understand what people across South West London consistently tell us matters most to them.

In March 2026, more than 70 community leaders from across South West London also came together to discuss local health needs and opportunities to improve care. They highlighted concerns about waiting times, access to services and fragmented care, alongside the importance of prevention, more joined-up services and working more closely with voluntary and community organisations.

7. Next steps and oversight

Work is ongoing to finalise our business cases and to test affordability within the Strategic Investment Fund envelope, this will need to be tested as work up continues over Q3. Through this process we will ensure interventions are strategically aligned to the five-year strategic commissioning plan, deliver a clear improvement in population health outcomes, reduce inequalities, are deliverable and that there is clear return on investment. As part of this process, the ICB will also be reviewing wider performance investment that may be required as well as reviewing other commissioning and provider intentions that sit outside the main priorities.

SWL ICB's Strategic Commissioning Committee will discuss and review the proposed areas for strategic investment at its next meeting before being shared with the SWL ICB Board to sign off. Expectation that business cases will then be agreed, in line with SWL governance, to be reflected in contracts in 2027/28.

We are developing our financial and non-financial (activity and performance) plans for 2027/28, with the expectation of a national planning return of draft plans in mid-December 2026. As noted in section 2, our expectation is that the starting point for our plans is year 2 of the three-year plan that was submitted last year, updated for our commissioning intentions.

Appendices and supporting information

SWL ICB Commissioning Intentions 2027/28 Board November 2026

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SWL ICB Commissioning Intentions 2027/28

Context and Background

NHS South West London

- **The NHS 10 Year Plan sets a clear ambition to change the way in which the NHS organises, delivers and funds services**. In response to this ambition, all NHS organisations have been asked to shift their focus towards a rolling five-year planning horizon and to prepare integrated five-year plans which support transformational change, delivery the three shifts set out in the NHS 10 Year Plan and demonstrate how financial sustainability will be secured over the medium term.
- The **role of ICBs within planning is one of strategic commissioners** with a core focus on improving population health, reducing health inequalities and improving access to consistently high-quality services.
- In May 2026 **SWL ICB agreed its strategic commissioning plan,** which sets out how the ICB will secure improvements for its population in line with its key responsibilities as a strategic commissioner.
- The plan was **developed in partnership with our system partners** and incorporated the findings from previous engagement work with residents and patients on their access and experience of care. In developing the plan and determining our commissioning priorities for the next five years, we:
    - **Undertook a population health needs analysis** to understand local need and in doing so, identified the healthcare interventions that will have the biggest impact on our population both now and in the future.
    - **Brought together insight and intelligence on our existing commissioned health care services** to ensure we continue to focus on the delivery of consistent, equitable and high quality services.
    - **Reviewed our current strategy and financial sustainability plans** to ensure our approach is fit for purpose for the next five years and supports delivery of our commissioning priorities.
- Our **strategic commissioning plan remains a current document in terms of the ambitions and outcomes SWL ICB want to achieve for our population**. We are currently progressing work in 2026/27 aligned to this strategy and **our commissioning intentions for 2027/28 build on this.**
- This is in the context that we have **not yet received the draft national planning guidance for 2027/28**, which will **include a number of operational planning asks of ICBs and providers** that we will need to work through when available.
- **This pack is designed to support discussion on our commissioning intentions for 2027/28**. The pack summarises the priorities set out in our strategic commissioning plan and our commissioning intentions as we move into 2027/28.

1. Executive summary

SWL commissioning intentions: strategic context and ambition

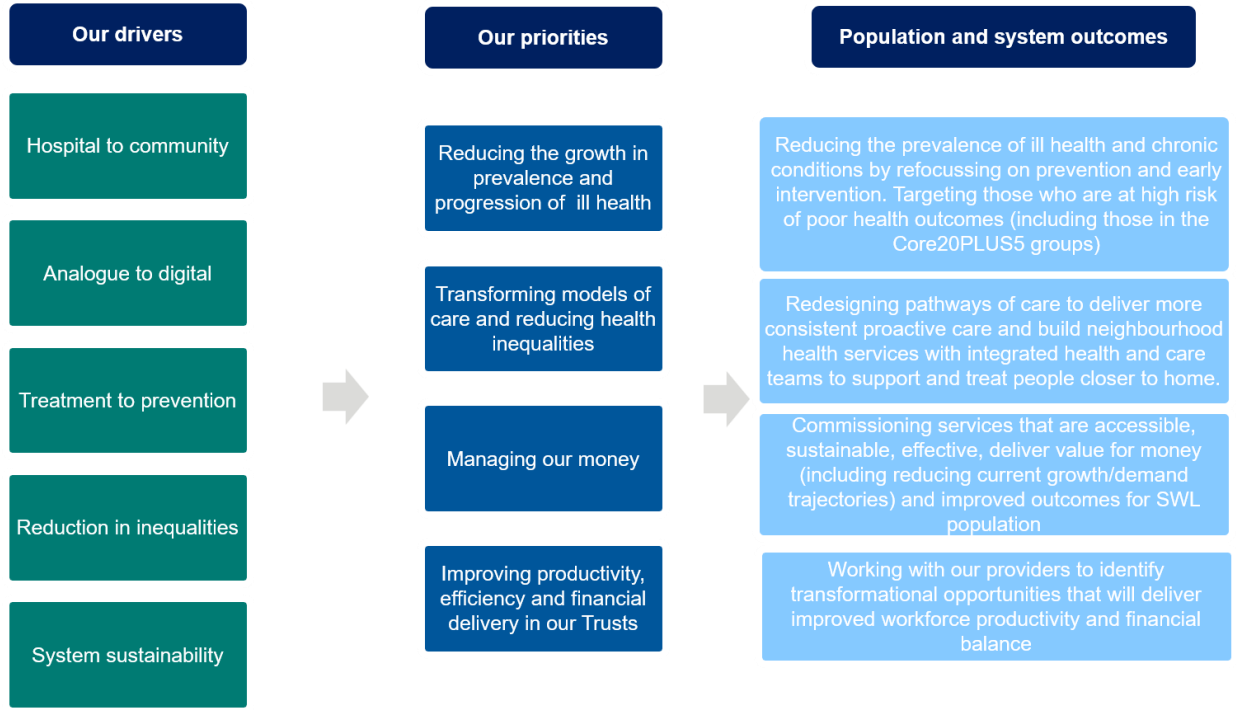
- South West London's (SWL) draft Commissioning Intentions for 2027/28 represent the next stage in implementing our Strategic Plan and developing SWL's role as a strategic commissioner. Our data analysis highlighted variation, and our interventions have been designed to standardise the care offer, tackle health inequalities and ensure equity of access. They respond to a clear and pressing case for change: an ageing population, rising prevalence of long-term conditions, increasing complexity, inequalities in access and outcomes, and growing demand across primary, community and acute care. Without intervention, these pressures are forecast to create a cumulative system financial deficit of **£1.5bn by 2035/36**.

- Overall, the 2027/28 commissioning intentions represent a significant step towards **changing the underlying model of care in SWL rather than managing continued growth within existing models**.

- As set out opposite, the commissioning intentions seek to move SWL away from predominantly reactive, episodic and hospital-based care towards a model that **prevents ill health, identifies and manages risk earlier, provides proactive support and delivers more care closer to home**. This directly supports the NHS three shifts of **hospital to community, treatment to prevention and analogue to digital**, while improving outcomes, reducing inequalities and unwarranted variation, and creating a more financially sustainable health and care system.

- The Strategic Plan identifies significant opportunities from delivering care differently, in particular opportunities to change models of care to deliver more consistent proactive care to support effective population health management, making the shift from acute to community. Strategic commissioning priorities were agreed to deliver against these opportunities. The commissioning intentions begin to translate these strategic opportunities into specific service and pathway changes for 2027/28.

SWL translation of drivers and priorities into outcomes



The image above sets out the relationship between our strategic drivers, priorities and expected population and system outcomes.

Key priorities for 2027/28

Urgent care: ensuring safe care for our population in the most appropriate setting

- Our commissioning intentions set out how we will develop services to ensure that we can provide safe care to our population, in the most appropriate setting for their needs.
- The **frailty model of care will be expanded**, developing a single integrated community frailty pathway, strengthening links with mental health, dementia and end-of-life care, reviewing polypharmacy and developing workforce capability. The intended impact is better outcomes and experience for older and frail residents alongside fewer non-elective admissions, improved flow, reduced bed utilisation and reduced unwarranted variation.

Redesigning planned care around care closer to home

- The Strategic Plan identified that SWL currently has comparatively high levels of outpatient activity and significant variation between specialties and providers. Without intervention, outpatient appointments are projected to increase by 31% over the next ten years, reinforcing the need to redesign pathways rather than simply increase acute capacity.
- SWL intends to reduce unnecessary secondary care activity by strengthening community pathways, specialist advice and triage, and enabling primary and community services to manage more patients safely outside hospital. Key areas of focus are:
    - New **Babies and CYP community hubs** to expand integrated, community-based health, mental health and social care across all six boroughs, with expected benefits including fewer acute referrals, reduced waiting times, improved experience and improved school attendance.
    - **Women's Integrated Neighbourhoods** will introduce a single SWL triage model and shift appropriate lower-acuity gynaecology activity from hospitals into community settings, establishing neighbourhood care as the default for routine gynaecology.
    - Implement **multi-disciplinary community care for people with cardiovascular, renal and metabolic conditions**. Neighbourhood MDT offer for higher complexity patients with CKD, diabetes and/or hypertension.

Key priorities for 2027/28

Prevention and proactive management of population health

- A continued focus for 2027/28 is to intervene earlier to prevent disease, slow progression and reduce avoidable complications. This is particularly important for **cardiovascular, renal and metabolic (CRM) conditions**, where prevalence is forecast to increase significantly over the next decade and where poorer outcomes disproportionately affect SWL's more disadvantaged communities. SWL will implement the national **Cardiovascular Disease Modern Service Framework.** Alongside this, multidisciplinary community CRM care will provide a more integrated approach to managing cardiovascular, renal and metabolic risk.
- An improved **adult weight management pathway** will provide a more integrated end-to-end offer, specialised weight management and greater use of digital weight management programmes.
- Taken together, these interventions signal an important change in commissioning emphasis: using population health intelligence to identify risk and unmet need, targeting resources towards communities experiencing the poorest outcomes, and investing earlier in pathways to reduce future disease prevalence, complications and hospital utilisation.

Improving quality of care and population inequalities

- We will review and update our **maternity service specifications** with our maternity providers to ensure that they reflect the recommendations from the Amos report and other national maternity reports.
- We will develop opportunities to **align ADHD services to a more consistent SWL model**, supporting equitable access, improved quality oversight, more efficient use of workforce, and stronger financial control
- Commission the **core mental health offer for CYP**, which will focus on early intervention, reducing escalation into crisis, improving access and waiting times and improving consistency of offer across SWL.

Alignment between key priorities for 2027/28 and ten year plan

NHS South West London

Population cohorts and key priority schemes

Population cohort	Key priority scheme	Hospital to community	Analogue to digital	Treatment to prevention	Reduction in inequallities	System sustainability
Babies, Children and Young People	Babies and Children and Young People's hubs	✓	✓	✓	✓	✓
	Core MH offer for children and young people	✓	✓		✓	✓
	Clearer SWL approach to ADHD/ASD (all age)				✓	✓
Working age adult population with rising risks	Women's integrated neighbourhood hubs	✓	✓	✓	✓	✓
	New model of care for SMI	✓			✓	✓
	Cardio Renal Metabolic pathway	✓	✓	✓	✓	✓
	Healthy weight pathway / obesity			✓	✓	✓
Frailty, multiple long term conditions and dementia care	Phase 2 of frailty model of care	✓	✓		✓	✓

The chart above sets out how each of SWL ICB's key strategic commissioning priorities delivers against the national asks set out in the 10 year plan (the "three shifts": hospital to community, analogue to digital and treatment to prevention). Each of the priorities is expected to improve health inequalities and improve system sustainability.

Wider system development and next steps

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Expanding neighbourhood health in 2027/28

- Neighbourhood health is central to the delivery model for the commissioning intentions. SWL's ambition is that neighbourhoods become the principal model for proactive, integrated and preventative care, organised around defined populations rather than organisational boundaries. This means moving from reactive care towards proactive and personalised support, with shared responsibility across primary care, community, mental health, acute services, local authorities and the VCFSE sector.
- In 2027/28 SWL will move from establishing the foundations for neighbourhood health to scaled delivery across Places, with neighbourhood working increasingly becoming the default model for planning, funding, delivery and assurance. Initial areas of focus include Women's Integrated Neighbourhoods (WIN) hubs, Babies, Children and Young People (BCYP) community hubs and expansion of our frailty model of care, supported by Integrated Neighbourhood Teams and Host Organisations.
- This provides an important mechanism for moving resources upstream, while integrating services around the needs of defined populations rather than individual organisational pathways.

Medium Term Financial Strategy

- The commissioning intentions are accompanied by an emerging financial strategy designed to shift resources over time. Supported by a Strategic Investment Fund, investment will be prioritised according to alignment with the three shifts, population health outcomes, inequalities, value for money, financial impact, deliverability and scalability. Further development of payment reform, gain-share, neighbourhood baselines and benefits realisation will be important if the left shift is to translate into a sustainable change in the pattern of system expenditure.

Prioritisation of investment

- Work is now underway to develop these commissioning ambitions into clear investment requirements, measurable outcomes (improved health outcomes, health inequalities and financial return on investment) and transition mechanics to ensure that they are both deliverable and affordable within the available Strategic Investment Fund.
- An outcomes framework will be developed for SWL which will sit alongside our prioritisation framework going forward to support greater comparability between proposed interventions.

2. Our case for change

Our integrated needs assessment, developed for the clinically-led work which informed our Strategic plan, identified that SWL faces growing demand of complex conditions and increasingly complex needs…

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The population profile is ageing with needs varying by geography

- SWL has a **larger proportion of working age adults** compared with England
- The **65+ population will grow by more than 25%** in the next ten years whilst **young people will decline by 12%**
- **Core20 populations** range from 1% in Kingston and Richmond to 18% in Croydon

Current spend is already concentrated on higher-needs cohorts

- **69% of commissioner spend*** supports **16% of the population,** with **medium to high complexity needs,** and **higher use of primary and acute care services**
- **Core20 populations with cancer and SMI** utilise a **greater amount of ICB spend** than non-Core 20 populations **(52% and 17% higher)**

Disease prevalence and complex needs are rising

- **Dementia prevalence is** higher than peer ICSs and SMI prevalence exceeds the national average
- Conditions such as **CKD and cancer** are growing **faster than the national average**

Variation and inefficiency in care provision exist today

- There is **variation in use of health care resources** by cohorts of patients who have similar needs
- When **quality is considered, spend differences between places remain significant**

* Includes acute, mental health, community, primary care, continuing care (CHC) and NHSE spend.

… and these factors will drive further capacity and financial challenges

+27% GP appointments 7.3M → 9.3M	**+57%** Community contacts 1.9M → 3.0M	**+39%** Mental health contacts 606K → 842K	**+31%** Outpatient appointments 3.7M → 4.8M
+44% Elective admissions 276K → 398K	**+23%** Emergency department (ED) attendances 686K → 844K	**+49%** Non-elective admissions 133K → 198K	**+40%** Mental health admissions 2,263 → 3,163

South West London activity forecasts: 2024/25 → 2035/36 (if no action is taken)

These factors drive increases in future demand and intensify capacity requirements

- Forecast demand will fuel **double digit activity growth in all points of delivery by 2035/36** from primary care through to community, acute (physical and mental health) and CHC
- The **highest rates of growth** in activity are forecast to be in **non-elective spells, CHC and community contacts,** including **primary care**

Without change, financial sustainability is at risk

- **By 2035/36, medium and high complexity** cohorts will require **88% of ICB spend** by **2035/36** with frailty and end of life needs alone accounting for 59%
- This trajectory leads to a cumulative **deficit of £1.5bn by 2035/36**

Without intervention, activity growth, increasing complexity and variation in care will create a projected £1.5bn system deficit by 2035/36. Strategic commissioning must therefore focus on **prevention, neighbourhood care, productivity and reducing unwarranted variation**.

Engaging with communities and service users to shape our plans

NHS South West London

To inform the development of this five-year commissioning plan, we undertook a structured review of relevant existing engagement insight to understand what people across South West London consistently tell us matters most to them. This work helps ensure our commissioning priorities are grounded in lived experience as well as population health data, and that we focus effort where there is both greatest need and what is most important to local people.

We reviewed qualitative and quantitative insights, which brings together engagement led by NHS organisations, provider Trusts, local authorities, Healthwatch and voluntary, community and social enterprise (VCSE) partners. This was complemented by a review of relevant national reports and surveys to provide wider context and test whether local experience reflected broader patterns. We analysed this combined insight to identify themes that recur across multiple sources, places and population groups, focusing on issues that are consistently raised by local people and communities.

Across different areas of care, people consistently describe the impact of long waits, fragmented services and difficulty navigating the system, alongside strong appreciation for frontline staff working under significant pressure. For example, in urgent and emergency care, people spoke about overcrowding, long waits and rushed discharge leaving them feeling unsafe and undermining trust, often linked to difficulties accessing timely GP, mental health or community support. In planned care and cancer services, long waits for appointments, diagnostics and results were described as frightening and, for some, a reason to delay seeking help. In mental health, families and individuals described long waits, stigma and lack of culturally appropriate support, alongside the wider impact of loneliness, financial pressure and digital exclusion.

Across population health and prevention, people were clear that health cannot be separated from wider life pressures. Cost of living, housing, access to green space, caring responsibilities and stress were repeatedly described as shaping people's ability to stay well, manage long-term conditions and engage with services. Many people highlighted the vital role of community and voluntary organisations in helping them navigate the system, understand information, reduce isolation and access support when statutory services feel difficult to reach.

In March 2026, more than 70 community leaders from across South West London also came together to discuss local health needs and opportunities to improve care. They highlighted concerns about waiting times, access to services and fragmented care, alongside the importance of prevention, more joined-up services and working more closely with voluntary and community organisations.



3. Our strategic commissioning strategy and development of neighbourhood health

SWL's strategic commissioning plan - summary

The SW London strategic commissioning plan brings together the work to-date of the clinically led strategic plan and our commissioning intentions for 2026/27, alongside plans for 2027/28 onwards, into a **single cohesive plan for the system**.

The population needs assessment, 10-year forecasting, and significant system surveillance work undertaken during Q2/3 of 2025/26 indicated **significant opportunities to close the £1.5bn financial gap over the next 10 years**.

The clinically led strategic plan developed several clinical workstreams, bringing together clinical experts from across SW London trusts, primary care, community care, and within the ICB, to **review these opportunities and design interventions to reduce demand and support the triple aims of the NHS 10-year plan**:

- Treatment to prevention,
- Analogue to digital, and
- Left shift from hospital to community.

These interventions were prioritised and aligned with our commissioning intentions and plans for 2026/27, further developing our operating model as strategic commissioners. Business cases were developed for the 2026/27 transformation fund, with pipeline interventions under discussion for future years' funding.

The strategic commissioning plan was discussed and agreed at the SWL ICB Board at its May 2026 meeting.

Our clinical strategy, agreed by the SWL ICB Board in May 2026, identified the following as the biggest opportunities to improve care

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There are four key areas where change could make the biggest difference to our system finances, and additional areas of opportunities to explore.

Prevention and early intervention

Investing in prevention so fewer people develop serious illness or see their condition worsen.

The same standard of care wherever you live

People with similar needs should receive the same standard of care across all parts of South West London.

Improving outpatient care

Reducing repeat follow-ups, improving access to tests and specialist advice closer to home.

Avoiding unnecessary hospital stays

Supporting people earlier so more conditions can be managed safely in the community.

Further opportunities for transformation

- System service design: service and specialty reviews, opportunities to be assessed. Services could include gastroenterology, general surgery, urology, ophthalmology, gynecology, pediatrics, and maternity.
- High-volume, low-cost activity review
- Workforce productivity

Developing opportunities for our strategic commissioning plan

NHS South West London

To translate these opportunities to a series of interventions for delivery, SWL ICB established seven workstreams with multidisciplinary and multi-organisational/sector involvement. A series of workshops were held for each workstream, enabling engagement, validation of analysis, exploration of opportunities and identification of interventions to model. Wider engagement with providers, communities, local authorities and professional groups such as the local medical committee (LMC), continued throughout.

1. **Planned specialist care** inc. outpatients, elective, cancer
2. **Mental illness**
3. **Maternity and neonatal**
4. **LTC and multi-morbidity**
5. **Frailty / end of life care**
6. **Children and young people**
7. **UEC / unplanned care**

Consistent considerations across every area include:

- Neighbourhood delivery
- Diagnostics
- Prevention
- Clinical stewardship, including medicines management
- Health Inequalities
- Digital
- Finance
- Generally healthy population
- Estates

The workstreams and interventions were then aligned with the new ICB structure and strategic commissioning approach, so that the interventions can be commissioned and delivered. These four main strategic commissioning areas are:

Planned care, diagnostics, cancer & maternity	Neighbourhood, primary care, pharmacy, ophthalmic & dental services	Mental health and learning disabilities	Urgent and emergency care

SW London strategic commissioning transformation pipeline set out in our strategy

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Our Strategic Plan identifies commissioner and provider opportunities to improve care and financial sustainability. If we are to achieve financial sustainability over the 10 year period, we will need to commence projects over the next 3 years.

2026/27

Urgent care
- Frailty model of care
- SDEC improvements
- Integrated urgent care (IUC)
- Mental health urgent crisis response
- Integrated care hub (ICC)
- Discharge and flow

Planned care
- Outpatient transformation
- Left shift transformation
- Elective transformation
- Specialty focused transformation
- Long-term conditions (LTCs) model of care: CRM (tier 2)
- RMP cancer strategy implementation

Mental health
- Serious mental illness (SMI) model of care approach
- Children and young people (CYP) mental health investment case
- Attention deficit hyperactivity disorder (ADHD) case for change

Neighbourhood health and care
- Neighbourhood development programme and related initiatives

Population health
- Service reviews: system work on specialisms
- CVD disease: lipid lowering management
- Obesity: Digital LTC self management and MDT management of tirzepatide (roll out over 3 years)
- Community health and wellbeing workers

2027/28

Urgent care
- Strategy for intermediate care
- Development of dementia & non-weight bearing pathway
- IUC optimisation aligned to neighbourhoods
- Development of frailty academy
- End of life care modern service framework

Planned care
- Outpatient transformation (inc. further digital transformation)
- Specialty focused transformation
- Elective transformation (high-volume, low complexity (HVLC))
- LTCs pathway: diabetes
- LTCs model of care: CRM (all tiers)

Mental health
- Depression prevention interventions: reduced disease prevalence and progression

Neighbourhood health and care
- CYP integrated paediatric hubs
- Continued neighbourhood development and left-shift

Population health
- Service reviews: review and develop service analysis
- Prevention: polypharmacy
- community-based clinics
- Prevention: hypertension case finding in community pharmacy
- Diabetes 3TTs

2028/29 onwards

Urgent care
- Specialist virtual pathways (frailty, chronic obstructive pulmonary disorder (COPD), heart failure)
- Care navigate
- Further develop anticipatory care

Planned care
- Further transformation following service analysis for system wide reviews
- Further digital innovation
- LTCs pathway: COPD
- Further LTCs cohorts MoC

Mental health
- Place standardisation: Standardise/ equalise treatment offers across the 6 SW London Places
- Neurodiversity model of care and approach

Neighbourhood health and care
- Continued neighbourhood development and left-shift

Population health
- Services and specialties reviews: Specialties TBC
- Prevention: respiratory/COPD

Neighbourhood health will become the principal model for proactive, integrated and preventative care delivery

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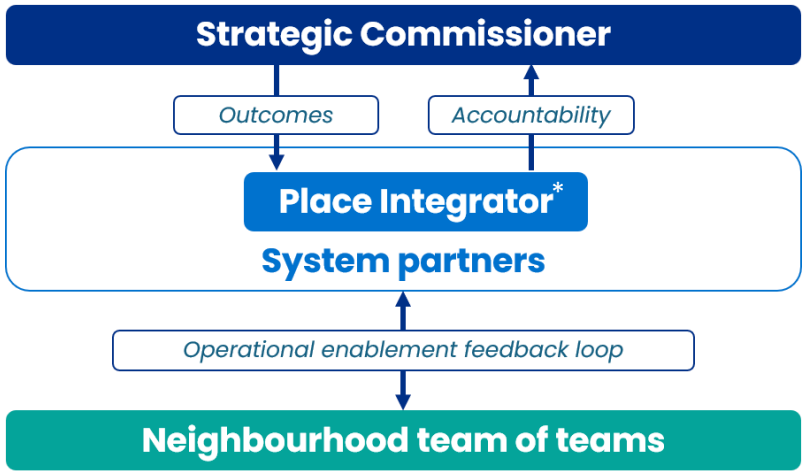
Our principles

As set out in the Medium Term Plan, delivering neighbourhood health at pace is central to returning patient and community trust in the NHS, breaking down siloed working among our staff and getting control of improving urgent care. Neighbourhood Health is not a discrete programme or structural re-labelling exercise. It represents a fundamental cultural shift in how the system operates and how health and care is organised and experienced.

SWL's approach is underpinned by the principle that: **"Neighbourhoods are the system, and the system is neighbourhoods."**

This means:

- Organising care around defined neighbourhood populations, not organisational boundaries. Services are shaped around population need, local assets and partnerships.
- Moving from reactive, episodic care to proactive, preventative and personalised support.
- Building shared responsibility across primary care, community, mental health, acute, local authority, VCFSE and residents.
- Enabling the ICB to act as a strategic commissioner, setting outcomes and expectations (the 'what') while Places lead local delivery (the 'how').



Source: London Neighbourhood Health Update, May 2026

Our Neighbourhood Model

In SWL the neighbourhood model will be delivered through partnership working between Host Organisation (Integrators as per the London TOM) and Integration Partners including, primary care, local authorities, VCFSE organisations and wider system partners.

To do this, partners are committed to working together as an alliance to build the relationships, trust and behaviours needed to support neighbourhood delivery at scale. This will include establishing collective accountability for neighbourhood outcomes.

In SWL it has been agreed that the Host Organisation will act on behalf of the partnership to hold and administer agreed resources, coordinate investment decisions, support delivery of neighbourhood priorities and provide assurance on the use of funding and delivery of outcomes

Success will depend as much on culture, collaboration and shared accountability as it does on governance and structures

**Please note, the London TOM uses the term 'Integrator' but in SWL we are using "Host Organisation".*

SWL Progress to Date: Establishing the Conditions for Neighbourhood Delivery

NHS South West London

1 THE FOUNDATION

Memorandum of Understanding

Being finalised between the ICB and Host Organisations. Sets governance, delivery, funding and Host Organisation expectations for 2026/27.
Separate MOU agreed between Hosts and Integration Partners to formalize partnership delivery.

INT Standard Operating Procedure

A consistent SWL framework for establishing and operating INTs, while retaining flexibility for local Place arrangements.

2 WHAT THIS FOUNDATION HAS DELIVERED SO FAR

Shared Vision

SWL principles and definitions agreed;
SWL Governance agreed.

Agreed Footprint

Geographies agreed across six Places: 26 neighbourhoods and 37 PCNs.

Host Organisations

Arrangements established for the 2026/27 foundational year. This has included agreeing the delivery expectations and initial areas of focus.

Delivery Fund

Implementation underway across all Places; early oversight and contract management established.

Shared Dashboard

Supports improvement and shared learning; aligned to 26 national neighbourhood health metrics

Neighbourhood health development in 2027/28

In 2027/28, SWL will move from foundation-building into scaled delivery, using agreed governance, dashboards and maturity criteria to strengthen accountability for outcomes and test more formal delegated arrangements where Places are ready.

- Move from foundation-building to **scaled neighbourhood delivery** across Places.
- **Strengthen Host** Organisation maturity and test the Host Organisation function.
- Neighbourhood working to be the default model for planning, funding, delivery and assurance.
- **Ensure MH transformation is embedded within neighbourhood, community and physical health transformation**, rather than developed as a standalone programme This approach will enable a more person-centred, preventative and population-based approach to care. It will improve outcomes for people with both mental and physical health needs, address wider determinants of wellbeing and reduce duplication across programmes.
- Continue to **scale INT and neighbourhood delivery models**, with local flexibility based on population need. For 2027/28, our initial areas of focus will be **Women Integrated Neighbourhoods (WIN), Babies, Children and Young People (BCYP), and Frailty**
- For frailty, places should be working towards the ambition for 1% of their population to be identified for proactive, coordinated care through INT arrangements by winter 2026/27. This should form part of a wider approach to identifying approximately 1.5% of the population by the end of the year.
- Use **agreed baselines, trajectories and dashboards to track outcomes** and support where delivery is off track.
- **Implement initial delegated funding arrangements where readiness, legal route and assurance criteria are met**. Confirm the scope, readiness and assurance arrangements for initial delegation to Host Organisations from April 2027; expected to include the Women's Integrated Neighbourhoods (WINs) and Babies, Children and Young People (BCYP) Health Network contracts at a minimum.
- Set the **foundations for additional transfer to Host Organisations in the future**. We will explore contractual arrangements that enable us to commission Host Organisations in a way that incentivises true collaboration across partners, end-to-end pathway redesign and expected outcomes to be delivered.
- To deliver improvements across these areas in 2027/28, SWL will further align SWL Neighbourhood Integrators with emerging NHSE strategy and **will contract with Host Organisations that are NHS Providers** with a fixed, permanent presence within the SWL system.

4. Our commissioning priorities for 2027/28 and next steps

Transforming models of care: SWL priorities

Babies, Children and Young People's hubs

- Establish and scale integrated community hubs to provide proactive and accessible services for children and young people.
- Build on neighbourhood working to improve outcomes and reduce inequalities from early years through to adolescence.

Maternity

- Revise maternity specifications to reflect the outputs and recommendations of the recent national maternity reviews and support delivery of Trust level improvement plans where needed with a focus on improving outcomes for babies and women and reducing inequalities in maternity outcomes.

Women's integrated networks

- Develop and expand Women's Integrated Networks to provide joined up care across the life course.
- Improve access, experience and outcomes for women and reduce health inequalities.

Cardio renal metabolic pathway

- Redesign and integrate pathways for cardiovascular, renal and metabolic conditions.
- Increase early identification and proactive management to reduce avoidable illness and hospital admissions.
- Pathway review for Heart Failure.
- Modern service framework for CVD.

Severe Mental Illness

- Implement a new, more integrated model of care for adults with severe mental illness (SMI) and redesigned crisis pathways.

Core mental health offer for children and young people

- Strengthen and expand the core mental health offer for children and young people.
- Improve access, early support and outcomes, with a focus on prevention and reducing inequalities.

ADHD (all age)

- Improve access to assessment, diagnosis and support for people with ADHD.
- Develop a consistent, high-quality all-age pathway, with a focus on early intervention and reducing inequalities.

Healthy weight pathway

- Commission an improved end-to-end adult weight management pathway.
- Expand access in primary and community care and specialist services, with a focus on earlier intervention and reducing inequalities.

Expanding the frailty model of care

- Scale an integrated community frailty pathway, including stronger links with mental health, dementia and end-of-life care.
- Improve outcomes and experience for older and frail residents, while reducing non-elective admissions and unwarranted variation.

Commissioning for Quality of care and Modern Service Frameworks

NHS South West London

These commissioning intentions signal the need for service change and service transformation, and where changes to services are being considered, including efficiency schemes, we expect all providers to undertake robust quality impact assessments (QIAs) and equalities and health inequalities impact assessments (EHIAs) to inform decision making. In addition to a strategic focus on quality, we expect all providers to comply with a core set of quality standards, including recommendations from national reports (such as the Thirlwell Report), as part of business as usual:

The ICB quality and commissioning / contracts teams will regularly assess the performance of commissioned services for quality as part of driving improved population health and maximising healthcare value. Where quality metrics for a service are not within the acceptable range, the ICB will expect an improvement plan to be in place. Persistent failure to deliver the necessary improvements may result in the ICB using contractual levers to drive improvement.

Modern service frameworks

Alongside local strategy and clinical leadership, commissioning intentions will continue to evolve as national Modern Service Frameworks are published. These frameworks will provide evidence based descriptions of best practice, expected outcomes, clinical standards and service models across major service areas including neighbourhood health, elective care, urgent and emergency care, mental health, cancer, cardiovascular disease, maternity, children and young people's services, frailty and long-term conditions.

As these frameworks are released (CVD and Sepsis published to date), SWL will work with providers to incorporate their requirements through service specifications, contract variations, outcomes measures and quality standards. This will ensure that local services remain aligned to emerging national evidence, policy and best practice while maintaining a strong focus on population need and local priorities.



The image above sets out the key areas of commissioning from a quality perspective that will be reflected in our commissioning intentions.

Spotlight on key transformation initiatives: Babies and CYP hub

NHS South West London



1. Babies, Children and Young People

Commissioning of babies and children and young people's integrated neighbourhood teams to provide joined up, proactive and family centred care closer to home.

There are 351,000 children and young people within SW London, with **increasing levels of need and demand** – total CYP contacts have increased by 11% since 2019/20. Their underlying health has been deteriorating, there is rising emergency service utilisation, fragmented community provision and widening health inequalities.

National policy provides a clear mandate for neighbourhood based multidisciplinary teams for CYP through the NHS 10-Year Plan and the Neighbourhood health framework, which includes a required 10% reduction to CYP outpatient appointments by March 2029. SWL analysis reinforces this direction, identifying **significant gaps in integrated paediatric support, variation in local offer, and a need for scalable, sustainable approaches**, with the established SWL clinics providing a strong local proof of concept.

Our proposed model is designed to:

	Support the **physical, mental and social needs of children**, young people and their families within SW London
	**Shift activity and resource from acute to neighbourhood settings**
	Standardise **best-value models that deliver the best outcomes** across boroughs
	**Target inequality** through focused proactive Core20Plus5 case-finding

Phase 1 will focus on children's physical health, with a clinical MDT comprising a GP, general paediatrician and psychologist, with planned expansion to include mental health and learning disabilities services in Phase 2, and social care services in Phase 3 through partnership with Best Start in Life hubs. Places will design the model to suit the needs of their population, and will target their BCYP population most at need.

The **expected ROI is +0.2 times over five years**, with all years having a positive net benefit. Benefits have been estimated based on expected reduction in outpatient appointments, including follow up appointments. Additional benefits include **reduced ED attendances and non-elective admissions, improved school attendance, strengthened referral pathways for complex children, and improved workforce efficiency**.

Spotlight on key transformation initiatives: cardiovascular-renal-metabolic

NHS South West London

4. Cardiovascular, Renal and Metabolic Care

Commission multi-disciplinary community care for people with cardiovascular, renal and metabolic conditions including implementing the CVD Modern Service Framework.

A three tiered integrated cardiovascular-renal-metabolic (CRM) model of care to **improve population health outcomes and maximise clinical efficiency** allowing for early detection, appropriate monitoring and optimal early management of CRM disease to both prevent progression and optimise care. The model supports a left shift from reactive specialist care to proactive population health management, reducing avoidable disease progression and demand on acute and specialist services.

Tier 0: Prevention
(Stage 0-1 CRM)

- Focuses on the general population and individuals at risk of CRM disease.
- Public health targeted approaches in the community, working with community pharmacy, community and VCSE
- Self-management.
- Emphasis on prevention, early risk identification, and population health interventions before long-term conditions develop or CRM related conditions progress.

Tier 1: Proactive management in primary care
(Stage 1-2 CRM)

- A consistent approach to allow **earlier identification, timely monitoring and optimised management** of patients with CKD (+/- Qrisk > 20% / SGLT2i in HF).
- CKD is often a marker of wider CRM risk providing the opportunity to identify and address associated risks, including hypertension, diabetes, CVD and metabolic factors.

Tier 2: Neighbourhood CRM MDT
(Stage 2-3 CRM)

- **Neighbourhood MDT offer for higher complexity** patients with CKD, diabetes and/or hypertension.
- Early optimisation of medications in context of underlying complexity,
- MDT case discussion as well as care planning and primary care education.
- Interface between primary care, community HF & DM services and secondary care.

Tier 3: Specialist MDT clinics
(Stage 4 CRM)

- Most complex patients with CKD, diabetes and heart failure reviewed in **specialist MDT clinic with 3 consultants:** cardiologist, endocrinologist, nephrologist.
- Advanced diagnostics and interventions for inpatient and outpatient specialist care.

Tier 4: Advanced specialist care
(Stage 5 CRM)

- Acute decompensation of CRM health as well as those with end stage disease.
- Also, pathway redesign for Structured Titration and Rapid Treatment for Heart Failure

Outcomes

Improved clinical outcomes - reduced complication rates, heart attacks, strokes, dialysis, foot amputations

Reduced health inequalities – closing the gap in known inequalities in CRM

Improved financial sustainability

Next steps to prioritise business cases

NHS South West London

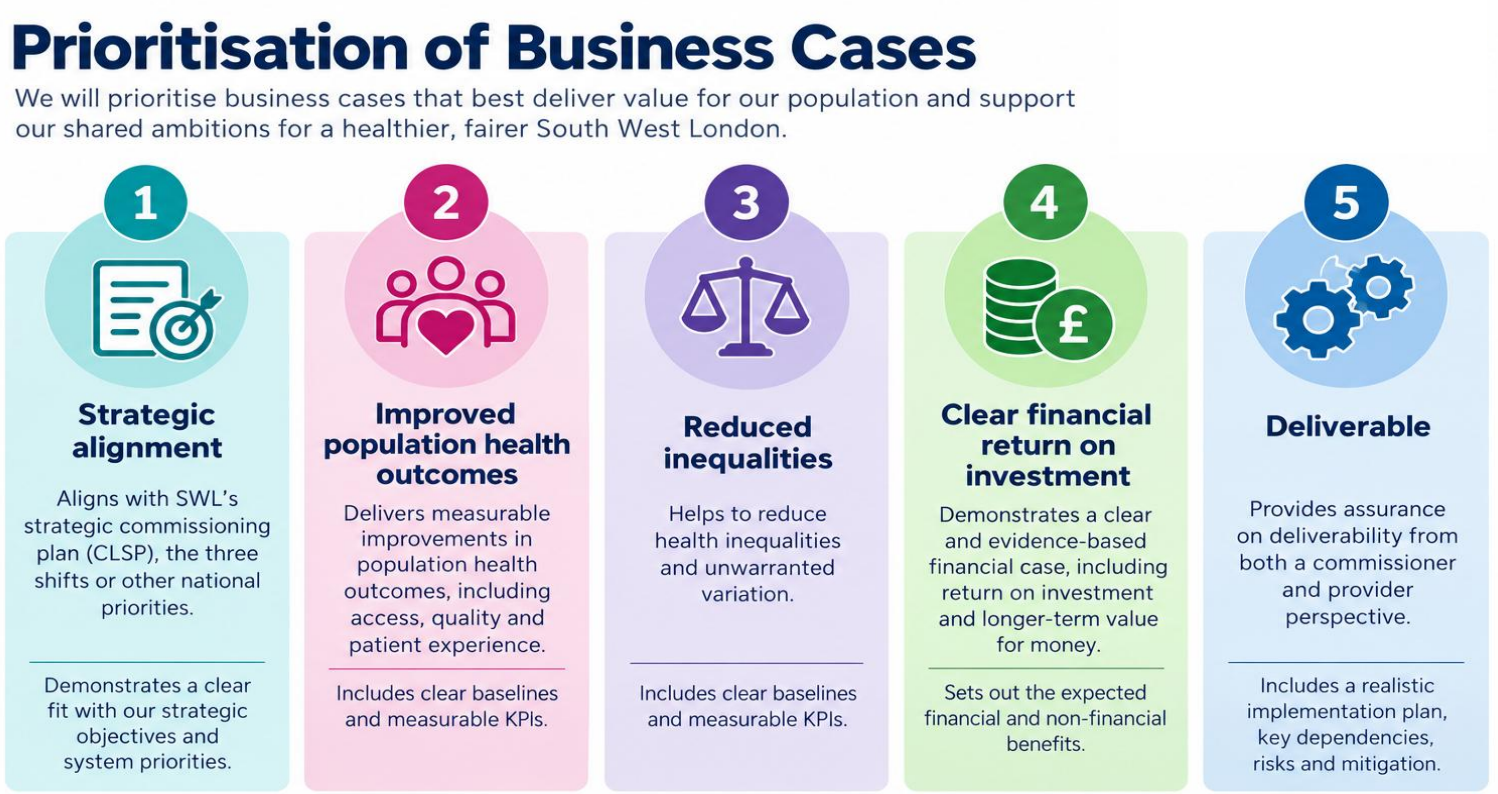


Image sets out areas on which SWL ICB will prioritise investment: alignment with strategy, improved population health outcomes, reduced inequalities, clear financial return on investment and deliverability.

- As set out in the Medium Term Financial Strategy document, we will maintain affordability by prioritising investment within available financial envelopes, improving productivity across existing services and testing whether investments deliver their expected benefits.
- Work is ongoing to finalise our business cases and to test affordability within the Strategic Investment Fund envelope, this will need to be tested as work up continues over Q3.. Through this process we will ensure interventions are strategically aligned to the five year strategic commissioning plan, deliver a clear improvement in population health outcomes, reduce inequalities, are deliverable and that there is clear return on investment. As part of this process, the ICB will also be reviewing wider performance investment that may be required as well as reviewing other commissioning and provider intentions that sit outside the main priorities.
- SWL ICB's Strategic Commissioning Committee will discuss and review the proposed areas for strategic investment at its next meeting before being shared with the SWL ICB Board to sign off. Expectation that business cases will then be agreed, in line with SWL governance, to be reflected in contracts in 2027/28.

NHS South West London
Integrated Care Board

Committee report – Audit, Risk and Assurance Committee

Agenda item: 3.2

Executive Lead: Dinah McLannahan, Chief Finance and Compliance Officer

Report by: Bob Alexander OBE, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Audit, Risk and Assurance Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the discussions and assurance received by the Audit, Risk and Assurance Committee and the outcomes set out in section 5, including the approval of the contract extensions, endorsement of the SoRD changes (presented to Board in the governance update paper), and acceptance of the Committee Terms of Reference.

2. Background and context

Since the last meeting of the Board on 15 July 2026, the Audit, Risk and Assurance Committee (ARAC) has met once. This was the first meeting of the Committee with its revised remit determined in the Terms of Reference agreed by the Board in July.

Membership comprises three non-executive members, with standing attendance from the Chief Finance and Compliance Officer (CFCO), Director of Corporate Affairs, and representatives from our partner audit agencies Grant Thornton (external audit) and RSM UK (internal audit and counter fraud).

3. Activity undertaken

The October 2026 meeting covered the following items:

Future planning and response to the new governance arrangements
Members discussed the contents of the revised Terms of Reference for the Committee and acknowledged their responsibilities within it.

Discussion took place on proposals for the future risk management framework, noting work was planned with the Board to agree a risk appetite statement, ensure risks were linked with corporate objectives, and to ensure the framework supported the Board in giving its focus to the principal risks genuinely requiring Board attention. Members supported the development of a common risk management framework whilst noting that statutory accountability for risk would remain with each individual ICB. Simplicity was considered important and the members underlined the need to actively manage existing risks whilst the new framework was developed.

An update was received on the plan to review and revise the ICB's Freedom to Speak Up (FTSU) arrangements to maintain FTSU visibility whilst providing proportionate support to staff.

Partner reports
Reports were received from external and internal audit partners. Both partners confirmed their audit workplans were on schedule.

Grant Thornton confirmed the 2025/26 Audit Certificate was outstanding, pending confirmation from the National Audit Office that its Whole of Government Accounts work had been completed. This was outside the ICBs control and affected NHS organisations nationally.

Internal audit confirmed the outcome of completed audits, including the non-acute contracting review and leavers process, noting partial assurance on the latter which required committee scrutiny. Areas for management action that were identified to resolve the partial assurance included updating leaver guidance, to clarify timelines and review arrangements, reconciliation of Electronic Staff Record (ESR) records to contractual documentation, and considering creation of a formal forum to oversee the end-to-end user process. Work was confirmed as already underway to strengthen the process. Planned audits were progressing and the members supported greater alignment of SWL and SEL internal audit activity where shared processes and systems were in place.

The counter fraud report covered proactive reviews, fraud risks, benchmarking, with the members discussing cyber-fraud threats and seeking management assurance over the appropriate use of single tender waivers. Management confirmed improved reporting arrangements provided greater transparency over individual waivers and their justification.

Governance and assurance
The Chief Finance and Compliance Officer (CFCO) presented proposed further amendments to the Scheme of Reservation and Delegation (SoRD), distinguishing these from the version approved by the Board in July 2026. The amendments were described as largely legislative or clarificatory. The Committee agreed escalation to the Board for final approval. The version for approval is included as part of the Governance Report presented to Board.

The Committee received the financial governance report, recognising the achievements of the finance team to meet its Key Performance Indicator targets and reporting any write offs, special payments, bad debts and tender waivers. The members welcomed the increased transparency and assurance the report would provide to the Committee.

Chair: Richard Douglas CB CEO: Andrew Bland

Finally, an update was delivered on the findings from two recently undertaken IT exercises to test the response of staff to potentially fraudulent activity. Members supported a more co-ordinated approach across ICB teams to increase staff awareness.

4. Part 2 meeting (Auditor Panel)

A part 2 meeting of the Committee, which excluded external partners, discussed a proposal to extend the Grant Thornton contract to make the audit contracts co-terminus across both SEL and SWL. This was agreed. It was confirmed that the members, acting in their capacity as Auditor Panel, had authority to approve the appointment of the auditors for the extension period, as per the current Scheme of Reservation and Delegation, without the need for onward referral to Board.

5. Decisions and Outcomes

The following outcomes were agreed by the Committee within their own scope of responsibility:

- Committee responsibilities as laid out in the Terms of Reference were **noted and accepted.**
- The proposed risk management operating model and approach to exploring risk appetite was **endorsed.**
- Amendments to the Scheme of Reservation and Delegation were **noted and agreed** for escalation to the Board for final approval.
- A contract extension for Grant Thornton was **approved** by the Committee members, acting as the Auditor Panel, in order to line contract termination dates with other audit providers and between SEL and SWL.

Decisions made by the Committee were within the scope of its delegated authority stated in the Scheme of Reservation and Delegation.

NHS South West London
Integrated Care Board

Committee report – Patient Safety Committee

Agenda item: 3.3

Executive Lead: Elaine Clancy, Chief Nursing and Quality Officer

Report by: Dr Masood Ahmed, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Patient Safety Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the items of discussion
- **Note** the outcomes of the discussions by the Committee members.

2. Background and context

Since the last meeting of the Board on 15 July 2026, the Patient Safety Committee (PSC) has met once. This was the first meeting of the Committee since its Terms of Reference were agreed by the Board at its July meeting.

Membership comprises two non-executive members, the ICB Chief Nursing and Quality Officer, and the ICB Medical Director, with standing attendance by the Deputy Chief Nurse and Director of Quality.

3. Activity undertaken

The October 2026 meeting covered the following items:

Future planning and response to the new governance arrangements
The Committee Chair reflected on the experience and expertise of the new leadership structure and recognised the stronger assurance focus under the new governance arrangements.

Terms of Reference were discussed with concerns raised about whether the membership provided the breadth of expertise required to provide comprehensive assurance to the Board. In particular, consideration was given to ensuring appropriate representation from quality and safety and medicines optimisation. The Terms of Reference were adopted with a note that further amendments may be required as arrangements mature.

Annual reports

The Committee received two annual reports:

- Learning from Lives and Deaths of people with Learning Disabilities and Autism Annual Report, which noted that SWL had been an early adopter of the learning from Lives and Deaths of people with Learning Disabilities and Autism (LeDeR) programme and provided assurance that the quality of care was rated highly in the majority of completed reviews. The Committee discussion focused on ensuring learning identified through individual reviews was translated into wider system improvement.
- Safeguarding Adults, Children and Children Looked After Annual Report, noting the increased significance of safeguarding assurance following publication of the Thirlwall Inquiry report and the need to ensure safeguarding was embedded as a core responsibility across the organisation. Assurance on governance arrangements, workforce capacity and statutory responsibilities was discussed, alongside impact of organisational change and the need to avoid overly focusing on compliance metrics to the detriment of competence and awareness assurance.

Quality and Safety report

The Quality and Safety report provided updates on infection prevention and control, especially seasonal risks from respiratory infections and responses to national maternity safety requirements, winter pressure risks and the need for ongoing oversight, and use of patient experience, complaints and staff concerns to inform the Committee's work, supporting the adoption of a proactive, multidisciplinary approach to complex complaints. This would enable the identification and addressing of system-wide concerns.

4. Decisions and Outcomes

The following outcomes were agreed by the Committee within their own scope of responsibility:

- Committee responsibilities as laid out in the Terms of Reference were **noted and accepted.**

NHS South West London
Integrated Care Board

Committee report – Neighbourhood Strategic Delivery Committee

Agenda item: 3.4

Executive Lead: Ed Waller, Chief Commissioning Officer

Report by: Jamal Butt, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Neighbourhood Strategic Delivery Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the activity of the Committee at its first meeting.

2. Background and context

Since the last meeting of the Board on 15 July 2026, the Neighbourhoods Strategic Delivery Committee (NSDC) has met once. This was the first meeting of the Committee with the new membership and remit determined in the Terms of Reference (ToR) agreed by the Board at its July meeting.

Membership comprises one non-executive member (as co-chair), a local authority representative (as co-chair), the ICB partner member for primary care, the ICB medical director, the Chief Commissioning Officer (proposed as an addition in revised ToR), Director of Neighbourhoods, and other colleagues representing strategic commissioning, public health, mental health, and the VCSE.

3. Activity undertaken

The November 2026 meeting covered the following items:

Future planning and response to the new governance arrangements
Committee members considered the Terms of Reference for the Committee and the scope of their responsibilities, noting their responsibility to provide strategic oversight and assurance in relation to neighbourhood working. The members discussed whether the proposed membership provided sufficiently broad system representation, including clinical leadership, public health, local authorities and the voluntary and community sector (VCSE). Although the Terms of Reference were noted, it was proposed membership and quoracy be reviewed, with the VCSE representation in particular progressed in advance of the next meeting. This review would be carried out in conjunction with the equivalent South East London arrangements to maintain alignment.

Programme development
The Committee received a briefing on the progress made in establishing the foundations of neighbourhood working across SWL, with a recognition focus should move from establishing structures and relationships to demonstrating delivery and measurable improvements. Emphasis was placed on the importance of ensuring consistency between stated priorities and the wider programme of work, and on delivering a whole-system approach. Clearer measures of success were required, including metrics around patient safety, clinical effectiveness, resident experience and improved population outcomes. A delivery dashboard was planned to be presented to the Committee at the next meeting, which would support further discussion on how to determine measures of success and evidence how interventions were delivering meaningful improvements.

Delivery reports and assurance
The Committee noted good progress on establishing neighbourhood arrangements within each Place in South West London. It was noted that significant commonality had been achieved in the priorities being progressed, whilst flexibility to address local population needs was maintained. The needs for different data to identify populations who would benefit from interventions, as well as to evaluate to success of those interventions, was considered.

The Committee noted the outcome of the national Neighbourhood Health assurance process run by Dr Claire Fuller and recognition of good practice within South West London. Recognising national expectations may evolve, it was agreed that SWL should maintain focus on locally agreed priorities while responding appropriately to future national requirements.

4. Decisions and Outcomes

The following outcomes were agreed by the Committee within their own scope of responsibility:

- Committee responsibilities as laid out in the Terms of Reference were **noted and accepted.**
- Progress with programme planning and delivery was noted.
- Outcomes of the national assurance process was noted.

Committee report – Joint Transition Committee

Agenda item: 3.5

Executive Lead:

Report by: Georgina Fekete, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Joint Transition Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the items discussed and actions agreed at the Committee

2. Background and context

Since the last meeting of the Board on 22 July 2026, the Joint Transition Committee (JTC) has met four times.

Membership comprises three non-executive directors, the ICB Chief Finance and Compliance Officer, and the ICB Chief People Officer, with standing attendance by the Director of Corporate Services as joint ICB change programme Senior Responsible Officer (SRO).

3. Activity undertaken

4 August 2026

The August meeting discussed the transfer of the Lewisham Neighbourhood team to Lewisham and Greenwich NHS Trust (LGT), staff appeals, and programme updates.

Key assurance issues to **note** were:

LGT transfer

- The report gave assurance on the timeline for transfer, the sign off process, and mitigation of risks.
- Agreement of KPIs and identification of a consistent documentation across transfers for integrators was discussed, and the Committee asked for some insight into the improvements or different ways of working that would evolve as a result of the new arrangements.

Staff Appeals

- The Committee received an update on the progress made to respond to and manage staff appeals, with assurance received that the outcomes indicated the process had been helpful in ensuring the right outcome for individuals.
- The SROs confirmed a lessons learned process had been adopted within this phase which identified consistency of policy, use of subject matter experts and impact of clustering as key themes.

Programme update and risks

- Progress against the programme plan was confirmed, with a request for risk scores to be reviewed.

1 September 2026

The Joint Transition Committee discussed the status of the change programmes which were reported as being on track, noting risks relating to the payroll provider and HR capacity that are being mitigated. The Committee discussed the transition plan and the learning review, including suggesting a dedicated Board lessons learned session on the change programme.

Key assurance issues to **note** were:

Programme update and risks

- SEL and SWL change programmes were reported as being on track, with ring-fenced interviews taking the place at the time of the Committee.
- The main risks outlined were: i) the risk of a gap in provision of payroll by NECS CSU which the Chief People Officers (CPOs) were working to mitigate; ii) shortage of HR capacity to manage the change programme - additional support has been secured for SWL and was under discussion for SEL and iii) a small number of grievances that were being reviewed.

Transition Plan

- A transition plan was shared focusing on the phased implementation of team structures, support to staff and knowledge capture.
- The Committee sought assurance on the legal and policy positions when staff are supervised by someone employed by the 'other ICB' and the importance of capturing historical workforce data before functions are transferred to Guys and St Thomas NHS Foundation Trust (GSTT).

Lessons Learned Review Process

- A proposal for capturing lessons learned during the change programme was shared, which will aim to understand stakeholder experiences, success factors, barriers, unintended consequences and put forward practical recommendations and a "playbook" for future change management programmes.
- The Committee welcomed a focus on learning, and sought clarification on the rollout, timing, qualitative data and suggested holding a Board lessons learned session.

29 September 2026

Committee members discussed transition of workforce data and received change programme and operating model design updates.

Key assurance issues to **note** were:

Programme update and risks

- Programme remained on track with ringfencing and transfer of functions processes commenced. Very Senior Manager (VSM) at risk business cases had been approved by NHSE and compulsory redundancy for Agenda for Change staff would be going to Remuneration Committees at the end of October.
- The risk for payroll provision was discussed, with assurance that mitigations were appropriate and residual risk sat with the previous provider.

Operating Model

- The Committee noted a third joint Board session was planned for 7 October 2026, with the approach that cluster first/ strategic commissioning would be at the centre of the organisation. It was expected to take at least 12 months to achieve a single IT approach.
- The Committee discussed the importance of landing decision making at the right level and achieving a cultural shift to achieve that.
- The Committee noted that engagement with Trade Unions was ongoing.
- No objections had been received from members concerning the estates transfer and therefore it was expected this would go ahead.

3 November 2026

The November meeting had a focus on the delegation of Lewisham neighbourhood development functions to Lewisham and Greenwich NHS Trust (LGT), plus the financial impact of the transition programme, as well as the usual programme update.

Key assurance issues to **advise** were:

LGT transfer

- The Committee received an update on the proposed delegation of budget and staff to LGT, acting as host integrator for Lewisham. Functions were noted as intending to transfer on 1 April 2027.
- Additional assurance was sought around capacity and performance risks, and arrangements for monitoring performance and intervening if delivery was not effective.
- Progression of the delegation was recommended, subject to some amendments and receipt of capacity evidence before referral to the Board for decision.

Key assurance issues to **note** were:

Financial review

- The committee received an update on the financial effect of the change programmes, noting sufficient non-recurrent mitigations for 2026/27 and assurance on funding. Work on establishment costs and comparison to the nationally mandated ICB running cost limit was ongoing.

Programme update and risks

- The Committee received confirmation that an equalities impact assessment had found no evidence of systemic disproportionate impact or unlawful discrimination associated with protected characteristics on the workforce across the change programmes. Continuing monitoring was

requested with further analysis and assurance on reasonable adjustments and support provided to disabled staff.

- The Committee received programme and HR updates, confirming the programme was progressing on timetable with compulsory redundancy business cases submitted to NHS England for approval and outplacement and colleague-support arrangements in place. Mitigations for any approval delays were in place. Comparative sickness absence data, pre and post change, was requested.

NHS South West London
Integrated Care Board

Committee report – Remuneration Committee

Agenda item: 3.6

Executive Lead: Dinah McLannahan, Chief Finance and Compliance Officer

Report by: Jamal Butt, Committee Chair

Paper type: Information

Conflicts of Interest: None identified

1. Purpose and recommendation

The purpose of this report is to provide to the Board an update on the activity of the Remuneration Committee, including decisions made, since the last Board meeting.

The Board is asked to:

- **Note** the items of discussion
- **Note** the decisions made by the Committee as listed in sections 3 and 4 of this report.

2. Background and context

At the last Board meeting held in public on 15 July 2026, the Board approved refreshed terms of reference for the Committee, effective from 1 October 2026. No significant changes have been made from the previous terms of reference for the NHS South West London ICB remuneration committee.

Since this meeting, the remuneration committee has met twice as detailed below.

3. Activity undertaken

The Remuneration Committee met on two occasions in the period:

- 1 September 2026 – at this meeting the Committee approved two compulsory redundancy payments relating to two VSM posts that were due to be deleted from the organisational structure.
- 27 October 2026 – approval of redundancy payments submission to NHS England for final approval, relating to compulsory redundancy of individuals whose roles were substantively

deleted as part of the ICB organisational change programme.

4. Decisions and Outcomes

Under its delegated authority stated in the Scheme of Reservation and Delegation, the Committee approved the payments requested above.

NHS South West London
Integrated Care Board

SWL Medium Term Financial Strategy

Agenda item: 4

Executive Lead: Dinah McLannahan, Chief Finance and Compliance Officer

Report by: Joanna Watson, Director of Strategic Finance

Paper type: Approval

Conflicts of Interest: None identified

No specific conflict is identified. Conflicts arising from individual investment, commissioning or contracting decisions will be declared and managed through relevant governance.

1. Purpose and recommendation

The South West London Medium Term Financial Strategy (MTFS) provides the financial framework for the Clinically Led Strategic Plan (CLSP) and the 10-Year Health Plan's three shifts. It sets the direction for resource allocation, strategic investment, commissioning and payment reform to improve population health, reduce inequalities and achieve financial sustainability.

The MTFS informs planning from 2027/28 onwards. Individual investments, budgets, contracts, service changes and transfers of financial responsibility require separate approval through commissioning, business-case, annual planning and governance processes.

The Board is asked to:

- Approve the MTFS and endorse its strategic direction and allocative principles

2. Background and context

The CLSP identifies a £1.5bn sustainability challenge over the next decade, driven mainly by population growth, ageing, increasing need and costs exceeding funding growth. Efficiency alone is insufficient. The ICB and providers must each achieve statutory financial breakeven; investment in new models must accompany recurrent efficiencies and organisational financial recovery.

The MTFS supports strategic commissioning rather than perpetuating historic spending. It targets prevention, neighbourhood and community care, including the voluntary, community and social enterprise sector, mental health, long-term condition management in primary care, prescribing and digital transformation, while maintaining safe acute services.

The Strategic Investment Fund (SIF) uses allocation growth and running-cost savings. SWL's indicative 2027/28 envelope is £53m, subject to national guidance and commissioning intentions. Staged business

cases will assess strategic fit, outcomes, Core20Plus5 and inequalities, value, financial impact, affordability, deliverability and scalability.
Alternatives often require investment before existing costs reduce. Resource shifts must reflect replacement services' readiness and effectiveness, providers' ability to remove costs and affordable double-running, transition and stranded costs.

3. Analysis and evidence

Without different care models, demand across primary, community, mental health and acute services will outgrow resources. The MTFS combines:

- protected SIF investment and growth directed towards priority care models;
- productivity improvements and reviews of duplication, unwarranted variation and lower-value expenditure; and
- block deconstruction, payment reform, risk/gain sharing, place and neighbourhood baselines, and benefits realisation.

Indicative modelling reduces acute services' share of ICB expenditure from approximately 48% to 43% by 2031/32, while providing core inflationary uplifts and operational funding. These are not approved budgets. Changes depend on national guidance, effective alternatives, removable provider costs and demonstrated benefits.

Benefits include outcomes, reduced inequalities, cost avoidance, released capacity and productivity - not necessarily immediate cash savings. Distinguishing these supports affordability assessment and avoids double counting.

4. Options and trade-offs

The strategic trade-offs can be summarised as follows:

Option	Advantages	Disadvantages / trade-offs
A. Continue historic funding patterns	Simple and provides short-term certainty.	Perpetuates existing models, fails to address the sustainability gap and leaves additional financial, workforce and estates capacity requirements unaffordable.
B. Immediate large-scale reallocation	Creates a faster visible shift in resources.	High risk of provider destabilisation, double-running and stranded costs; replacement capacity and cost removal may not be ready.
C. Managed strategic transition - recommended	Protects investment, links funding to evidence and allows alternatives to develop before larger resource shifts.	Change is slower and requires strong prioritisation, benefits tracking, transition management and sustained strategic discipline.

Option C balances timely change with safety, financial stability and affordability. Inaction prolongs lower-value spending and avoidable demand, leaving less time to address the sustainability challenge.

5. Implications, impacts and risks

- Quality and safety: phase changes following clinical and safety assessment; demonstrate replacement provision and safe transition before moving funding.

- Equalities and residents: allocate against weighted population need, unmet need and Core20Plus5. Evidence may justify differential investment between places. Assess equality and health-inequality impacts through business cases and service-change processes.
- Finance: assumptions do not authorise spending. Annual plans will test ICB and provider impacts of investment, efficiencies, block deconstruction, transition costs and funding changes.
- Workforce, estates and digital: assess clinical, commissioning, analytical, digital and estates capacity within programmes and the investment pipeline.

Principal risks and mitigations:

Risk	Mitigation
Strategic investment is diverted to short-term pressures.	Protect SIF funding for prevention, neighbourhood/community care and digital transformation; prioritise within available resources.
Benefits emerge later or do not create cash savings.	Use proportionate business cases, clear baselines and staged benefits reviews; distinguish cash savings from cost avoidance and released capacity.
Resource shifts destabilise providers.	Phase changes against demonstrated impact and removable costs. Agree organisational financial impacts, transition funding and risk/benefit sharing.
Information or delivery capacity is insufficient.	Strengthen population, pathway, place and cost intelligence, alongside clinical, commissioning, analytical, digital and estates capacity.
Better access may initially increase demand and spending by uncovering unmet need.	Plan for unmet need; monitor access, outcomes and beneficiaries so savings pressures neither discourage appropriate care nor widen inequalities.
Activity-based payments could reward hospital activity rather than the left shift.	Test national and local incentives against agreed delivery and outcomes, managing financial consequences for the ICB and providers.
National guidance changes key assumptions.	Refresh the MTFS and annual plans; adjust SIF size, prioritisation or phasing before creating unsupported recurrent commitments.

6. Engagement and approvals

Finance colleagues developed the MTFS from CLSP evidence, informed by wide clinical engagement. An earlier draft went to the August 2026 Board seminar and October's Strategic Commissioning Committee. It was shared for comment with the SWL CFOs group and System Sustainability Group, including key system leaders.

Development alongside 2027/28 commissioning intentions aligns assumptions, prioritisation and investment. Further work involves providers, Places, Host Organisations, Integration Partners and the voluntary and community sector. Individual proposals require appropriate clinical, resident, patient and stakeholder engagement and governance.

7. Next steps and oversight

Following approval, the MTFS will guide 2027/28 planning and commissioning. Subsequent planning rounds will update it for national guidance, allocations, delivery evidence and affordability. Implementation will focus on:

- confirming and protecting the SIF envelope through annual planning;
- applying the agreed prioritisation and proportionate business-case process;

Chair: Richard Douglas CB CEO: Andrew Bland

- maturing the CLSP pipeline and linking investment to accountable owners, milestones and outcomes;
- developing population, pathway, place and neighbourhood baselines and a single benefits-realisation approach;
- developing and testing payment, risk-share and provider-model options with partners; and
- monitoring the share and annual growth of expenditure by point of delivery, SIF deployment, benefits realised, priority-pathway demand against the CLSP counterfactual.

Commissioning and finance governance will oversee delivery, with Board reporting through planning, budget setting and MTFS updates. Without approval, 2027/28 assumptions, SIF arrangements and commissioning priorities require reconsideration.

8. Appendices and supporting information

South West London Medium Term Financial Strategy

NHS
South West London

Medium Term Financial Strategy

November 2026

National and Local Financial Context

From April 2026 the NHS entered a markedly different financial environment. A combination of the **10 Year Health Plan**, the **Medium-Term Planning Framework**, the **London Health Plan** and the 2026/27 **finance business rules** reset both the expectations of systems and the role of ICBs.

The 10 Year Health Plan sets the long-term direction for the NHS, aiming to move from a system focused on treating illness under pressure to one that delivers sustainable, preventative, and digitally enabled care. At its core, the plan recognised that:

- Demand, workforce pressures, and funding constraints are structural and enduring
- The NHS cannot meet future need by scaling the current model
- Fundamental redesign of care models was required

For the past five years, financial strategy has centred on **system-wide balance**, with flexibility to manage deficits collectively and an ability to manage capital investment via a single capital envelope. From 2026/27, this fundamentally changed.
Both ICBs and NHS providers are now required to **deliver financial breakeven as individual statutory bodies**, with performance assessed directly against organisational plans.

For ICBs, this means a step change in it's role, a move away from a system lens around finance to a shift towards proactive incentivisation of behaviours through strategic commissioning to improve the population's health.

In response to this our **clinically led strategic plan (CLSP),** establishes system-wide transformation, underpinned by the three 'left shifts' which are central to the 10 year health plan. These shifts will reshape how care is delivered and how resources are used in SWL:

- Move care out of acute hospitals into **neighbourhood, primary and community settings**, reducing avoidable admissions and treating people closer to home.

From hospital to community

- Use **data, technology and digital tools** to improve productivity, standardise care and enable more efficient, accessible services.

From analogue to digital

- Shift focus from treating illness to **preventing it earlier**, tackling risk factors and reducing long-term demand on services.

From treatment to prevention

Purpose and scope of the MTFS

The MTFS translates the CLSP into a medium-term financial direction; annual plans then convert that direction into funded delivery.

Purpose of our MTFS

South West London ICB's Medium Term Financial Strategy is the financial framework for delivery of the CLSP. It sets out how we intend to use our resources to improve population health, reduce inequalities and achieve financial sustainability. It provides the financial direction for delivering our strategic commissioning priorities, guiding how we allocate resources, prioritise investment and make decisions about the services we commission. Our approach combines continued improvements in productivity and efficiency with **investment in prevention, care closer to home and digital development**.

The CLSP shows us that without a different model of care, population need, activity and cost will grow faster than resources available; demand will increase across primary care, community, mental health and acute services, creating additional capacity requirements throughout the system. It estimates a financial sustainability challenge of around **£1.5bn over the next decade**, the majority of which is driven by future demographic growth, increasing health need and cost pressures above expected funding growth, rather than the current underlying deficit alone.

We also recognise that we do not yet have all the answers about how best to deliver these changes. The MTFS therefore identifies areas where we will need to develop and test different approaches with partners, particularly around provider arrangements, budget responsibilities and payment mechanisms. We will use the evidence and experience from this work to inform future decisions.

How the MTFS will be used

The MTFS provides the framework for our financial and commissioning decisions over the medium term, recognising that changes to services and the allocation of resources will need to be developed and implemented over several years. Detailed plans will be developed in line with our MTFS and agreed separately, following publication of national planning guidance and through the established approval processes.

What are we asking the SWL Board?

We are seeking approval of the MTFS and continued support for our established strategic direction and the approach to delivering it.

(The MTFS will inform our financial and commissioning plans for 2027/28 and beyond. It does not constitute approval of individual investments, budgets, contracts or changes in financial responsibilities, which will be considered separately.)

MTFS on a page

The strategy will change how SWL makes financial decisions: shifting away from perpetuating historic patterns of spend, towards targeted investment in the 3 shifts based on population need, Core20Plus5 and benefits realisation.

1. Create and protect the strategic investment fund (SIF)

Creation of a dedicated fund, derived from allocation growth and running cost savings for **investment and deployment in strategic objectives,** as identified by the CLSP, national and local priorities.

2. Prioritise investment through agreed framework

Investment decisions based on the **3 shifts** through the CLSP, population health outcomes, **health inequalities**, value for money, financial impact, deliverability and scalability

3. Shift resources over time

Growth **directed preferentially towards community services, long-term condition management in primary care, mental health and prescribing**, whilst maintaining safe acute services.

4. Build the financial architecture for strategic commissioning

Payment reform, block deconstruction, gain share, place/neighbourhood baselines and benefits realisation will all need further development to ensure the strategy is deliverable.

What are our aims and how will we deliver them?

The MTFS combines protected strategic investment with continued productivity and financial recovery, supported by three connected enablers. The strategy is implemented through our commissioning intensions and annual plan.

1. Our MTFS aims, approach and 3 key enablers

Our aims

Deliver the three strategic shifts
- From treatment to prevention.
- From hospital to community.
- From analogue to digital.

Improve outcomes and reduce inequalities
Improve population health, reduce inequalities and improve the quality and performance of services.

Achieve financial sustainability
Deliver year-on-year improvements in productivity and efficiency, alongside sustained improvements in the SWL system's underlying financial position.

Our medium-term approach

- We will continue to **improve productivity and efficiency** across existing services while **protecting investment** in prevention, care closer to home and digital development. Efficiency remains essential but cannot close the gap alone.
- Initially, we will use the **Strategic Investment Fund** to develop alternative models of care, alongside directing a greater proportion of funding growth towards our strategic priorities.
- **Investment is prioritised to slow progression into ill health and moderate demand**
- **Prevention and care closer to home will** develop alongside safe acute services
- **Value will include avoided future costs** and released capacity

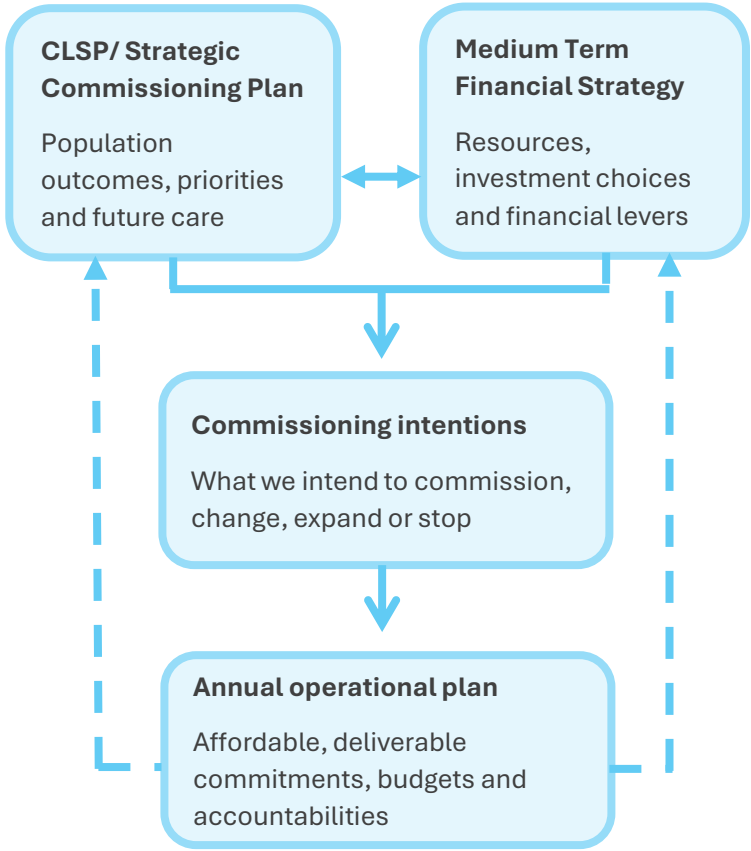
3 key enablers to support our objectives

Enabler 1. ICB Allocative Strategy
- Update our financial planning assumptions and approaches.
- Review growth funding and deconstructing-block adjustments.
- Protect investment through the Strategic Investment Fund and manage the financial consequences of changing services.

Enabler 2. Commissioning Approaches and Provider Models
- Strengthen how we prioritise investment, assess its value and evaluate the benefits delivered.
- Review existing expenditure to ensure effective use of resources.
- Develop and test neighbourhood and provider arrangements.

Enabler 3. Contract and Payment Approaches
- Develop contractual approaches that support our strategic priorities and financial sustainability.
- Review the implications of national payment arrangements and incentives for local services.
- Explore and test alternative payment approaches.

2. How strategies becomes delivery



Delivery evidence informs the next planning cycle

Enabler 1: Using our allocative strategy to achieve our goals

In SWL we will use our allocative strategy to support our strategic priorities, not just distribute annual growth. The over arching principle will be to enable increased investment into left shift priorities while reducing health inequalities.

The allocative approach will support and enable a different service model where funding will be directed towards models and pathways that better support prevention, integrated neighbourhood working and **improve health inequalities**. This is not about destabilising acute provision; it is about reshaping investment in a managed and strategic way. Acute services will continue to receive core inflationary uplifts and funding to meet operational requirements, for example elective recovery funding. However, **additional differential investment through our growth funding will increasingly be linked to left shift redesign and reducing health inequalities.**

We are proposing to adopt over arching **common resource allocation principles** across SWL and SEL, while allowing local decisions to reflect need, performance and existing commitments aligned to our **commissioning intentions and affordability**. A tiered approach is set out below:

National requirements and recovery funding
Apply national allocations, planning guidance and performance funding, including elective recovery and deconstructing blocks

Ringfenced commitments
Deploy mental health investment standard (MHIS) and other ringfenced funding within the national guidance, using discretion to align with our financial strategies

Evidenced BAU growth
Recognise population and incidence growth where the activity basis is clear, subject to opportunities for pathway transformation — including hospices, CHC, prescribing and ADHD.

Quality and safety priorities
Address material risks such as maternity through an explicit and transparent prioritisation process.

Strategic Investment Fund
support for prevention, neighbourhood services, digital and transformation against deliverable benefits and outcomes with close alignment to 10 Year Health Plan priorities

Our resource allocation will be supported by a proportionate, staged process to demonstrate **return on investments** to strengthen the connection between investment decisions and outcomes and to **support prioritisation**. This will be particularly key for the allocation of our Strategic Investment Funds, which are currently planned to total £45m in SEL and £53m in SWL in 2027/28 (this will be dependent on planning guidance and commissioning intentions).

Strategic Investment Fund and Financial Sustainability

The SIF turns the CLSP into strategic investment, supporting earlier intervention, care closer to home and a more sustainable pattern of demand.

Financial sustainability is a central objective of our MTFS. We face two related challenges. First, **noting all of our acute trusts are receiving deficit support in 2026/27** we need to **address the SWL system's underlying financial deficit,.** Second, demographic changes, including an ageing population and increasing numbers of people living with multiple long-term conditions, mean that **demand for services and the costs of providing care are expected to grow faster than the funding available**. We therefore need to improve the productivity and value of existing services while changing how we deliver care to meet future demand more effectively. This requires us to protect investment in our strategic priorities, alongside continued financial recovery.

Our approach brings together priorities to support financial recovery while investing in future care, as set out below:

1. **Protecting investment in our strategic priorities**
   Financial pressures have historically meant that short-term financial delivery has often taken precedence over investment in longer-term service change. Our SIF provides a means of protecting investment in prevention, neighbourhood care, digital development and acute & specialised service transformation. We need to maintain this investment while strengthening how we prioritise schemes and assess the benefits they deliver. These benefits may include better outcomes, reduced inequalities, improvements in productivity and avoided future costs, as well as cash-releasing savings.

2. **Continuing financial recovery across existing services**
   Investment in new models of care does not replace the need for organisations to improve productivity, deliver recurrent efficiencies and address the SWL system's underlying financial deficit. We also need to look critically at our existing expenditure, identifying opportunities to reduce duplication, improve services and change or stop spending that no longer represents the best use of our resources.

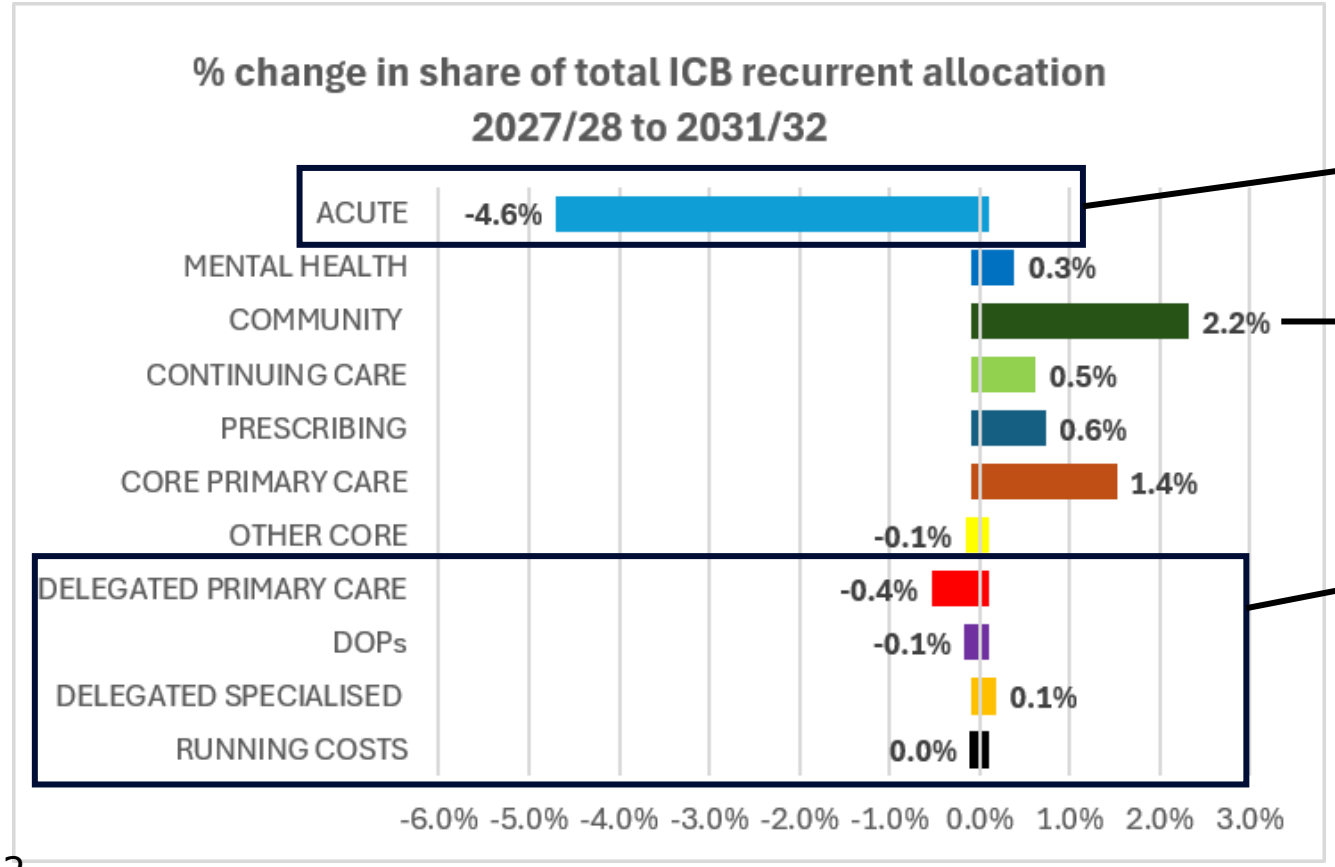
3. **Clarity on what we will expect to deliver**
   Investment in prevention and alternatives to hospital care should help us improve outcomes and moderate the growth in demand for more expensive services over time. However, we need to be clear about what we expect each investment to deliver, including the impact on demand, activity and costs across different services. Moving activity out of hospitals does not automatically release equivalent savings. We need to distinguish between avoiding future costs, releasing capacity and making actual reductions in expenditure that can be reinvested.

4. **Managing the transition within available resources**
   We will often need to invest in alternative services before existing hospital capacity and costs can be reduced. This may require periods of double-running, and some costs will take longer to remove than others. Our annual financial plans will therefore need to test the impact of investment, efficiency requirements and changes in resource allocation on the ICB and providers.

How will the strategy impact growth across SWL?

Over the next 5 years, more of our allocation will be directed toward the left shift priorities, which will result in acute spending falling as a share of total spend and an increase in areas such as community, mental health and long term conditions management in primary care.

The chart shows indicative change in share of total spend between 2027/28 and 2031/32. The numbers are inclusive of the strategic investment fund. **Figures are indicative and subject to change.**



Acute spend falls as a share of total spend, as strategic investment is made largely in community, mental health and primary care.

Our VCSE services are included within community

Delegated expenditure and running costs are assumed to grow in line with the corresponding allocation uplift.

Changing the balance of expenditure:
The cumulative effect of changes in growth funding is a gradual shift in the distribution of our resources. Acute services currently account for approximately 48% of total ICB expenditure. Under our indicative modelled assumptions, this reduces to around 43% by 2031/32. **Over time more of our funding will be spent delivering the left shift, and therefore areas such as; community services (including VCSE), mental health and primary care are expected to grow.**

Enabler 2: Commissioning approaches and provider models

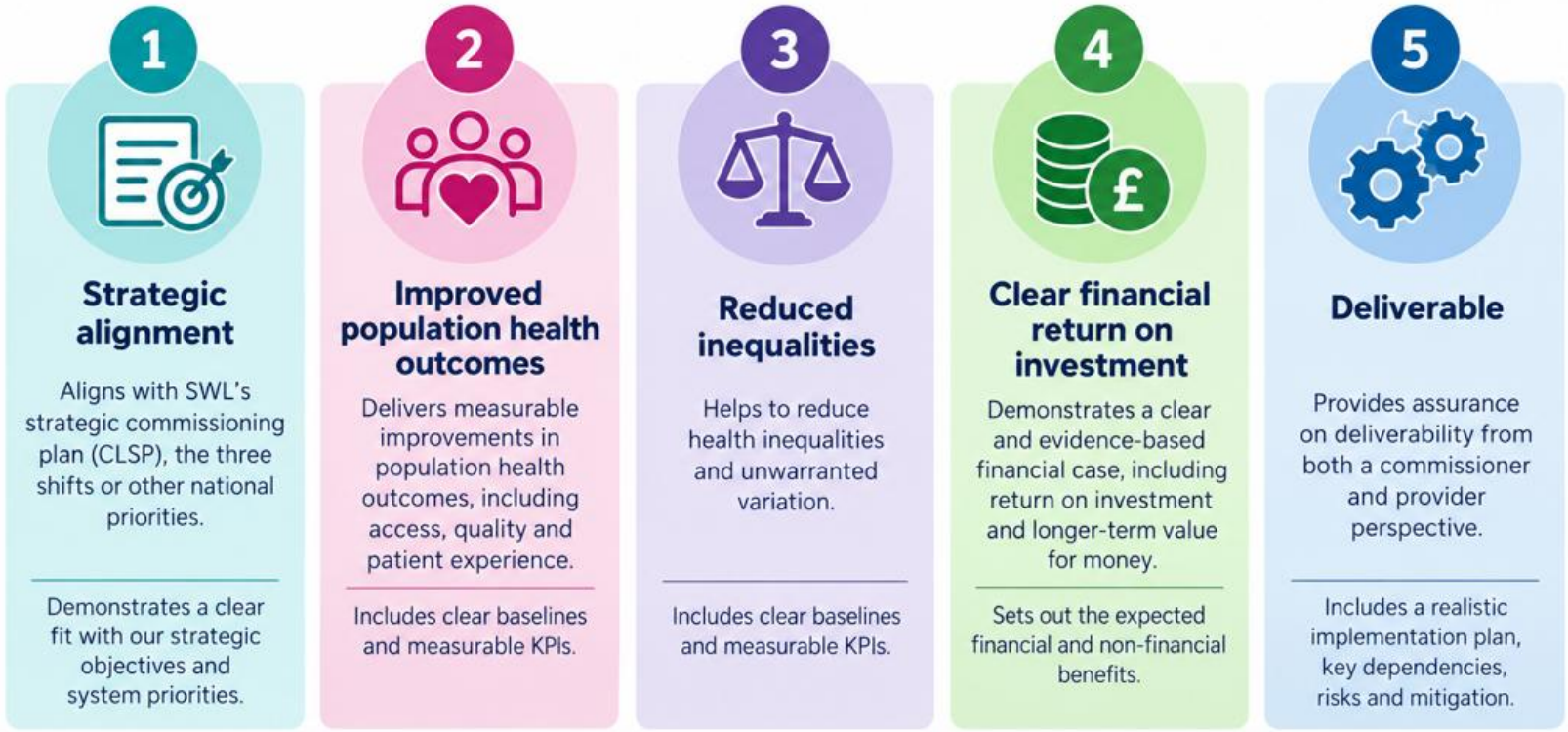
Stronger strategic commissioning will ensure that new investment and existing expenditure deliver better outcomes, reduce inequalities and demonstrate value

We will maintain affordability by prioritising investment within available financial envelopes, improving productivity across existing services and testing whether investments deliver their expected benefits. In particular we will focus on:

- **Prioritisation:** approve schemes within the available envelope through proportionate business cases and governance, allowing for recurrent commitments and transition costs.
- **Productivity:** improve the value of existing spending, reduce duplication and review lower-value provision. Including reviewing existing expenditure.
- **Return on investment:** assess outcomes, inequalities, productivity and financial benefits against what would happen without investment. Count cash savings only where expenditure can genuinely reduce.

We will prioritise investments that best deliver value for our population and support shared ambitions for a healthier South West London; funding will be linked to population health data sets, **with targeted approaches for our core 20 population**. Investments targeting our core 20 population in this way will mean differential borough investment.

The prioritsation process will help us to decide which business cases will be funded and the size of the funding:



How we will measure delivery and outcomes

We will assess each investment against the financial and non-financial value it is expected to create, compared with its cost and what would otherwise have happened. This can be linked to broader health outcomes as set out in our Strategic Outcomes Framework. Every investment must demonstrate measurable value—but benefits should only be monetised where this can be done credibly. This will broaden the assessment of value beyond immediate cash-releasing savings and will provide a consistent basis for comparing investments, tracking benefits and evidence will inform decisions to continue, adapt or stop investment.

Enabler 3: Contract and Payment Approaches

Contract and payment reform must support prevention and care closer to home, while managing transition risk and maintaining provider stability

National payment arrangements are evolving, and we will need to consider how these changes affect our existing approach.

We will also need to consider our options regarding **contractual form and approaches to their agreement** to ensure that these; most closely incentivise performance delivery, agreement of contracts, facilitate left shifts and the development of integrator functions, our ability to ringfence our Strategic Investment Funds and the delivery of financial balance. Given our respective financial positions and history, this may require differences in approach across providers and/or the two ICBs.

1. **Retaining the benefits of our existing approach**
   Our majority block contracts have supported collaborative working and the management of financial risk across the system. They have provided greater certainty about provider income, helped us manage the financial implications of major operational changes. As national payment arrangements change, we need to consider how we retain these benefits while ensuring that our contracts continue to support operational performance, productivity and improvements in outcomes.

2. **Aligning payment incentives with our strategic priorities**
   Payment arrangements can influence how organisations respond to changes in demand and activity. Greater use of activity-based payments may help support operational priorities but can also create incentives to increase hospital activity and income when our strategy is seeking to provide more care in community settings. We therefore need to understand how different payment approaches can support our strategic priorities as new provider arrangements develop. This may include exploring payments covering whole pathways or defined populations, alongside incentives linked to delivery and outcomes.

3. **Managing the financial consequences of change**
   Changes to payment arrangements can have significant implications for providers' income and financial risk. Redirecting some away from hospital activity does not necessarily mean that providers can reduce their costs by an equivalent amount and benefits may emerge later or mainly as future cost avoidance. We will need to consider how changes in activity, income and costs are managed as alternative services develop. This will require agreement between partners.

4. **Developing and testing alternative approaches**
   We do not yet have all the answers about which payment arrangements will best support our strategic priorities. We therefore intend to work with partners to develop and test different approaches before making decisions about wider changes. One possibility is that we could use a defined CLSP population or pathway, such as frailty and end-of-life care, long-term conditions or serious mental illness, to test a shadow population budget across primary, community, mental health and acute services. This would allow Host Organisations, Integration Partners and the ICB to test shared outcomes, payment incentives and risk-sharing before changing actual funding or responsibilities.

Financial risks and dependencies

Delivery of the MTFS and the 2027/28 commissioning intentions depends on managing demand, transition costs and system financial risk within the available funding envelope.

Our plans offer opportunities to improve care and financial sustainability; however, delivery depends on managing the following financial risks and developing the information, capabilities and agreements needed to support change, alongside risks to manage as we test and deliver changes.

National guidance and allocations

Our plans are based on national 3-year allocation plans, beginning in 2026/27. Should guidance and allocations change significantly, we will need to rapidly agree changes to our plans accordingly, whilst maintaining our strategic direction.

Underlying financial recovery

SWL's deficit requires transformation and recurrent efficiencies while maintaining quality. Income may fall before costs reduce. We should test affordability, double-running and stranded costs, distinguish cash savings from cost avoidance and allow for smaller or later benefits, with review points to adapt investment without transferring deficits.

Payment reform and the left shift

Payment reform could reward hospital activity rather than care closer to home, undermining the left shift and population benefits. We need to test national and local incentives together to support agreed delivery and better outcomes, while managing the financial consequences for both the ICB and providers.

Information for commissioning

Gaps in linked spend, need, activity and outcomes data could weaken investment decisions and benefits tracking across cohorts, boroughs and neighbourhoods. Finance, contracting and reporting must meet information requirements and free strategic capacity without weakening controls.

Unmet need and inequalities

Better access and earlier identification may initially increase demand and spending by meeting previously unmet need. Plans must allow for this and monitor access, outcomes and who benefits, so pressure for savings does not discourage appropriate care or widen inequalities.

Agreement on resource changes

Partners may support the strategy but disagree on the budget and cost changes needed to deliver it. We will need agreement on the financial impacts for each organisation, transition funding and how to share benefits and risks across boundaries. Delays could defer savings or prolong double-running and other additional costs.

Capacity to deliver

Insufficient clinical workforce, estates, digital infrastructure or commissioning capability could slow the left shift, fragment delivery and undermine financial sustainability. A leaner ICB must retain capacity to prioritise investment, manage contracts, track benefits and support service redesign at pace.

Strategic investment diverted to short-term pressures

Short-term operational pressures could absorb growth intended for the Strategic Investment Fund, weakening the left shift and action on health inequalities. We must protect funding for prevention, neighbourhood and community care, and digital transformation.

Consequences of delaying change will need robust assessment including continued lower-value spending and unmet need, so short-term financial pressures do not repeatedly displace investment in prevention and longer-term improvement.

Conclusion – Delivering our Medium Term Financial Strategy

The MTFS provides SWL's financial route to deliver the NHS 10 year plan as articulated in our CLSP: protecting strategic investment, improving the value of existing spend and progressively shifting resources towards prevention, neighbourhood care and better population outcomes

The MTFS combines productivity and financial recovery with protected investment in prevention, neighbourhood and community care, mental health, primary care and digital transformation. Delivery must maintain safe services and strategic direction while managing the pace, sequencing and financial consequences of change.

Making the strategy work

The SIF will fund CLSP opportunities and models of care, prioritised by population need, inequalities, outcomes, value, affordability and deliverability. Resource shifts will follow demonstrated impact and providers' ability to adjust activity, capacity and costs.

The opportunity for SWL

By sustaining this direction over successive planning rounds, SWL can meet need earlier, reduce inequalities and moderate future growth in demand for higher-cost care. This will support better outcomes for residents, while maintaining safe services and recognising the financial stability of providers during transition. The central choice is not whether to change, but how SWL manages the pace, sequencing and financial consequences of change while holding to its long-term strategic direction.

Next steps for implementation

Several areas of further work are needed:

1. Development of population health baselines linking; spend, need, activity and outcomes by place, neighbourhood and disease group,
2. Strengthening of CLSP business cases,
3. Development ofmental health and community payment reform,
4. Assessment of estates, digital, workforce, clinical and commissioning capacity constraints,
5. Further development with providers, Places, Host Organisations and Integration Partners,
6. Testing of pathway and population-based commissioning, payment reform and risk or gain sharing, subject to evidence of benefit, affordability, provider impact, organisational readiness and national guidance,
7. Development of outcomes framework and delivery metrics

We are seeking the Board's approval for the MTFS and the strategic direction and principles within it.

NHS South West London
Integrated Care Board

Board Assurance Framework

Agenda item: 6

Executive Lead: Dinah McLannahan, Chief Finance and Compliance Officer

Report by: Kieran Swann, Deputy Director Risk and Assurance

Paper type: Information and discussion

Conflicts of Interest: No specific conflicts identified.

1. Purpose and recommendation

This paper presents the current South West London (SWL) Board Assurance Framework (BAF) for assurance and discussion. The SWL BAF remains in place and will continue to be reviewed and updated until it is formally superseded by a refreshed SWL BAF developed through the aligned risk approach across the South East London (SEL) and SWL ICB cluster.

The future risk operating model endorsed by Audit Risk and Assurance Committee (ARAC) in October 2026 provides the basis for this work. It aligns the approach to risk management while retaining a separate BAF and Board accountability for each ICB. In the meantime, the current SWL BAF continues to support Board oversight of principal risks, controls and gaps in assurance.

The Board is asked to:

- Note the current SWL BAF position which retains the same residual scoring and assurance assessment compared to the latest Board update in July 2026.
- Note that the current SWL BAF remains in use until formally superseded, with separate but aligned SEL and SWL BAFs targeted for April 2027 under the October-endorsed risk operating model, subject to the necessary approvals.

2. Background and context

Both SWL and SEL ARACs endorsed the future risk operating model on 27 October 2026. This provides for a common structure and methodology across SEL and SWL, supported by a shared risk function, while each ICB retains its own BAF, statutory accountability and Board oversight. Existing risk controls and reporting routes will continue during the transition.

All principal risks have been reviewed this cycle. The current BAF supports the ICB's objectives to develop a Clinically Led Strategic Plan (CLSP) and return to financial balance; redesign the ICB as a strategic commissioner; and prioritise delivery of the annual operating and financial plan and oversight of performance, quality and safety.

Since the July BAF, the updated BAF001 controls reflect the established System Sustainability Group (SSG) and agreed CLSP delivery mandates, with Finance & Planning Committee references removed from this risk. The Medium-Term Financial Strategy has been updated and is due for Board approval in

November 2026. The BAF008 system quality oversight risk owner has been updated to Elaine Clancy; other reported risk scores remain unchanged.

BAF010 (organisational transition) was closed in September 2026 following the substantive conclusion of the transition programme, with emerging risks to be managed through the Joint Transition Committee and ICB risk registers.

3. Implications, impacts and risks

All principal risks have a medium assurance rating: controls and assurance are in place across the three lines of defence, but some oversight arrangements continue to develop. Key areas remain urgent and emergency care, contractual delivery, system quality and safety, financial sustainability, cyber resilience and estates.

This paper is an assurance update and does not itself propose changes to services, expenditure or staffing. It therefore has no direct financial, resource, workforce, quality and safety, safeguarding, equality or health inequalities, legal or sustainability implications.

An equality impact assessment is not required for this update. These implications are distinct from the underlying risks recorded in the BAF, which remain subject to existing and planned controls.

4. Engagement and approvals

The Strategic Commissioning Committee reviewed relevant current risks on 23 October 2026.

The Audit and Risk Committee considered and endorsed the future risk operating model on 27 October 2026.

Patient and public engagement is not required for this assurance update.

5. Next steps and oversight

The Board is asked to note the current risks, controls and assurances, and the planned refresh.

The BAF refresh will be undertaken jointly with SEL ICB over Q3/4 2026/27 and will reflect the Boards' work on corporate objectives in November 2026. Initial changes are expected in January 2027 alongside a Board seminar on risk appetite. Separate but aligned BAFs are targeted for the April 2027 Board cycle, subject to revised objectives, testing and the necessary committee and Board approvals.

The refreshed SWL BAF will supersede the current framework only once approved; until then, the current BAF will continue to be maintained and reported through existing arrangements.

Progress and remaining assurance gaps on the current SWL BAF will be brought back through committee and Board reporting.

Appendices and supporting information

Appendix 1: BAF Risk Reporting – Board – November 2026 (supporting report).

Chair: Richard Douglas CB

CEO: Andrew Bland

Strategic Objective at Risk	Develop a clinically led Strategic Plan: We will develop, and start to implement, a clinically-led Strategic Plan which will meet the needs of our populations and return the system to financial balance
Strategic Objective at Risk	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
Risk Title	**Failure of the ICB to discharge its strategic responsibility to oversee and secure a financially sustainable health and care system – BAF 001**
Managing Oversight / Reporting Committee	Audit & Risk Committee
Executive Risk Lead	Dinah McLannahan
Next Review Date	31/12/2026

Residual Risk Score

20

Level of Assurance

Medium

Risk Statement	Controls In Place	Controls in Development
There is a risk that the ICB is unable to ensure that the system operates within available resources to deliver the left shift through a credible medium-term financial plan. **Causes** • Demand and acuity growth above planning assumptions (elective, urgent care, CHC, mental health & prescribing). • Insufficient productivity and efficiency delivery across providers and primary care. • Cost pressures from pay awards, drugs, estates, digital and PFI. • Fragmented decision-making and weak alignment of incentives across partners. • Insufficient grip over system cost drivers (agency,	• CLSP in place with "Do Something" model reflecting a financially sustainable position for the SWL system. • Comprehensive ICB planning and budget-setting process to prioritise resources appropriately, including an agreed savings programme to support delivery of financial balance while minimising running costs. • System Sustainability Group (SSG) established with agreed mandates to deliver the opportunities identified through the CLSP, supported by a governance framework. Its remit includes	• Further work required on CLSP financial model and assumptions to ensure alignment of the ICB's medium term financial plan with system provider partners • Benefits realisation and transformation impact not yet fully independently validated at system level. • Further development of resourcing and detailed delivery plans to implement the agreed SSG mandates and realise the CLSP opportunities. • Reliance on non-recurrent measures and slippage risk within elements of the savings programme. • Variable productivity and cost improvement delivery across system partners, with limited levers in primary care and social care interfaces. System wide working

length of stay, OOA placements) • Delays to transformation programmes and capital constraints. • Data quality and analytical capability insufficient to support system decisions. • Ongoing financial pressure across the system. • Significant change within ICB teams • Structural difficulty in releasing funding from acute provider baselines to enable timely investment in community and neighbourhood services, creating a risk that the left shift is not affordable in practice without destabilising provider financial positions or service delivery **Impacts** • A failure to address health inequalities and improve the health of our population. • System deficit and breach of NHS financial duties. • Regulatory escalation and loss of autonomy. • Reduced ability to invest in prevention and service transformation. • Cash flow pressures and increased borrowing. • Deterioration in access standards and quality of care. • Reputational damage with partners and the public. • Workforce instability and industrial relations risk. • Reduced flexibility to invest in priority areas. • Increased focus on short-term financial management. • Inability to deliver the required shift from hospital to community-based care at pace and scale, resulting in continued inefficiencies, unmet demand growth, and increased risk of financial and operational instability across acute providers.	oversight of transformative plans, benefits realisation, management of delivery risks and co-ordination of productivity improvement, urgent and emergency care cost reduction, and future service configuration within the financial envelope. • Monthly financial reporting to the SCC, with clear accountability through budget holders and Place leads, and the ICB Board reviewing the financial position and required mitigations at each meeting. • Quarterly NHSE assurance meetings and CFO participation in regional ICB forums to ensure local assumptions and approaches align with regional and national expectations. • Board seminars to oversee the wider service transformation required to deliver the savings programme and enable medium-term financial sustainability. • Work undertaken in response to NHSE planning letter to set out financial reforms required to support delivery of the NHS 10 year plan • Explicit recognition, through system financial strategy and engagement with NHSE, that delivery of the CLSP requires aligned payment mechanisms, benefit and risk share arrangements, and transitional protections to enable investment in community services without destabilising acute providers.	will work to address this. • Ongoing exposure to demand growth and acuity exceeding planning assumptions, particularly in urgent care and continuing healthcare – business cases from transformation fund should directly address this, with development and agreement of benefits and risk share approach across the system to ensure finance does not create disincentives to change. • Transformation fund business cases reaching the final stages of development, service specifications in development • Medium-Term Financial Strategy (MTFS), aligned to the CLSP, has been updated and is due for Board approval in November 2026. • SFIs and SORD refreshed to reflect new strategic commissioner responsibilities • Development of system-wide benefit and risk share approaches, as set out in the Jim Mackey response, to ensure that financial benefits from reduced activity or redesigned pathways are shared appropriately across the system and that transitional risks are managed. This includes alignment with payment reform and alternative contracting models to support delivery of the left shift while maintaining provider stability.

Sources of Assurance (Lines of Defence)

First Line (Management & Operations)	Second Line (Oversight)	Third Line (Internal Audit)	Gaps in Control & Assurance
• ICB and system partners operating within the agreed financial plan and savings programme, with named SROs for each workstream. • Monthly budget holder accountability meetings and recovery actions to manage run-rate. • System Financial Recovery Group driving in-year efficiency and productivity delivery across providers and Place. • Demand management controls (CHC, prescribing, UEC pathways) to mitigate cost growth. • Workforce controls including agency reduction and establishment management. **Evidence**: monthly finance reports, CIP trackers, workforce dashboards, CHC panels, recovery plans.	• System Sustainability Group oversight of delivery against the agreed CLSP mandates, associated financial opportunities, risks and mitigations, supported by its governance framework. • ICB Board review of financial position at each meeting and oversight of transformation impact. • Audit & Risk Committee oversight of this BAF risk, its controls and associated assurance gaps. • PMO assurance on benefits realisation and non-recurrent reliance. **Evidence**: SSG governance framework and agreed CLSP delivery mandates; committee minutes, deep dives, internal audit opinions, PMO assurance reports, risk registers.	• Internal audit reviews of financial governance, savings governance and budgetary control. **Evidence**: internal audit opinions.	• The SSG is established with agreed CLSP delivery mandates and a supporting governance framework. The effectiveness of these controls remains dependent on partner delivery and the strength of system levers. • Monthly monitoring and recovery structures are established, but delivery is focused on 2526 plan delivery and is exposed to demand volatility, productivity variation and reliance on non-recurrent actions. • The remaining assurance gap is evidence that the agreed SSG mandates translate into deliverable, resourced plans and realised CLSP benefits, aligned with all partners' financial and savings plans. Further assurance is required on recurrent efficiency delivery and management of system-wide cost drivers; establishment of governance alone does not demonstrate delivery.

Risk Score	Consequence	Likelihood	Score
Inherent Risk Score	5	4	20
Residual Risk Score	5	4	20
Target Risk Score	5	3	15
Risk Appetite			**TBA**

Risk Score Movement	No movement	**Last Review Date**	16/11/2026
Overall Level of Control Assurance		**Medium**	

Strategic Objective at Risk	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
Risk Title	**Urgent & Emergency Care – BAF 002**
Managing Oversight / Reporting Committee	**UEC Board**
Executive Risk Lead	Jonathan Bates
Next Review Date	30/11/2026

Residual Risk Score
20
Level of Assurance
Medium

Risk Statement	Controls In Place	Controls in Development
There is a risk that the ICS is unable to deliver a consistently safe, timely and/or affordable urgent and emergency care pathway which could lead to harm, poorer outcomes, delayed care and failure to meet national performance standards, undermining delivery of the 2025/26 Operating Plan. **Causes:** • Poorly designed, fragmented pathways with multiple handoffs and delays. • Poorly designed/ maintained estate footprints. • Flow constraints delaying discharge, causing ED crowding and ambulance delay. • Workforce fragility across the pathway. • System interdependencies and constrained capacity. • Rising and variable demand. • Demographic pressure (aging population, frailty	**Strategic Governance & Oversight** System-wide Urgent & Emergency Care (UEC) Board * and a dedicated Program Board providing strategic direction, accountability and formal oversight of delivery across SWL. Four Local Delivery Boards operating as place-based governance structures ensuring local issues are escalated rapidly and aligned to system priorities. Monthly performance triangulation between quality, workforce, finance and operational leads to maintaining a system view of risks. **Whole-Pathway Improvement Infrastructure** Two-year SWL UEC Improvement Plan (2024) focused on Access, Flow and Workforce led by three clinical SROs and two clinical leads providing clinical ownership and accountability for pathway redesign.	Current work is not yet yielding sufficient change, resulting in continued corridor care, 12-hour and ambulance delays. Further work is required to: **Establish a Systemwide UEC Safety Oversight Framework** • Define system-wide safety expectations for corridor care, ambulance handover delays and 12-hour breaches. • Set minimum assurance standards for mandatory provider reporting. • Use commissioning levers including contracts, quality schedules and incentives to drive compliance. **System-Level UEC Safety Intelligence Function**

and increasing complexity. • Seasonal surges (heat waves, respiratory illness, infection spikes. **Impact of the risk:** • Increased patient harm from long waits. • Poor performance against national standards. • Reduced psychological safety for staff impacting on productivity. • Damage to relationships and reduced trust. • Reputational damage, loss of public confidence. • Provider overspending.	**Performance Monitoring, Data & Insight** UEC dashboard in place tracking 4-hour performance, ambulance handovers, 12-hour DTA breaches, length of stay and mental health waits. Monthly reporting to the UEC Board, including ED demand profiles, bed occupancy and discharge timeliness. Regular deep dives into sites experiencing deteriorations, supported by the UEC Team. **Access** Integrated Care Co-ordination Hub pilot in place to support LAS crews with decision-making to reduce conveyances to ED, keeping more patients at home/in the community **Workforce Mitigations** Clinical network established to input into service planning and triangulate data. **Flow & Discharge Improvements** • Operationalisation of system-wide discharge improvement actions including daily multi-agency discharge events. • Mature system co-ordination centre (SCC) providing co-ordination across the ICS Standardised escalation models linking acute trust with community and social care partners. • Deployment of trusted assessor models to speed up discharge processes.	• Analyse population-level safety trends including deterioration, inequalities impacts and recurrent harms. • Ensure capacity within the ICB to independently review, challenge and interpret patient safety intelligence. **Use Contracts to Drive Safety Improvement** • Integrate UEC safety requirements into acute and mental health provider contracts. • Deploy contractual levers where sustained breaches occur. • Commission upstream pathways to reduce avoidable ED attendances and waits. • Commission improvements to capacity flow outside of hospital. • Enhance community urgent crisis response and virtual ward services. • Develop additional mental health crisis alternatives to ED attendance. **CLSP** • Work is required to align and prioritise the initial findings from the CLSP into the UEC work program.

Sources of Assurance (Lines of Defence)

First Line (Management & Operations)	Second Line (Oversight)	Third Line (Internal Audit)	Gaps in Control & Assurance
• Provider-level operational and clinical oversight and governance. • Local policies, SOPs, and standardised procedures. • Safety huddles, site visits, improvement events. • Local improvement programmes e.g. each acute trust has its own Flow Board.	• System Control Centre providing daily oversight and support of the system. • SWL UEC Board meets four-weekly, reviews performance and is a point of escalation for the system. • Local UEC Boards overseeing local performance and working collaboratively with partners to address issues impacting negatively on UEC services. • Monthly Integrated Board Report to the ICB Board that includes updates on UEC performance against the national targets.	• NHSE Regional & National oversight which includes formal tiering of trusts requiring support, support from (Get it Right First Time) GIRFT and improvement support from NHSE on specific programme priorities. • National, published reporting on performance against the national targets. • Collaborative working with Quality on specific areas e.g. harm and 12 hour waits in EDs. • Active participation in NHSE oversight and programme meetings and London UEC Board.	Although significant operational data exists on discharge activity, it is not presented in a commissioning-useful currency. Current reporting describes service usage but does not quantify the commissioned discharge capacity available (e.g., number of discharge packages or pathways purchased per day, or expected run-rate). This limits the ICB's ability to assess whether commissioned discharge services are sufficient, sustainable or delivering expected throughput, restricting system-level assurance on flow and discharge performance. Work is in progress to address and enable the UEC team to model.

Risk Score	Consequence	Likelihood	Score
Inherent Risk Score	5	5	25
Residual Risk Score	5	4	20
Target Risk Score	3	3	9
Risk Appetite			**TBA**

Risk Score Movement	**None**	**Last Review Date**	10/09/2026
Overall Level of Control Assurance		**Medium**	

Strategic Objective at Risk	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
Risk Title	**Oversight of contractual delivery (access, outcomes and constitutional standards) – BAF 003**
Managing Oversight / Reporting Committee	Quality Oversight Performance Committee (QPOC)
Executive Risk Lead	Jonathan Bates
Next Review Date	31/12/2026

Residual Risk Score

16

Level of Assurance

Medium

Risk Statement	Controls In Place	Controls in Development
There is a risk that the ICB's existing processes are insufficient to ensure comprehensive oversight / management of additional responsibilities, as a strategic commissioner; in particular, performance against contracts which will be more outcomes focused, in addition to national and Medium-Term plan priorities. This applies to all commissioned services, e.g. Primary Care, Integrated Care, Community, Mental Health, Acute, Specialised. **Impact of the risk:** • Increased patient harm from long waits. • Poor performance against national standards. • Reputational damage, loss of public confidence. • Provider overspending • Missing early warning signals of rising tide risks	• Quarterly ICB triangulation is undertaken through the identification of key risks, informed by finance, contracts, planning, quality, and oversight teams. • Focus meetings drawing on formalised delivery agreements with Place Based Systems, Cancer Alliance and Acute Provider Collaborative were established to coordinate priorities and identify emerging issues for management. • Senior Responsible Officers (SROs) attend Senior Management Team monthly. • ICB leads routinely attend system-wide Programme Board and sub-groups for oversight of performance delivery. • Assurance to the ICB board is via the Integrated Board Report for Performance, Quality Report, Operating Plan report. • Transformation Teams / Commissioners attend monthly Regional Transformation Programmes to	As we shift to strategic commissioning, the ICB is in the process of establishing a cycle of Quality-Performance meetings and Finance-Contracting-BI meetings with providers in order to manage performance against agreed contractual outcomes. A Multi-disciplinary Team (MDT) approach is required to build a comprehensive view across all priorities and articulate meaningful challenge around contractual performance. Work is underway to develop MDT working, aligned to the proposed structures set out in the ICB staff consultation. Work has also commenced to consider the recommendations from NHSE's "the insightful ICB Board" to ensure that we are optimising the use

• Inability to respond as strategic commissioner to emerging risks in a timely manner Addressing this risk is required under organisational objective 2 and mitigates risk to objective 3, delivery of our Medium-Term Plan.	assure NHSE and benefit from regulator and peer insight. • Senior COO Directorate representation at Elective, Outpatient, UEC, Diagnostic Transformation Boards and clinical networks. • From Q2 of 2025/26 the London Region took on greater responsibilities for Elective Performance Management under the Model Region Blueprint, leading to fortnightly meetings with the ICB and our Acute providers, to oversee elective national priorities.	information to spot early warning signs of quality, performance or financial issues across the system

Sources of Assurance (Lines of Defence)

First Line (Management & Operations)	Second Line (Oversight)	Third Line (Internal Audit)	Gaps in Control & Assurance
• Provider-level operational and clinical oversight and governance. • Local policies, SOPs, and standardised procedures. • Transformation programmes boards. • Operational dashboards and local risk registers.	**Weekly forums:** • SWL Elective, Performance and Transformation group. • Alignment with NHS England Regional team on performance and planning priorities. **Monthly forums:** • SWL UEC Board meets four-weekly, reviews performance and is a point of escalation for the system • Diagnostics Transformation Board, review performance and transformation • Outpatient Transformation Board reviews performance, productivity and service change • South London Mental Health Partnership Delivery Group. • RMP Focus Group **Reporting:** Monthly ICB Performance Report to the ICB Board	• NHSE Regional & National oversight which includes formal tiering of trusts requiring support, support from (Get it Right First Time) GIRFT and improvement support from NHSE on specific programme priorities • National, published reporting on performance against the national targets • Active participation in NHSE oversight and programme meetings • Internal audits of governance, provider performance, and system-wide performance oversight	Second line oversight (i.e. ICB oversight) is currently fragmented. The Planning and Oversight teams are challenged in forming an accurate, comprehensive, accurate view of performance due to the lack of MDT working across Quality, Finance, Commissioning and Contracting teams. A shadow form of MDT contractual management governance needs to be in place by 1st April to manage contractual delivery until the future ICB structure is implemented.

Risk Score	Consequence	Likelihood	Score
Inherent Risk Score	4	5	20
Residual Risk Score	4	4	16
Target Risk Score	3	2	6
Risk Appetite			**TBA**

Risk Score Movement	**None**	**Last Review Date**	10/09/2026
Overall Level of Control Assurance		**Medium**	

Strategic Objective at Risk	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
Risk Title	**Interruption to Clinical & Operational Systems due to a Cyber Attack – BAF 004**
Managing Oversight / Reporting Committee	ICB Digital Board
Executive Risk Lead	Martin Ellis
Next Review Date	30/11/2027

Residual Risk Score
16
Level of Assurance
Medium

Risk Statement	Controls In Place	Controls in Development
There is a risk that persistent cyber-attacks on South West London Integrated Care System services could lead to data breaches and disruption to critical clinical and operational systems. This could negatively impact patient care, cause financial loss, and result in regulatory non-compliance and reputational damage. The risk is heightened by inconsistent cyber maturity, limited visibility of digital assets, variable access controls, and uneven incident response capabilities across organisations. While the ICB coordinates system-wide cyber assurance, accountability for cyber security remains with individual providers, creating potential gaps in control. Work is underway to implement the ICS cyber strategy and improve system-wide cyber resilience.	• Completed a system-wide cyber baseline assessment to establish current risk position. • Established joint governance and appointed an ICS cyber lead to coordinate risk reduction. • Approved and launched the SWL ICS Cyber Strategy and implementation roadmap. • Delivered key cyber foundations including MFA review, incident exercises, and shared standards. • Submitted bids for further cyber improvement funding to NHS England.	• Modernise the cyber-risk management, incident response and asset management practices. • Standardise cyber training and promote awareness across the ICS. • Support risk remediation and monitor cyber compliance across the ICS. • Secure cyber funding and allocated to providers as per the cyber risk exposure to mitigate cyber risk.

Sources of Assurance (Lines of Defence)

First Line (Management & Operations)	Second Line (Oversight)	Third Line (Internal Audit)	Gaps in Control & Assurance
• A system wide SWL ICS Cyber Assurance Group brings together provider cyber leads to provide regular updates on their cyber risk position and progress against agreed actions.	• The ICB Digital and Cyber Team provides assurance to the Digital Board through regular cyber updates, highlighting current risk positions, emerging concerns, and progress on mitigation actions outlined in the risk register. This ensures board-level visibility of cyber posture and ongoing efforts to reduce system-wide risk.	• An independent cyber audit is undertaken by external auditors to review system-wide cyber activities, assess the effectiveness of the Cyber Assurance Group actions, and evaluate overall cyber controls. • Audit findings, recommendations, and escalations are reported to the Digital Board, where they are reviewed and agreed actions are monitored to completion.	• Assurance gaps are identified through reviews and audits, addressed through targeted support and corrective actions, and tracked through the Cyber Assurance Group with escalation to the Digital Board where needed.

Risk Score	Consequence	Likelihood	Score
Inherent Risk Score	5	4	20
Residual Risk Score	4	4	16
Target Risk Score	3	2	6
Risk Appetite			**TBA**

Risk Score Movement	**None**	**Last Review Date**	08/09/2026
Overall Level of Control Assurance		**Medium**	

Strategic Objective at Risk	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
Risk Title	**System Quality Oversight – BAF 008**
Managing Oversight / Reporting Committee	Audit & Risk Committee
Executive Risk Lead	Elaine Clancy
Next Review Date	31/12/2026

Residual Risk Score

16

Level of Assurance

Medium

Risk Statement	Controls In Place	Controls in Development
There is a risk that the quality, safety and experience of care across South West London deteriorates, leading to avoidable patient harm, widening inequalities, staff moral injury and loss of public confidence, during the ICB's transition and organisational redesign. This risk arises from the transition of quality oversight and accountability arrangements among NHS England (Region), providers, and the ICB during implementation of the new NHS Operating Model. This is also compounded by ongoing operational, financial and workforce pressures, efficiency programmes, increasing the likelihood that emerging safety risks are not consistently identified, escalated or mitigated. **Causes**	• Continued development of the ICB's corporate governance framework which includes the establishment of a Quality Committee as we move to strategic commissioner. • Draft Terms of reference has been developed for Board sign off. • Continued work with commissioning, contracting and procurement teams to embed quality, safeguarding and inequalities requirements within provider contracts. • Ongoing focus on staff wellbeing, psychological safety and leadership support within providers and the ICB during the transition period. • Committee and Board-level deep dives into high-risk areas (e.g. urgent and emergency care,	• Implementation of the revised NHS England quality oversight and escalation framework, including updated System Quality Group (SQG), Regional Quality Group (RQG) and NQB escalation arrangements, providing clearer definition of ICB, provider and regional responsibilities for quality assurance, contractual oversight, escalation and improvement support under the new NHS Operating Model. • Implementation and embedding of the nationally defined NHS England oversight and escalation arrangements, including clarified regional, provider and ICB responsibilities, agreed escalation thresholds and use of NQB RASCI/SBAR processes.

• Transition from the previous ICB system convenor and direct oversight arrangements to a strategic commissioning and assurance model, with transitional implementation risks as revised quality oversight, escalation and intervention responsibilities become embedded across the system. Sustained system-wide operational, financial and workforce pressures, including mandated cost reductions, provider efficiency programmes, and bed or ward closures. • Reduced organisational capacity and morale within provider and ICB clinical leadership teams as roles, functions, structures and expectations change. • Pressures on urgent and emergency care flow, elective recovery, diagnostics and mental health services, increasing the risk of harm. • Delays in discharge and constrained social care capacity impacting patient flow & safety • Leadership turnover, instability or fragmentation within system governance arrangements during transition. **Impacts** • Risk to the ICB's ability to demonstrate effective discharge of its statutory quality duties while operating within a changing assurance model. • Increased risk of patient harm, avoidable safety incidents and poor patient experience leading to adverse outcomes due to service pressure, fragmentation or gaps in quality assurance during transition. • Staff burnout, low morale, moral injury and reduced psychological safety, particularly where service pressures intersect with organisational uncertainty. • Increased likelihood of regulatory scrutiny, NHSE scrutiny, adverse CQC ratings or intervention if quality governance is perceived as insufficiently robust.	mental health, maternity), explicitly linking quality, safety, finance and health inequalities. • Continued supportive engagement by the ICB CNO Directorate, including peer review, site visits, learning events, advice and guidance, and support for CQC inspection readiness. ICB workshops focusing on quality oversight and assurance have commenced.	• Ongoing alignment with NHS England (Region) on respective roles in quality surveillance, escalation and intervention, including agreed thresholds for action. • Ongoing assurance of provider EQIAs relating to planning rounds, large-scale efficiency programmes, service change and bed closures.

Sources of Assurance (Lines of Defence)

First Line (Management & Operations)	Second Line (Oversight)	Third Line (Internal Audit)	Gaps in Control & Assurance
• Provider-level governance and clinical oversight. • Local policies, SOPs, and standardised procedures • Staff training, competency frameworks, and incident reporting. • Operational dashboards and local risk registers. • Safety huddles, site visits, learning events.	• ICB Quality and Patient Safety team oversight. • Risk management and escalation processes embedded in clinical governance committees and system-level safety meetings. • Alignment with NHS England on quality surveillance and thresholds for action. • Committee and Board deep dives into high-risk areas.	• Internal audits of clinical governance, provider performance, and system-wide quality oversight • Audit of escalation and assurance pathways during transition • Reviews of high-risk service areas (urgent care, mental health, maternity).	• Transition of form and function still ongoing as ICB goes through change management process. • External assurance is evolving during organisational redesign. • Not all transition-related quality risks are fully visible to external regulator.

Risk Score	Consequence	Likelihood	Score
Inherent Risk Score	4	5	20
Residual Risk Score	4	4	16
Target Risk Score	3	3	9
Risk Appetite			**TBA**

Risk Score Movement	**None**	**Last Review Date**	10/09/2026
Overall Level of Control Assurance		**Medium**	

Strategic Objective at Risk	Develop a clinically led Strategic Plan: We will develop, and start to implement, a clinically-led Strategic Plan which will meet the needs of our populations and return the system to financial balance
Strategic Objective at Risk	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
Risk Title	**Failure to secure and align system estates and infrastructure to deliver the Clinically Led Strategic Plan and strategic commissioner objectives – BAF 009**
Managing Oversight / Reporting Committee	Audit & Risk Committee
Executive Risk Lead	Dinah McLannahan
Next Review Date	31/12/2026

Current Risk Score **16**
Level Of Assurance **Medium**

Risk Statement	Controls In Place	Controls in Development
There is a risk that the ICB is not equipped / resourced sufficiently to, or does not, maintain strategic oversight, planning and coordination of the system-wide infrastructure. If the ICB and partner organisations fail to work together, we will be unable to optimise existing estate resources, all of which will impact the system's financial efficiency and capacity to deliver services to the population effectively. Causes • Capital allocations insufficient against system backlog • Change in capital funding framework, with majority of local capital funds directly allocated to individual trusts following the removal of the system capital envelope • Fragmented ownership of estate across multiple providers and landlords • Weak alignment and joined-up decision-making between clinical strategy, digital and infrastructure plans across trusts, ICB and other partners • Capacity and resource constraints in the system estate function • National policy changes displacing local priorities **Impacts** • Unsafe or non-compliant estate. • Inability to deliver strategic objectives and productivity requirements of the CLSP and 3 shifts. • Lost capital opportunities. • Increased revenue costs and backlog maintenance through under-investment in critical infrastructure. • Investments create additional cost pressure, adversely impacting financial sustainability. • Failure to meet Net Zero and digital enablement commitments.	• Expert team in place to ensure strategy aligns with agreed clinical models and neighbourhood delivery. • System-wide engagement with partners to support coordinated investment aligned to the clinically led strategy and neighbourhood developments. • Engagement with regional and national teams to understand new processes and funding opportunities and support access to system infrastructure development. • Business case approval processes to support sound decision-making. • Liaison with Place leads is embedded during neighbourhood development to ensure estates and infrastructure considerations enable service delivery.	• SWL 10-year Infrastructure Strategy (approved in July 2024) provides an overarching vision of where we want to be, however, this and its delivery plan will need to be refreshed as new models of delivery are formed. How the ICB supports this from a financial point of view will be updated as part of the financial strategy development in June 2026. • Detailed development of programme based around Neighbourhood Health Centres and INTs, working closely with other public partners (such as Local Authorities) to align investment plans for infrastructure at a place based level such as Neighbourhood localities with identified population clinical needs. • Work with regional and national teams to develop priority pipeline and secure funding for system infrastructure investment. This remains an ongoing piece of work as new NHSE operating model is implemented. • Ongoing assessment of risks caused by adverse weather and longer-term impacts of climate change and make progress on developing adaptation plans across SWL organisations. • Ensuring system wide estates risks nationally identified (such as RAAC) have system wide coordinated approach implemented and monitored via ICB Estates governance.

Sources of Assurance (Lines of Defence)

First Line (Management & Operations)	Second Line (Oversight)	Third Line (Internal Audit)	Gaps in Control & Assurance
• Skilled team with specialist skills in estates and infrastructure and finance, overseeing Infrastructure Strategy and capital prioritisation process • Regular team meetings and weekly updates in 1:1s. • Capital and backlog monitoring through PAM data, RAAC returns and local risk registers. • Business case development aligned to clinical strategy, Net Zero and digital enablement standards. • ICS Capital Investment Group and System Financial Recovery Group consideration of revenue consequences of estate decisions. • Evidence: capital pipeline, PAM submissions, local estates risk registers, business case gateway approvals, CQC assessments referencing environment and safety compliance.	• Independent challenge within the ICB/system. • ICS Estates Board, ICS Digital Board and ICS Capital Investment Group scrutiny of prioritisation, affordability and alignment to strategy. • Finance & Planning Committee oversight of capital and revenue consequences. • Board seminars reviewing transformation dependencies on estate and digital. • Evidence: committee minutes, internal audit opinions, business case approvals including capital and revenue affordability assessments, NHSE feedback letters.	• Internal audit reviews of capital governance, estates compliance and benefits realisation.	• Data quality in relation to national estates metrics and system infrastructure mapping (PAM, ERIC, SHAPE, Net Zero reporting). • Further work needed to strengthen and incentivise system collaboration across partners and with digital teams in order to deliver system-wide estates optimisation and support neighbourhoods and left shift. • Comprehensive capital governance and reporting arrangements have been in place however there is a requirement to re-establish and reset appropriate capital governance arrangements relevant to the ICB's new role • OPE and local authority engagement with wider infrastructure strategy could be strengthened alongside identification and scrutiny of joint estate schemes.

Risk Score	Consequence	Likelihood	Score
Inherent Risk Score	4	4	16
Residual Risk Score	4	4	16
Target Risk Score	4	3	12
Risk Appetite			**TBA**

Risk Score Movement	**See scoring table below**	**Last Review Date**	10/09/2026
Overall Level of Control Assurance		**Medium**	

Risk scoring movement

Risk			Risk Score			Scoring Movement	Level of Assurance	Rationale for change to score/controls/assurance & commentary
Ref	Description	Risk owner	Inherent	Residual	Target			
BAF001	Failure of the ICB to discharge its strategic responsibility to oversee and secure a financially sustainable health and care system.	CFCO	20	20	15	↔	Medium	Controls updated to reflect the established SSG, agreed CLSP delivery mandates and governance framework; Finance & Planning Committee references removed from this risk. MTFS updated and due for Board approval in November 2026. Residual risk score was 20 in July, then reduced to 15 in August and September, and increased from 15 to 20 (consequence 5 × likelihood 4) in November. Inherent score 20, target score 15 and Medium assurance unchanged pending evidence of delivery and realised benefits. Reviewed 16/11/2026; next 31/12/2026.

BAF002	Urgent & Emergency Care	COO	25	20	9	↔	Medium	Scores unchanged. Review 10/09/2026; next 30/11/2026.
BAF003	Oversight of contractual delivery (access, outcomes and constitutional standards)	COO	20	16	6	↔	Medium	Scores unchanged. Review 10/09/2026; next 31/12/2026.
BAF008	System quality oversight	Elaine Clancy	20	16	9	↔	Medium	Owner updated from Fergus Keegan to Elaine Clancy. Review 10/09/2026; next 31/12/2026.
BAF004	Interruption to clinical and operational systems as a result of a cyber attack	CMO	20	16	6	↔	Medium	Scores unchanged. Review 08/09/2026; next 30/11/2026.
BAF009	Failure to secure and align system estates and infrastructure to deliver the Clinically Led Strategic Plan and strategic commissioner objectives	CFCO	16	16	12	↔	Medium	Scores unchanged. Review 10/09/2026; next 31/12/2026.

Strength of assurance

Risk Reference	Risk Type	Residual Score	1st Line of Defence	2nd Line of Defence	3rd Line of Defence	Reviewed Assurance level
BAF001	Finance	**20**	Medium	Medium	Medium	Medium
BAF002	Performance	**20**	Medium	Medium	Medium	Medium
BAF003	Performance	**16**	Medium	Medium	Medium	Medium
BAF008	Quality	**16**	Medium	Medium	Medium	Medium
BAF004	Reputational	**16**	Medium	Medium	Medium	Medium
BAF009	Finance	**16**	Medium	Medium	Medium	Medium
BAF010	Delivery	**16**	Medium	Medium	Medium	Medium

HIGH	MEDIUM	LOW
• Full assurance provided over the effectiveness of controls. • Assurance across all lines, positive assurance on all lines and within 3 years	• Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed at this time. • Assurance across all lines within last 3 years	• Assurance indicates poor effectiveness of controls. • Assurance across 1st line of defence only • Assurance older than 3 years

NHS South West London
Integrated Care Board

Organisation Update

Agenda Item: 7

Executive Lead: Andrew Bland, CEO SWL ICB

Report by: Ben Luscombe

Paper type: Information

Conflicts of Interest: Not applicable for this report

1. Purpose and recommendation

The Board is asked to note this report which provides an overview and update to the Board on specific issues in South West London (SWL).

2. Background and context

This report provides an operational update from the SWL Integrated Care Board (ICB), regarding matters of interest to members of the Board that are not noted in other papers.

Thirlwall Inquiry
The Thirlwall Inquiry was established following the convictions of former neonatal nurse Lucy Letby to examine events at the Countess of Chester Hospital between 2015 and 2018 and their wider implications for NHS patient safety. Its final report, published in September 2026, identified profound failures in management, governance and safeguarding, including failures to act quickly enough on concerns raised about the safety of babies.

The findings have prompted a national programme of action to strengthen neonatal safety, safeguarding, leadership and accountability. NHS England has asked every trust and ICB Board to consider the findings, seek assurance that appropriate safeguards and escalation arrangements are in place, and promote a culture in which staff feel able to speak up, challenge and raise concerns.

NHSE Senior Management Changes
Caroline Clark recently left her role as Regional Director for NHS England London Region, to take a new position as the Chief Executive Officer of NHS Online. We're pleased to welcome Lesley Watts, as Caroline's successor. Lesley is also the CEO of the Chelsea and Westminster NHS Foundation Trust.

NHS SWL Change Programme
Since the beginning of March this year, the ICB has undertaken a major organisational change programme in order to realise the Government’s commitments made through the Model ICB Blueprint and the vision and aspirations of the NHS 10-year plan.

Our new structures were implemented across October and November and are now operational meaning that we are entering into the final stages of the programme. During this stage a number of ICB staff will be issued with notice of Compulsory Redundancy, and we expect to have completed this stage of the programme by the end of March, in line with the timetable agreed with NHS England. Comprehensive support packages for all staff affected by these changes have been put in place.

Moving forward we have started to discuss new Ways of Working with the organisation to ensure that we become an effective, efficient and resilient Strategic Commissioner delivering improved health outcomes across South London.

Special Educational Needs and disability (SEND) Reviews

A child or young person has special educational needs and disabilities if they have a learning difficulty and/or a disability that means they need special health and education support,

Against a backdrop of the implementation of the Model ICB and the associated changes in the ICB's workforce, the planned SEND reforms in England will involve major planned changes to Education, Health and Care Plans (EHCPs), a new tiered support system, stronger inclusion in mainstream schools, and early-intervention measures, with full implementation expected by September 2029. Inspections of current SEND Partnerships and Local Plans occur throughout the year, and 2026 has been a busy one for the ICB's.

Ofsted and the Care Quality Commission (CQC) jointly inspect the arrangements in local areas for children and young people with special educational needs and/or disabilities. Across SWL and SEL Boroughs there have been several inspections during 2026 (listed below).

- **Croydon Local Area Partnership**, October 2026
- **Lambeth Local Area Partnership**, October 2026.
- **Bromley Local Area Partnership**, October 2026
- **Kingston upon Thames Local Area Partnership**, June 2026
- **Sutton Local Area Partnership**, January 2026
- **Richmond upon Thames Local Area Partnership**, last inspected October 2023, with a recently announced Thematic Review of The Local Offer (this is the provision available across education, health and social care for children and young people with SEND, and their families, in a local area).

Inspection outcomes for local SEND services in England are published by Ofsted and the Care Quality Commission (CQC). Outcomes are categorised as:

- **Positive experiences and outcomes:** Local arrangements typically lead to good support for children and young people with SEND. (19%)
- **Inconsistent experiences and outcomes:** Local arrangements require improvement to ensure consistent support. (56%)
- **Widespread or systemic failings:** Significant concerns exist, requiring urgent action and submission of a priority action plan. (25%)

Nationally in 2025, positive outcomes rating has reduced, inconsistent outcomes have increased and widespread or systemic failings outcomes remains similar to overall rates since 2023.

In both SWL and SEL, inspections have provided outcome reports in all three domains and local Borough teams all have partnership plans in place (including when found to have widespread and/or systemic failings, when Boroughs are required to produce a priority action plan). There are a range of

areas which the ICB's are progressing as key areas of development, in addition to previous programmes of work already underway:

- **Strengthening partnership** and shared governance across LA, ICB and Providers including scrutiny around SEND partnership board risk registers
- **Joint commissioning arrangements** in each area are different and this is an opportunity to develop greater consistency
- **Improvement work** required on service specifications to include key metrics to demonstrate compliance with statutory processes
- **Strategic commissioning and development** of Local Area responses whilst children and young people are awaiting neurodevelopmental assessment
- **Therapies demand and capacity work** extension of this work to consider a future for the increased provision of therapies which link with the SEND Reform "Experts at Hand" model
- **Health contributions** indicate further work required on some elements of the Education, Health and Care Needs Assessment (EHCNA) process – the first stage in obtaining an EHCP – and annual reviews
- **Alignment of programmes** related to SEND, including All Age Learning Disability and Autism, Mental Health.

Women's Health Services at St Helier Hospital

Epsom and St Helier University Hospitals NHS Trust is developing a proposal to replace ageing water infrastructure in the Women's Health E Block at St Helier Hospital because of water quality issues. The trust has put stringent water safety measures, filtration and regular testing in place and has confirmed the building remains safe to use. These measures are effective but are not considered a long-term solution.

The trust has been considering how the underlying water infrastructure issue can be addressed safely while maintaining women's health services. This includes whether remedial works can be undertaken while services remain in E Block and, if not, whether services could be temporarily accommodated elsewhere.

The options currently being worked on include moving services out one floor at a time or temporarily moving all services to other locations while the work takes place. The trust has not yet made a decision about how to carry out the work safely or what implications would be for services in the building. If a temporary move is proposed, the trust would need to set out how long it is expected to last and its plans for restoring services at St Helier once the work is complete.

If the trust proposes temporarily moving, changing or suspending services because of an immediate or imminent risk to patients or staff, it must formally notify the Integrated Care Board (ICB). Any significant proposed service change would require ICB approval, with enough time for the ICB to consider the proposal.

The ICB understands that the trust expects its board to consider the two options on 3 December, alongside evidence of the potential impact on equality, quality of care, staff and finances. The trust then intends to carry out a period of engagement with patients, families and other people affected and develop the proposal further. The engagement plan would be discussed and agreed with the affected local authorities through a Joint Health Overview and Scrutiny Committee. The trust will consider feedback from the engagement before making a decision, which is expected in March 2027. Should

the water quality deteriorate, the trust may need to take more immediate action to protect patients, families and staff.

If formally notified of a proposed temporary service change, the ICB would work with NHS England to assess whether to support it. This would include:

- Reviewing the trust's plans, the urgency of the work to maintain the safety and welfare of patients, families and staff, and any impacts on other services.
- Reviewing the impact on local people, including whether the changes would affect some groups more than others and the implications for health inequalities.
- Assessing the impact on the wider health and care system and identifying further ways to reduce any adverse effects, including working with other local providers.
- Supporting the trust to engage with patients, families and other stakeholders, including local authority health overview and scrutiny committees and other affected ICBs.

The ICB would consider the trust's final proposal and decide whether to approve a temporary service change, timing of which is dependent on the trust's timetable. ICB and NHS England approval would be required before any such change could take place.

Appointments

Elaine Clancy formally took up her role as Chief Nurse and Quality Officer for the cluster on 7 September 2026. Elaine has returned from a secondment at St George's, Epsom and St Helier University Hospitals and Health Group (GESH) where she has been the Group Chief Nurse. Elaine has more than 30 years' experience in the NHS. A trained adult, paediatric and A&E nurse, Elaine has worked on the frontline of the NHS - as well as holding a range of senior roles at hospitals and community providers across London.

Ed Waller took up his role as Deputy Chief Executive and Chief Commissioning Officer for the cluster on 7 September 2026. Ed joins us from NHS Kent and Medway ICB where he was the Deputy Chief Executive and Chief Commissioning Officer. In this role he led the development of the organisation to become a strategic commissioner, implementing commissioning change in a challenged system through planning and strategy as well as playing a major role in the ongoing ICB change process.

SWL GP practices rated best in London for patient experience.

The latest GP Patient Survey shows continued positive experiences of primary care in SWL, with 81% of respondents reporting a good experience of their GP practice, above the England average of 77% and the highest result in London. Access to services has continued to improve, with SWL performing above the national average for contacting practices, including by telephone, practice websites and the NHS App. Patients also reported positive experiences of care once accessing services, with strong levels of trust and particularly positive feedback on feeling listened to and involved in their care.

Wide Way Medical Centre recognised for innovative care

The planned care team at Wide Way Medical Centre in Merton has been recognised by the Primary Care Cardiovascular Society for its innovative VIP Model of Care. The multidisciplinary, data-driven approach brings together primary care professionals to proactively identify and manage patients at cardiovascular risk. The model has improved monitoring and treatment outcomes, strengthened patient experience and multidisciplinary working, while saving more than 4,000 appointments and an estimated £40,000 annually.

London Maternity and Neonatal Excellence Awards 2026
The SWL Local Maternity and Neonatal System (LMNS) has won the Quality and Safety category at the London Maternity and Neonatal Excellence Awards 2026 for its Perinatal Optimisation Programme. The programme has strengthened collaboration across maternity and neonatal services and improved access to specialist care for extremely preterm babies. Key outcomes include a 38% reduction in in-utero transfer refusals, a 50% improvement in successful transfers for women in threatened extremely preterm labour, and the lowest transfer refusal rates in London. The successful improvement model is now being adopted more widely, recognising the significant contribution of teams across SWL to improving outcomes for babies and families.

Mayor of London visits new Brocklebank Health Centre.
The Mayor of London, Sadiq Khan, visited the new Brocklebank Health Centre in Wandsworth, where he unveiled a plaque, toured the new facilities and met staff. The purpose-built centre brings together GP, community health, podiatry and specialist dental services, supporting more joined-up care for local residents.

Sutton Place Update

Overview

Reimagining Outpatients Bridging the Gap Interface Event
At the Interface Event on 24 September 2026, stakeholders from across primary, community, mental health and acute services endorsed the development of a neighbourhood-based cardio vascular renal metabolic model of care. Feedback is informing plans for a tier 2 virtual multidisciplinary team pilot across three Sutton practices, bringing together primary care, community and specialist expertise to improve coordination of care and evaluate impact on patient experience and service delivery.

Neighbourhood Community Appointment Days
Across Sutton's four neighbourhoods, community appointment outreach days are supporting earlier identification of residents who may need additional health and care support, with particular focus on frailty, housebound residents and unpaid carers. Activity continues to strengthen partnership working between primary care, community services, adult social care and the voluntary sector.

Progress includes earlier frailty identification in Central Sutton, development of a multidisciplinary 'Team of Teams' model in Cheam & South Sutton, enhanced care planning and frailty management in Carshalton, and ongoing community-based prevention initiatives in Wallington. The Healthy You programme in Wallington has delivered over 20 events, with more than 350 attendances and over 200 blood pressure checks, demonstrating the value of neighbourhood approaches in improving wellbeing and social connectedness.

System Leaders Group
Sutton System Leaders continue to provide strategic oversight and challenge to the work of the Sutton Alliance, bringing together leaders from health, care and the voluntary and community sector to support neighbourhood delivery. The group recently reviewed neighbourhood progress, with focus on proactive support. Members also considered emerging learning from Community Health and Wellbeing Workers and volunteer Wellbeing Buddy programmes, alongside work to strengthen community engagement and ensure resident voices continue to inform local priorities and service development.

Health and Wellbeing Board
The Health and Wellbeing Board reviewed progress against both the Sutton Joint Carers Strategy 2025-2030 and the Sutton Health and Care Plan 2025-2028. The Board approved the 2026/27 Joint Carers Strategy workplan, including actions to strengthen support for young carers, improve carer involvement in decision-making and expand community-based support. The Board also noted continued progress against key priorities within the Sutton Health and Care Plan, including neighbourhood working, proactive care for people living with frailty, improvements in GP access, hospital discharge arrangements, SEND services and cardiovascular health initiatives.

Primary Care Plenary
The Sutton Primary Care Plenary continues to support delivery of borough priorities through collaboration across general practice and Primary Care Networks. Recent discussions have focused on reducing unwarranted variation in GP access, strengthening proactive anticipatory care

Kingston and Richmond Place Update

Kingston and Richmond Place partners continue to work closely together to improve health and care outcomes for local residents. As neighbouring Places, many of our priorities, programmes and challenges are shared, and much of the work described in this report is delivered jointly across both boroughs through partnerships involving NHS organisations, local authorities, primary care, community services and the voluntary sector. While there is significant overlap in our programmes and priorities, some initiatives are tailored to meet the specific needs of each borough. This update provides an overview of key Place-based activity undertaken over recent weeks.

Progressing Kingston and Richmond's focus on frailty
Colleagues and partners from across Kingston and Richmond came together in October to mark the first anniversary of the National Frailty Improvement Collaborative and to launch the next phase of the programme. Kingston and Richmond Places continue to lead NHS England's frailty improvement work across South West London, bringing together health, care and community partners to improve outcomes for people living with frailty.

The programme has delivered clear progress over the past year. The Clinical Frailty Score is now recorded for 67.5% of emergency attendances by people aged 65 and over, helping teams better understand patients' needs and identify opportunities for earlier intervention, reducing long waits and avoiding unnecessary hospital admissions. A number of successful tests of change have also been undertaken, including the introduction of a more consistent approach to frailty identification, improvements to the use of the "ageing well" questionnaire, and the development of a single point of contact in Kingston Hospital's Emergency Department to help people access the right support more quickly. Following a successful application, Kingston and Richmond have been invited to continue into the next phase of the national programme, with a focus on embedding and scaling improvements across the system to provide more timely, coordinated care for people living with frailty.

Neighbourhood health development
Progress continues to strengthen neighbourhood health arrangements and develop more integrated ways of working between health, social care and wider system partners. Neighbourhood governance and leadership arrangements are being established providing a framework for shared priorities, accountability and delivery. Both boroughs have agreed priorities for their respective £250,000 Neighbourhood Delivery Funds, with schemes progressing through development and implementation. Initial neighbourhood health maturity assessments have also been completed, and these will be developed further in the coming months. The next phase will focus on strengthening neighbourhood-level leadership, developing population health profiles, agreeing measurable outcomes and translating strategic priorities into coordinated local delivery.

Kingston Health and Wellbeing Board
At the October meeting, the Health and Wellbeing Board received an update on the development of neighbourhood health and care in Kingston, noting progress in establishing governance arrangements, neighbourhood leadership groups and delivery plans. The Board also considered the annual Director of Public Health report on race, ethnicity and health, highlighting inequalities in areas including vaccination uptake, diabetes, cardiovascular disease, mental health and frailty. Members agreed that tackling racial and ethnic health inequalities should be a key part of Kingston's neighbourhood health model and supported further work on community engagement, improved ethnicity data and co-production with residents to help shape future services and improve health outcomes.

Richmond Health and Wellbeing Board
The Richmond Health and Wellbeing Board also received an update on neighbourhood health in the October meeting, endorsing the move from programme development to delivery. Members heard how work is building on established neighbourhoods, integrated services and the Joint Local Health and Wellbeing Strategy, with priorities including frailty, urgent and emergency care, mental health and wellbeing, cardiovascular disease prevention and proactive support for families.

In addition, the Board reviewed the midpoint assessment of Richmond's Joint Local Health and Wellbeing Strategy and noted positive progress across a range of priorities, including mental health support in schools, immunisation outreach, falls and frailty prevention, dementia care and action to reduce social isolation. The Board also received an update on the SEND Futures Plan, highlighting progress in improving services and support for children and young people with special educational needs and disabilities, alongside preparations to implement national SEND reforms and strengthen inclusive education across the borough.

Kingston SEND inspection outcome
The outcome of a joint Ofsted and Care Quality Commission (CQC) inspection of SEND services in Kingston was recently published, recognising strong partnership working across health, education and local authority services to support children and young people with special educational needs and disabilities (SEND).

Kingston's SEND partnership achieved the highest possible outcome from the inspection, which found that children and young people with SEND generally receive effective support and have positive experiences of local services. Inspectors highlighted strong multi-agency working, a shared commitment to improving outcomes, and positive feedback from children, young people and families.

The report also identified some areas for further improvement, including reducing waiting times for certain health services. Partners across the local SEND system are now reviewing the findings and recommendations and will continue to work together to build on the strengths identified and improve access, experiences and outcomes for children and young people with SEND.

Regional Chair for NHS London visits Kingston and Richmond
In October, Chair of Kingston and Richmond NHS Foundation Trust, Phil Hill, welcomed Ian Peters, Regional Chair for NHS London, to the Trust. The visit provided an opportunity to discuss the Trust's strategic priorities, including ambitions for integrated care, neighbourhood health, prevention and population health, as well as the opportunities and challenges facing the organisation. During his visit, Ian met with colleagues from across the Trust and toured a number of services, including maternity services, the Intensive Care Unit and the Emergency Department. The visit provided an opportunity to showcase the excellent care delivered by teams, while also highlighting some of the operational pressures, and current priorities.

Primary and secondary care interface working
Colleagues at Kingston and Richmond NHS Foundation Trust, and in primary care across Kingston and Richmond, have continued regular forums to share ideas, strengthen collaboration and support more efficient patient pathways. Topics of discussion have included the emerging national direction for outpatient services, a South West London consensus on primary and secondary care interface working, and the consolidation of key information and contacts, enabling GPs and practice teams to

quickly access guidance on urgent and routine secondary care referrals, diagnostics, digital services, and patient support.

Employment, Health and Inclusive Opportunities Workshop
The most recent joint Place Provider Alliance focused on how organisations can work together to improve employment, skills and inclusive opportunities for local residents. Discussions focused on inclusive recruitment and retention, support for carers and young people, employment as a health outcome, and opportunities to strengthen partnership working. A key output was agreement to explore a rotational work-experience model across NHS, local authority and voluntary sector organisations, alongside actions to improve employer engagement and inclusive employment practices.

Croydon Place Update

Neighbourhood Health and Care Delivery
Neighbourhood Health and Care remains a key system priority. Learning from the National Neighbourhood Health Implementation Programme (NNHIP), local test-and-learn activity and resident feedback is informing the next phase of delivery. Two models, focused on prevention and frailty, were tested across 10 GP practices serving approximately 150,000 residents. The Health and Wellbeing Board has approved a new model comprising one borough, three localities and six neighbourhoods, and the programme is now moving from design into mobilisation, focusing on prevention, integrated neighbourhood teams, care coordination, frailty transformation and reducing health inequalities.

Croydon Health and Wellbeing Board
The Board reviewed progress against the Joint Local Health and Wellbeing Strategy (2024-29), the One Croydon Health and Care Plan and the Joint Outcomes Monitoring Framework. Members received a detailed update on mental health services and programmes, reviewed annual safeguarding reports, considered progress on neighbourhood health and care, and reaffirmed their commitment to embedding anti-racism across all priority programmes.

Homelessness
Croydon continues to work with health, housing, care and voluntary sector partners to respond to homelessness and rough sleeping. Current priorities include earlier identification, improved referral pathways and more integrated support across housing, primary care, mental health, substance misuse and social care services, supporting wider aims to reduce inequalities and improve outcomes.

Primary, Community and Mental Health Integration
Work continues to strengthen collaboration between primary care, Croydon Health Services and South London and Maudsley. Key priorities include improving communication, redesigning pathways, managing demand more effectively, increasing access to specialist advice and improving transfers of care.

One Croydon Alliance
Partners have agreed a two-phase approach to future partnership arrangements. A streamlined Memorandum of Understanding will be introduced by April 2027, followed by programme-specific governance and contractual arrangements where required.

Area SEND Inspection
Croydon has recently completed a joint Ofsted and Care Quality Commission SEND inspection. Findings are awaited and will help shape future improvement activity across health, education and social care.

External Engagement
Croydon Health Services hosted the London Regional Chair, Ian Peters, who visited frontline services at Croydon University Hospital and discussed service improvements, operational challenges and the needs of Croydon's diverse population

Merton Update

Health and Wellbeing Board
The Health and Wellbeing Board received focussed papers on the **Start Strong** pillar of our Joint Health and Wellbeing Strategy. The plan is ambitious and covers areas such as a CYP Plan, Eat Well, Be active schools' food and activity, Family Hubs and Child Poverty. There was also reference to the Alliance work of developing Babies, Children and Young People (BCYP) integrated neighbourhood work

In addition, the **Child Poverty Strategy** was presented and wholly endorsed asking for partner participation in addressing child poverty in the borough

Merton Place partnership
The first co-located **Integrated Neighbourhood team (INT)** in Morden was launched at the end of September with planned checkpoint evaluations in December and March. Initial feedback is very positive from both patients and professionals with specific reference to the benefit of having mental health practitioners as part of the multi-disciplinary teams

Aligning to the Health and Wellbeing Board presentation's, the Merton Alliance agreed the plan to drive forward the first **BCYP integrated neighbourhood team**, aligning to INT and Family Hub developments.

The ICB and Local Authority Children and Lifelong Learning team received positive feedback on our recently submitted **SEND reform plans**, with particular emphasis on its engagement, partnership working and level of ambition. Key challenges to the success of the plan is the recruitment of specialist staff across the capital

Key events in the Borough
Borough wide events in the last period include:

- Jobs and Cost of Living event supporting residents around employment, training and budgeting
- Health and Wellbeing Fair focusing on Dementia awareness, kidney health and smoking cessation
- Carers wellbeing event focusing on health checks, vaccinations and stress
- A performance event delivered by the SEND community

Wandsworth Update

Health and Wellbeing Board
The Health and Wellbeing Board with its new Chair, Councillor Ghossain, considered **Neighbourhood Health**, agreeing the neighbourhood footprint, and the Wandsworth Alliance plans for **Frailty** across Virtual Wards, Urgent Community Response, Home First and Proactive and Anticipatory Care. Data sharing, Carers VCSE and the patient voice were key considerations

The Board had an update on the age well initiatives of the Health and Wellbeing Strategy including **Falls, Dementia** (including diagnosis rates and Universal Care Plan coverage in Care Homes) and **social isolation**

Additionally, a carers charter updates, the annual Adults safeguarding report and a Healthwatch update were also considered

Wandsworth Place partnership
Progress was presented on key workstreams including **integrated neighbourhood teams**, **outpatient transformation** and the **Urgent Community Response** developments (Frailty business case).

Invited guests from other London systems provided learning on models of partnership, partnership development, Place governance and leadership ahead of the partnership development day in December

The ICB and Local Authority Children Services received positive feedback on recently submitted **SEND reform plans**, with particular emphasis on data, performance and again, its level of ambition.

Key events in the Borough
Borough wide events in the last period include:

- Two Housing engagement events focussing on improving council housing and changes in housing priorities
- A range of Black History month activities and celebrations
- Smoking cessation events across the borough
- Community Safety events