
NHS
South West London
Clinical Commissioning Group

# Annual Report & Accounts

## April 2021 to March 2022

# About this report

The NHS South West London Clinical Commissioning Group (CCG) Annual Report 2021/22 has been produced in response to the NHS England requirements as published in the Department of Health and Social Care Group Accounting Manual 2021/22. The structure closely follows that outlined in the guidance and includes three core sections:

- **The Performance Report** - including an overview, performance analysis and performance measures
- **The Accountability Report** - including the members' report, corporate governance report, annual governance statement, remuneration and staff report
- **Annual Accounts** - including the independent auditor's report and the financial statements

This report has been approved by the Governing Body members, and all the content has been checked for accuracy and consistency with reporting data sources and to make sure that all requirements are met by our auditors.

# Contents

# 1 Performance Report

# 1.1 Welcome and overview

This annual report is a record of the second year of our clinical commissioning group and the challenges and achievements faced in another year in which we led the NHS response to the Covid-19 pandemic in South West London.

It is also the final full year report of NHS South West London Clinical Commissioning Group (CCG). From July 2022, a new Integrated Care Board will be in place to oversee the planning and funding of health services in South West London.

NHS South West London CCG came into being in unprecedented times and we are proud of the way our Governing Body, GP members and staff adapted to being in a new organisation while responding to a global pandemic. Their ability to lead and respond in unknown and changing circumstances to meet the needs of our communities demonstrated the very best of what NHS staff can do.

## Delivering the Covid-19 vaccination programme

The Covid-19 vaccination programme has been the biggest vaccination programme ever delivered by the NHS and we have been a top performer in London throughout, delivering over 3 million jabs by March 2022. In the course of the programme we strengthened relationships with our communities and found new ways to make getting vaccinated more accessible for people who don't normally engage with health services.

We are grateful to GPs, nurses, pharmacists, volunteers and CCG staff who are delivering the vaccination programme, and the community and faith leaders and the voluntary organisations whose work with us has significantly reduced the impact of this pandemic on our communities in South West London.

## Our other priorities

Responding to the ongoing Covid-19 pandemic and delivering the vaccination programme were major areas of focus for the CCG but alongside these we continued our work to address the health needs of local communities; to catch up on the back log of diagnostics and treatments delayed because of Covid-19; and to further develop our ability to deliver health and care in partnership with our Integrated Care System (ICS) partners.

## Reviewing borough health and care plans

Patients are at the heart of everything we do and we wanted to understand the impact of the pandemic on individuals and communities so that we could build this insight into how we deliver services.

In 2021, CCG leaders in each of our six boroughs talked to local people, partner organisations and stakeholders to review their local health and care plans. These plans will be the building blocks for the NHS and local authorities to improve health outcomes and health services in the next couple of years to be delivered by the new Integrated Care System.

## Engaging communities and addressing health inequalities

We made good progress on our approaches to addressing health inequalities, but recognise we have a great deal more work to do. We deepened our understanding of the current challenges and adopted more systematic ways to use data. We also built new relationships with communities who have the greatest health needs, for example in Sutton where our work with Sutton Housing Partnership helped us to connect with the Gypsy Roma Travelers community and homeless residents.

We were also successful in our bid to become a Wave 1 national Core20 Connectors NHS site, receiving funding from the NHS to recruit community connectors to support individuals, families and communities, to achieve better health and social outcomes.

Insight from engagement with people and communities was a key influencer in the way we delivered the vaccination programme and supporting campaign. It also influenced many of the programmes and projects highlighted in this report.

## Primary care developments

Primary Care Networks (PCNs) continued to play an essential role in delivering the Covid-19 vaccination programme, setting up local vaccination centres; vaccinating in care homes; and vaccinating the most clinically vulnerable groups.

Through the PCNs, primary care also played a major part in managing demand for urgent care services through extended access to GPs and nurses and a telephone number set up for patients to get help during the busy winter period.

## Service recovery and improving access following Covid-19

The pandemic contributed to the continued pressures that we have seen on NHS services. Ensuring that vital non-Covid-19 NHS services were available to those who needed them remained a priority for us. Health and care organisations collaborated across South West London to increase capacity and our clinicians continued to lead the work to find new and better ways to make services more efficient and effective for patients.

This collaborative approach helped us to maintain our position as the highest performing ICS in London for the Referral to Treatment standard but there is still much to do and our recovery plan for the coming year will seek to further reduce the number of people waiting.

Similarly, we were the highest performing system in London for the number of patients with cancer treated within 62 days of referral and our aim is to build on this and return to pre-pandemic rates of access to treatment and meet the increased number of referrals.

Our work to improve diagnostic services was boosted by a £10 million investment in developing a community diagnostic centre at Queen Mary's Hospital in Roehampton, to be supported by new 'satellite' sites in areas of greatest need.

## Transforming care, joining up services and preventing ill health

Some of the work to improve care out of hospital was accelerated because of the need to keep patients safe and reduce pressure on hospital services during the Covid-19 pandemic. In this report we have highlighted some of the many initiatives introduced in the past year to support priority work programmes.

For example, teams of health professionals now care for patients in the comfort of their own home through virtual wards; social prescribing is helping people to be more independent, active and improve health and wellbeing; a proactive care model is helping patients stay healthier longer; technology is helping GPs to prevent complications for people with diabetes; and a 'Stay Steady, Stay Well clinic' in Croydon is helping older adults to live independently for longer.

In 2020/21 we established 15 elective recovery clinical networks to support restarting elective surgical operations and treatments. Last year the networks, each led jointly by acute and primary care clinicians, continued to support our hospitals to work together to transform services and to make sure our patients got the treatment they needed. As a CCG, we have supported these networks with experienced primary care clinicians and commissioning managers, making sure we are focused on the whole patient journey and coordinating patient care across different settings.

## Responding to the mental health crisis

We know people's emotional health and wellbeing was affected by the pandemic and demand increased, especially for children and young people's mental health services.

We have worked with mental health service providers to focus on prevention and early intervention and develop the capacity we need to support people including support for people who are waiting for treatment. Services such as crisis cafés and health and wellbeing spaces have helped patients without the need for them to go into hospital.

In 2022, we will have finalised and begun implementing a new mental health strategy for South West London.

## Developing a Green Plan for South West London

Embedding a sustainable approach to NHS services is a big challenge but one where many of our trusts saw progress in 2021. Initiatives such as virtual wards, and a ground-breaking partnership between a Primary Care Network in Merton and the London Ambulance Service, where a paramedic cycles to deal with acute calls, are reducing travel emissions.

The move to more virtual consultations by phone, video and online in primary and secondary care introduced during the Covid-19 pandemic also continued to contribute to reducing the impact of travel while being a safe and convenient option for many patients.

At the start of 2022, we finalised the first NHS South West London Green Plan and during 2022 we will be delivering the jointly agreed priorities.

## Becoming an Integrated Care System (ICS)

We now look forward to the transition to the South West London Integrated Care System (ICS) and the NHS South West London Integrated Care Board (ICB), which will take on the CCG's core functions.

During the Covid-19 pandemic, the NHS in South West London, local councils and the voluntary sector demonstrated what we can achieve by working together, quickly identifying and supporting those at greatest risk. We know that by working together with a shared ambition to help our communities thrive, we can achieve the best for everyone.

The clinical leadership that has been the cornerstone of the CCG will continue to drive our Primary Care Networks, leading the design and delivery of integrated services in their local area to improve quality and access to health and care services, and working with clinical networks and provider collaboratives to benefit from working at scale.

We are fortunate to have such strong relationships with our partners forged through hard work over a long time. Our ICS will be built on these partnerships including all parts of the NHS – primary care, community services and hospitals – and local authorities and the community and voluntary sector.

Thank you to CCG staff, our Governing Body and GP members for your commitment and contribution to the success of the CCG and for the proud legacy that we will build on in the coming years.

Dr Andrew Murray
Clinical Chair

Sarah Blow
Accountable Officer

## 1.1.1 About us

NHS South West London Clinical Commissioning Group (CCG) is responsible for planning, commissioning and buying health services for people living and working in South West London.

As a CCG, we're a membership organisation made up of over 180 GP practices within South West London. We serve just under 1.5 million people across our six diverse boroughs:

- Croydon
- Kingston
- Merton
- Richmond
- Sutton
- Wandsworth

We were formed on 1 April 2020 through the merger of these six borough CCGs.

We manage local healthcare budgets of over £2.3 billion and commission a range of health services on behalf of our residents. The services that we're responsible for include primary care (the services you receive at your GP practice), hospital treatment, rehabilitation services, urgent and emergency care, community health services, mental health and learning disability services.

Our vision is to make South West London a great place to live and work.

We value:

- treating people with kindness
- being inclusive and respectful
- flexibility in how we work and how we react to change
- diversity of thought and seeing the possibilities
- delivery, and
- doing our personal best every day.

### 1.1.1.1 Our constitution

Our CCG constitution sets out our responsibilities for commissioning care for patients. It also sets out the rules and procedures we follow to ensure probity and accountability in the day to day running of the CCG. This is to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central.

You can read or constitution and standing orders on our website at https://swlondonccg.nhs.uk/about/constitution/

You can also read the Handbook to the NHS constitution on our website. This explains each right and pledge in the NHS Constitution and the legal sources of both patient and staff rights and outlines the roles we all play in protecting and developing the NHS.

### 1.1.1.2 Our role in delivering health and wellbeing strategies

In 2021 we reviewed and updated the Health and Care Plans for each of our boroughs in the context of the impact of the Covid-19 pandemic on our local communities. Originally developed in 2019 by local people, and health and care staff, these plans are centered around the people who use our services rather than the organisations that provide them.

The Health and Care Plans support delivery of each borough's Joint Health and Wellbeing Strategy (JHWS) developed by the Health and Wellbeing Board, to meet the health needs identified in the borough's Joint Strategic Needs Assessment (JSNA). Each of our locality executive directors and clinical chairs represent their borough on the local authority Health and Wellbeing Board along with representatives from local NHS acute, mental health and community providers, Healthwatch, community and voluntary sector and other partner organisations.

You can read more about how we have developed borough health and care plans in 2021/22 and our borough-based work in section 1.2.1.2 Further key priorities in 2020/21.

You can read the Health and Care Plans for each borough on the new South West London ICS website www.southwestlondonics.org.uk

You can find details of each borough's Health and Wellbeing Board on the local authority websites:

**Croydon:** https://www.croydon.gov.uk/council-and-elections/council-committees-and-meetings/committees-boards-and-meetings/health-and-wellbeing-board

**Merton:** https://www.mertonpartnership.org.uk/thematic-partnerships/health-and-wellbeing-board

**Kingston:** https://moderngov.kingston.gov.uk/mgCommitteeDetails.aspx?ID=488

**Richmond:** https://www.richmond.gov.uk/council/how_we_work/partnerships/health_and_wellbeing_partnership/health_and_wellbeing_board

**Sutton:** https://moderngov.sutton.gov.uk/mgCommitteeDetails.aspx?ID=471

**Wandsworth:** https://www.wandsworth.gov.uk/the-council/council-decision-making/wandsworth-health-and-wellbeing-board/

### 1.1.1.3 Developing South West London Integrated Care System

South West London Health and Care Partnership was first established in 2018 and brings together the CCG, local authorities, NHS providers, healthwatches and community voluntary organisations across our six boroughs. We were formally granted Integrated Care System (ICS) status in April 2021.

The Health and Care Bill introduced in Parliament on 6 July 2021, confirmed the Government's intentions to introduce statutory arrangements for integrated care systems from July 2022. Since this point, we have been working with our partners to make sure all the elements of our system are ready to take on these statutory roles and responsibilities.

We believe that one of the strengths of our South West London Health and Care Partnership has been the strong engagement across all our partners. Therefore, as the Health and Care Bill progresses through Parliament and national guidance is published, we have been continuing conversations on how best to work together to develop our partnership to help improve the health and care of the people in South West London.

**Engaging with our partners**

Throughout October and November 2021, we engaged health and care partners across the system in the design of our future ICS ways of working. This engagement has included 150 people attending six 'listening events' to hear from partners including local authorities, health and wellbeing board chairs, NHS provider chief executives and chairs and colleagues from the voluntary and community sector.

In line with national guidance, South West London Health and Care Partnership became known as South West London Integrated Care System (ICS). Our ICS is being developed to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

South West London ICS will be made up of three parts as described in the diagram below:

## South West London ICS Places

There are six 'places' in South West London: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth. These six places have the same borough boundaries as our six local authorities. The purpose of the ICS place is to:

- **support and develop primary care networks** which join up primary and community services across local neighbourhoods
- **simplify, modernise and join-up health and care** including through technology and by joining up primary and secondary care where appropriate
- **understand and identify** – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them
- **coordinate the local contribution to health, social and economic development** to prevent future risks to ill-health within different population groups

## South West London ICS Provider Collaboratives

Provider collaboratives are partnerships made up of two or more NHS trusts working across multiple boroughs to help bring the benefits of working at scale and mutual aid of sharing resources and services for mutual benefit.

There are three provider collaboratives in South West London:

- **South London Mental Health Partnership** is made up of:
  - South West London and St George's Mental Health NHS Trust
  - South London and Maudsley NHS Foundation Trust
  - Oxleas NHS Foundation Trust
- **South West London Acute Provider Collaborative** is made up of:
  - Croydon Health Services NHS Trust
  - Epsom and St Helier University Hospitals NHS Trust
  - Kingston Hospital NHS Foundation Trust
  - St George's University Hospitals NHS Foundation Trust
- **Royal Marsden Partners** is made up of all South West London and North West London organisations supporting the NHS cancer pathway, including primary, acute and specialist providers and screening services

The purpose of provider collaboratives is to support each member organisation to work together to continuously improve the quality of health services, efficiency and health outcomes, including proactively working to address inequalities in service access and experience across different NHS providers.

## South West London ICS SWL level

The South West London level of the South West London Integrated Care System will have in place an Integrated Care Partnership (ICP) and an Integrated Care Board (ICB).

- **South West London Integrated Care Partnership** will bring together organisations and representatives to reduce health inequalities and improve the care, health and wellbeing of the people in South West London.

**Membership:** The ICP will bring together representatives from local authorities, the South West London Integrated Care Board, NHS providers, the voluntary sector, healthwatch and other partners.

- **South West London Integrated Care Board** will bring the local NHS together to improve population health and care. It will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of the population.

**Membership:** Millie Banerjee was appointed as the Chair of South West London Integrated Care Board, the membership of the ICB will also include four non-executive directors, executive directors, members selected from nominations made by NHS trusts and foundation trusts, general practice and a local authority representative.

NHS South West London Integrated Care Board will also be a statutory organisation that will take on many of the NHS planning functions previously held by South West London Clinical Commissioning Group. Staff employed by the CCG transferred to the ICB on 1 July 2022.

Partners across South West London worked together to design the ICS, which was established on 1 July 2022. This work is described more fully on the new South West London ICS website www.southwestlondonics.org.uk.

You can also read more about our work to develop a People and Communities Strategy for South West London in section 1.2.2.

## 1.1.2 Finance summary

This information serves as a summary of the CCG's annual accounts including the controls assurance and auditor's statements. Our performance against the key financial performance indicators is summarised below.

### 1.1.2.1 Income and expenditure target

For the 2021/22 financial year, the NHS continued to operate under a different financial framework due to the impact of the Covid-19 pandemic. For the first six months of 2021/22, the CCG was allocated funding in line with actual expenditure incurred in 2020/21, including funding for the additional costs of Covid-19. For the second half of the financial year the CCG received a fixed level of funding at system level including additional funding for the expected costs of Covid-19.

Within this funding the CCG was set a target of break even by NHS England for the first half of the year, and a surplus target of £591k for the second half of the year. The CCG achieved a surplus of £144k for the full year. It should be noted that the South West London system as a whole was broadly in balance for the year.

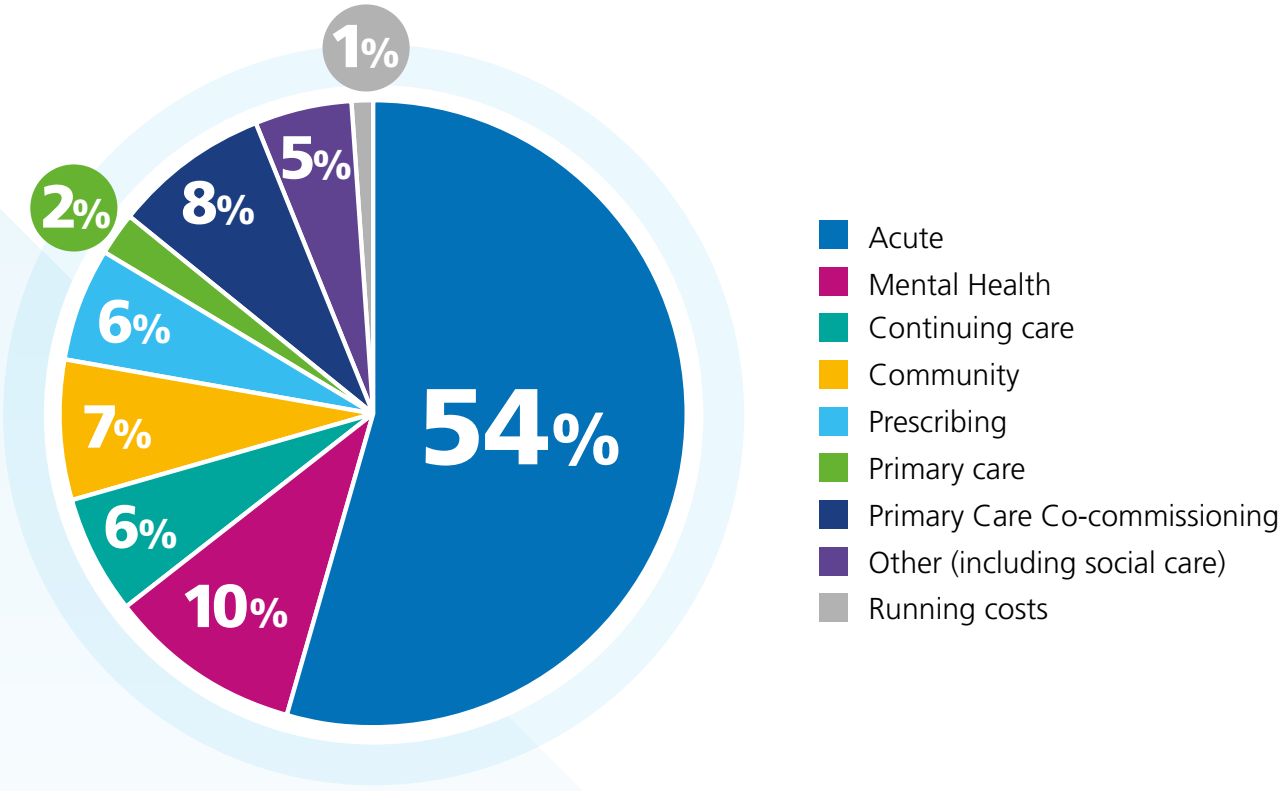
### 1.1.2.2 How we spent our budget

The CCG was allocated a total of £3.090bn to spend in 2021/22 and spent £3.089bn, giving a surplus of £144k (allowing for roundings). About half of this expenditure was acute services (£1.664bn). The other significant areas of expenditure were mental health services £309m, community health services £211m, continuing care placements £200m and primary care (including prescribing) £510m. The CCG spent £31m on the organisation's running costs.

**An analysis of the CCG's net expenditure in 2021/22 is set out below.**

| Commissioning area | £m |
|---|---|
| Acute | 1,664 |
| Mental Health | 309 |
| Continuing Healthcare | 200 |
| Community | 211 |
| Prescribing | 179 |
| Primary Care | 69 |
| Primary Care Co-Commissioning | 262 |
| Other | 165 |
| Running Costs | 31 |
| **Total** | **3,090** |

Percentage of total spend




### 1.1.1.4 Going concern

The accounts have been prepared on a going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

## 1.2 Performance analysis

In this section we describe our key achievements in 2021/22 including delivering the Covid-19 vaccination programme in South West London; the impact of the Covid-19 pandemic on services; our progress in delivering key programmes of work; how we delivered our statutory duties – to involve, reduce health inequalities and improve quality of services; and our role in assuring delivery of performance and constitutional standards.

### 1.2.1 2021 – 2022 highlights

#### 1.2.1.1 Delivering the Covid-19 vaccination programme

**Leading the South West London programme**

By February 2022, the Covid-19 Vaccination Programme in South West London had administered more than 3 million jabs. This milestone was reached around 14 months after the launch of the biggest vaccination programme in the NHS's history.

By June 2022, 1,191,957 people had received their first dose, 1,095,657 had received their second dose, 9,282 had a third and 870,164 had received their booster – a total of 3,167,060 vaccinations.

The South West London vaccination programme has consistently delivered the highest performance across most patient groups (cohorts) throughout the programme. According to NHS England (NHSE) data, our uptake for the booster dose is the highest across all cohorts. However, we are still working hard to increase vaccination rates, particularly in communities where uptake is lower. We are making sure that people know that the offer of vaccination will never expire and encouraging people who are hesitant to come and have a no pressure chat with their GP, local pharmacist, or a member of the vaccination team at their local vaccination centre.

The dedicated work of GPs, nurses, pharmacists and volunteers to deliver the vaccination programme has significantly reduced the impact of this pandemic on

our communities in South West London. New research shows that the risk of death involving Covid-19 is 93% lower for those who have had a booster or third dose compared to those who are unvaccinated. The Covid-19 vaccination is believed to have saved over 130,000 lives in the UK.

**Responding to new guidance**

In 2021, we moved quickly to respond to new guidance as it came out from the Joint Committee on Vaccinations and Immunisations (JCVI) and the government. We successfully redeployed large numbers of staff across the programme to undertake new and different roles. 1,500 workers from our temporary staff bank supported the programme, drawn from different industries, including the airline industry, many of whom have now chosen the NHS as their preferred career route.

In the first wave of cohorts, a particular success was the vaccination of people in care homes where 95.5% of care home staff and 95.6% of care home residents received their first Covid-19 vaccination. This phase of vaccination started in early 2021 and carried on into the 2021/22 reporting year.

In the lead up to 'Freedom Day' on 19 July 2021, we opened the doors of our vaccination clinics to all those aged 18 and over encouraging them to come forward for their first dose. Once 1.8 million jabs had been delivered and after six months of activity with restrictions easing, four of our community vaccination sites; Battersea Arts Centre, AFC Wimbledon, Crystal Palace Football Club and Harlequins Rugby Club returned to business as usual for their fans, patrons, and customers.

**New pop up vaccination sites**

Our five other community vaccination sites and three hospital hubs at St George's Hospital, Croydon University Hospital and the Royal Marsden continued to operate alongside GP led vaccination centres and numerous community pharmacies. Throughout 2021/22, these have been complemented by hyperlocal pop up clinics in community centres, churches and shopping centres. Since December 2021, 150 pop up clinics have been delivered and supported with outreach to our communities. These are designed to reach those who experience health inequalities and have been delivered in partnership with the six local authorities. We set up regular pop up vaccination clinics in local maternity wards and supported the wider system through a mobile vaccination service for those waiting to be discharged to a care home.

**School vaccination programme**

Following guidance, we also delivered a school vaccination programme for those aged 12-15, in partnership with our School Age Immunisation Service (SAIS) providers, Hounslow and Richmond Community Healthcare NHS Trust and Croydon University Hospital. We developed an in-school and out-of-school offer, working with local schools and headteachers to minimize the impact on the school day. Our offer of dedicated clinics in our community vaccination sites have proved popular – particularly over the school holidays and weekends. To date 50% of 12–15-year-olds in South West London have received their first vaccination and South West London has the highest uptake rates in London for this cohort.

### Covid-19 booster vaccinations

In autumn 2021, we focused on promoting the Covid-19 booster vaccination alongside the flu vaccine for all those eligible. Both vaccines help to protect people from the worst outcomes, whilst reducing the spread of the viruses and helping to protect the wider community. Where possible, we developed clinics to co-administer the Covid-19 booster with the annual flu vaccination for adults. The booster vaccination offer was extended to those aged 40 and over in November 2021 and pop ups opened at Southside Shopping Centre and Harlequins Rugby Club, to support the programme. We also continued to run our evergreen offer with hundreds of people each week continuing to come forward for their first dose.

On 12 December 2021, the government announced that the booster vaccination would be offered to all those aged 18 and over with the gap between the second dose and the booster reducing to three months. Our clinicians and other staff pulled out all the stops to offer every eligible adult the chance to book a Covid-19 booster in a race to protect the nation against the Omicron variant. Community vaccination centres stayed open to midnight and we were supported by the Armed Forces. In just three weeks, we delivered 249,775 vaccinations; 221,649 booster vaccines, 14,408 second doses and 13,719 first doses.

### Looking ahead

As we look ahead to the future of the vaccination programme, we are focused on key priorities outlined by NHS England. We will continue to be ready to mobilise in response to new guidance from the JCVI as well as continuing to offer first, second and booster doses to those that have not yet come forward.

While this report focuses on our activities in the previous year, the vaccination programme continues to play an important role in combatting Covid-19. From spring 2022, we introduced the offer of a further booster dose to those who are over 75, or who are immunosuppressed and aged over 12. Our vaccination programme for 5–11-year-olds also began. We developed a successful overseas vaccination verification service at Roehampton and Centrale Shopping Centre in Croydon. A South West London Vaccination Board has been set up, to oversee a programme of work for the wider immunisation programme, including Covid-19.

We also continue to offer vaccinations to those who have not yet come forward. Individuals can walk into any of our sites across South West London www.southwestlondon.icb.nhs.uk/covid-19. To support individuals in making an informed decision about the vaccine, our clinicians are on hand at our vaccination clinics, hyper local pop ups and via a phone line to have a chat about the jab.

#### 1.2.1.1.1 Engaging with communities on vaccinations

### Our overall vaccination engagement approach

Over the past year our engagement leads continued to build on each borough's communications and engagement plans – focusing on reaching people and communities who experience health inequalities and where uptake rates are low. Following an in-depth mapping exercise in each borough, working with colleagues in local authorities, the voluntary sector and business intelligence, we focused on the following populations – people from Black, Black Caribbean and Black

African communities, Eastern European and Baltic communities, Bangladeshi and Pakistani communities, and people in areas of deprivation. Each borough worked closely with local authority, voluntary and community sector, and NHS partners to develop their plans. Successfully reaching underserved population cohorts in each of the boroughs, has cemented the building blocks needed to continue the work towards reducing health and inequalities through the Core 20 Plus 5 programme recently launched.

Each plan provides evidence based information to encourage vaccination uptake and has successfully evidenced the strong and trusted relationships formed as a result of tailored engagement. The plans are tailored according to borough population data – accounting for specific communication and engagement needs, as identified by working closely with community leaders and champions.

We have also worked in partnership with faith leaders, local BME forums and key community connectors to share the latest information. In Croydon, for example, we gathered insight from Black and Ethnic Minority communities to shape a more culturally responsive vaccine service. We worked with specific communities to ensure that we are providing the best information – for instance, work with the Muslim community has included specific content about the vaccine ingredients, work with faith leaders connected to Ramadan and pop ups at local mosques. In Kingston, we worked in partnership with Refugee Action Kingston to deliver sessions in Arabic. These reached refugees, asylum seekers and permanent residents in who speak Arabic in the borough.

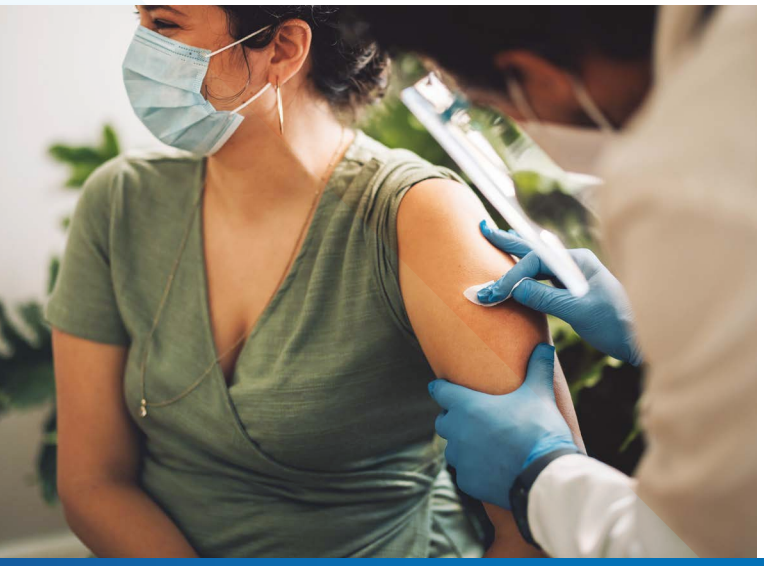
Insight from our communities informs the delivery of the vaccination programme and how we engage. In 2021, we collected insight via focus groups and surveys - completed by over 10,000 people including from our people's panel. We also collated insight from communities who are digitally excluded via voluntary sector partners and local authority staff such as housing managers who have wider reach into those communities. The impact of this engagement work has influenced our messaging, how we reach people as well as operational planning for how and where to deliver vaccinations. For example, young people stressed the need for a friendly, welcoming environment; and one in three people participating in our autumn insight work felt reassured after speaking to a clinician. This insight led to us offering bookable conversations with friendly clinicians to enable people to make an informed choice about the vaccine.

As well as data and insight, our approach to engagement is informed by learning and best practice gathered throughout the programme. We are proactive and go out into local communities. This includes regular attendance at events, working with foodbanks, housing providers, asylum seeker hotels and more. Across all six boroughs, local leads have connected with public health and community partners to support the planning and promotion of hyperlocal pop ups, delivering information in the many languages spoken across boroughs. Every contact counts was evidenced in our local engagement where we offered the vaccines to people from underserved communities at their home of residence, offering health checks at the same time.

We developed the way that we partner with the voluntary sector to expand our reach and strengthen our work setting up partnerships with community-based organisations. As a result, networks of community champions regularly share information about the vaccine through webinars and in person sessions. In Sutton, for example, our 70 Health Champions helped us to reach over 100,000 residents through their own networks, including the digitally excluded by disseminating key vaccine information and giving us feedback about the information from residents.

Giving people clear information about the vaccine via these networks has served to build trust and enable individuals to make an informed decision about getting vaccinated. During the lead up to Christmas, in response to the Omicron variant, we commissioned street ambassadors who spoke to over 20,000 people in a three-week period.

Where specific groups have low uptake of the vaccine, we work in partnership to deliver sessions in response to community need. For instance, to support uptake among the 12 to 15-year-old cohort, we co-delivered a programme of borough-based webinars with clinicians and local authority colleagues. In response to the lower uptake among pregnant women, we organised



webinars with midwives, created fact sheets and shared stories of vaccinations. In Wandsworth, for example, we codesigned a pilot sensory clinic, transforming the Covid-19 vaccination experience for people with Learning Disabilities and Autism. In Merton, we worked with Merton Vision to develop resources for those who are visually impaired. In Richmond, we organized a specific Q & A event for unpaid carers in partnership with Richmond Carers Centre and Healthwatch Richmond.

The learning from our engagement activity continues to inform our approach.

### 1.2.1.1.2 Delivering the vaccination programme in our six boroughs

## CROYDON

In Croydon we continued to set up vaccination sites in areas with low uptake and higher deprivation such as Selhurst Park, St Chad's Church and Legacy Youth Zone. In addition, GPs set up three new sites working through Croydon's Primary Care Network (PCN). The overseas vaccination validation service was expanded to Centrale Shopping Centre vaccination clinic. Centrale Shopping Centre was one of two sites where people could book a chat with a healthcare professional, as part of the 'Come and have a Chat campaign'. Our engagement team worked in partnership with the local

authority, and community and voluntary groups to organise virtual meetings, and events and focus groups to help maintain an ongoing dialogue about the vaccine.

From July 2021, this work was complemented by funded face to face engagement from the 'Ask Me' team who have conversations about the vaccine in Croydon on a weekly basis. The 'Ask Me' team brand identity was co-designed with members of Black and Minority Ethnic community groups to create a visual identity. Working alongside the council's pop-up testing team, we have been able to plan routes based on areas which have the lowest vaccine rates and are able to advertise which clinics are available each week The team has been very successful in providing information that leads to a change of intention around the vaccine, for instance when engaging with college students in Croydon, the 'Ask Me' team prompted 23% of individuals to come forward and get their vaccine. The team have supported our vaccine pop ups in community locations by providing leaflets advertising the events and answering questions in the local area in the lead up to the events. Each week the team feeds back insights about what they are hearing from residents which allows us to tailor our messaging in 'real time'. Towards the end of 2021, we enhanced this offer with a vaccinator working from a van in static locations in the same areas as the engagement teams.

## MERTON

Our GPs, nurses and pharmacists worked with local communities and faith groups to set up clinics in various community locations to bring vaccinations closer to local people. Pop ups were run at New Horizon Centre Pollards Hill, St Olave's Church, Power Centre Church and AFC Wimbledon. These clinics have enabled us to reach groups in the population who have had lower take up of the vaccine. Throughout the programme, our engagement team worked with GPs and pharmacists and local councils to talk to different groups and communities online through virtual meetings and events, answering questions to help address the concerns of many people about the vaccine. Community engagement on the vaccine programme has helped to foster better relationships with community and voluntary groups. A specific example includes working with Merton Vision to provide training to volunteers to enable them to better support those who are visually impaired to get the vaccine.

## WANDSWORTH

In Wandsworth, we worked with local community groups to set up clinics in various community locations to bring vaccinations closer to local people. We ran pop-ups at the Alton Estate, Katherine Lowe Settlement and the Holy Trinity Church. In addition, local insight led to the delivery of a sensory clinic in Wandsworth. This provided an immersive sensory experience aimed at helping young people with a learning disability conquer their fear of needles. We have worked closely with the Roehampton Response Network to ensure the vaccination approach is suitable for the community and continued to offer opportunities to engage to residents and communities. In addition, the overseas vaccination validation service at Roehampton Vaccination Centre was the first mass vaccination site offering appointments to validate overseas appointments.

## KINGSTON

In Kingston, we have continued to work together with health and care partners as well as local voluntary and community organisations. We delivered virtual meetings and events for our diverse communities, including residents from ethnic minorities, those with learning disabilities and younger people. This included supporting a Kingston Facebook Live Q & A session, which had over 11,000 views, a 'Building Vaccine Confidence' event hosted by the Kingston Race Equality Council, and funding grassroot groups to run activities about the Covid-19 vaccine for their communities. We worked with local community groups to set up clinics in various community locations such as schools, Kingston Mosque, and for staff at Chessington World of Adventure. At Kingston United Reform Church we held a health and wellbeing day for those who are experience homelessness or seeking asylum. We also partnered with Kingston Hospital to identify hospital clinicians who speak languages including Polish and Filipino to support vaccine Q & A sessions and vaccine pop ups.

## RICHMOND

Richmond has some of the highest vaccine uptake rates in South West London and the highest uptake at our local vaccine clinics set up in community locations. We worked with local community groups to set up clinics in various community locations and together with local authority colleagues we have developed a communications and engagement plan to promote each clinic. Pop up clinics have taken place in local schools and colleges, community centres, such as at Castelnau and Cambrian centres and a Health and wellbeing day for people who are homeless at The Exchange, Twickenham. This integrated approach has led to high vaccine rates.

Our engagement team is continuing to work with local health and care partners, Healthwatch Richmond and local community organisations and groups to talk to different groups and communities online, and through health and community events and visits, answering questions to help address people's concerns about the vaccine. These include an event Celebrating Black History Month which was attended by 70 individuals and 15 organisations and a neighbourhood care group garden party attended by 40 local vulnerable and older residents.

We continue our partnership work with Richmond Council including supporting the local community Covid-19 champions programme and working with Public Health to deliver health-focused outreach work to targeted communities and areas in Richmond. Our community health vehicle will be visiting locations in the borough chosen due to continue low vaccine uptake. This will be an opportunity to promote local services, health and wellbeing information and have conversations and make connections with local people and communities.

## SUTTON

Sutton's vaccination programme has performed very well since the start. The borough has consistently had the highest percentage of vaccine uptake for 1st and 2nd doses in South West London.

The opportunity to make a real difference to our vulnerable communities in Sutton is the driver behind the engagement work we have been undertaking in Sutton to "make every vaccine count."

Helping our most vulnerable residents and communities to have the Covid-19 vaccination has been an important part of our engagement with residents since the start of the vaccination programme in December 2020.

We targeted vulnerable communities through setting up pop up clinics in various locations across the borough, with more planned in 2022. We have visited a local Traveler's site; several supported living schemes; supported housing for homeless people; and social housing estates – including high rise residences across the borough. We offered pop ups for homeless people at the Salvation Army in Sutton and at Sutton Nightwatch in Wallington delivering first, second and booster doses to hundreds of vulnerable residents.

The effort this takes is not lost on the people receiving the vaccine – who genuinely appreciate the team coming to them as many of them have struggled to engage with local health services in the past. There are wider health and care benefits too, working with our partners we ensure that we make every contact count. We have been able to offer blood pressure checks, support residents to register with a GP and link people into support services available through social prescribing, particularly as the issues identified often relate to the wider determinants of health. This will help our wider work in Sutton – especially our focus on reducing health inequalities through our population health programme of work with our local primary care network colleagues.

### 1.2.1.2 Further key priorities in 2021/22

Responding to the ongoing Covid-19 pandemic and delivering the vaccination programme were major areas of focus for the CCG but alongside these we continued our work to address the health needs of local communities; to catch up on the back log of diagnostics and treatments delayed because of Covid-19; and to further develop our ability to deliver health and care in partnership with our ICS partners. In this chapter we look at some of the challenges and achievements in delivering our key programmes of work.

#### 1.2.1.2.1 Reviewing and revising borough health and care plans

Our vision for the six boroughs in South West London is for them to be places where people are supported to live healthy, fulfilling lives in thriving and supportive communities. We want to work with our partners to ensure people have the same life chances, regardless of where they are born or live, as well as equal access to health and social care.

Our health and care plans describe what we and our borough-based partners will do to improve people's health and meet their needs at every life stage – in other words, what we'll do to help them to start well, live well and age well. Health, social care

and community organisations across each borough helped shape and develop the plans.

Our original plans, published in 2019, were co-produced with residents and stakeholders. Over the past two years the coronavirus pandemic has had a huge impact on people's health. So, starting in summer 2021 each borough refreshed its plan, with borough Health and Wellbeing Boards signing them off early in 2022.

We developed a consistent engagement framework for this refresh – mapping existing insight; working with partners and stakeholders through specific workshops; and testing the plans with community groups and networks. Targeted engagement was undertaken if changes had been made to specific clinical areas or affecting a particular community.

Addressing health inequalities is a vital element in each plan. Increasingly we will be adopting a population health management approach to tackle health inequalities, building on an NHS England funded pilot that ran in Sutton in 2021.

You can read more about our approach to population health management and health inequalities in chapter 1.2.3 Reducing Health Inequalities.

**Below is a snapshot of how each borough reviewed their plans:**

## CROYDON

To help us refresh the Croydon Health and Care plan in 2021, health and care partners continued to engage with local people to understand how we are meeting their needs and improving health and care outcomes and how we can improve. Programme and clinical leads for each programme led engagement on specific areas of the plan, including:

- Mental health community hub and spoke model co-design engagement
- All age disability hub
- Learning Disabilities and autism strategy
- One Croydon Service User Group
- Primary Care - integrating primary and secondary care
- Healthwatch led engagement on areas including urgent and emergency care, young people's experiences of mental health and ICN+
- Over 70 engagement events across the borough as part of the Covid-19 vaccination programme
- Building community partnership workshops held in each locality strengthening partnerships

After analysing feedback from this engagement, emerging themes were that people wanted joined up care closer to home. We drafted a set of priorities and undertook a stakeholder discussion exercise to test these.

We remained committed to our original aims and, following the impact of Covid-19, we added new aims to:

- support people to recover from the effects of the pandemic;
- support our health and care workforce;
- embed a population health management approach; and
- tackle inequalities in wider areas that impact health, like housing, employment and education.

The Croydon Health and Care Plan was approved by the Health and Wellbeing Board on 19 January 2022.

Read the Croydon Health and Care Plan at www.southwestlondonics.org.uk/croydon

## KINGSTON

The plan for 2022/2024 is a refresh of some of the existing priorities with a new focus on tackling health inequalities across the life course, tackling obesity, improving mental health, and improving the lives of carers.

To help us refresh the 2019 plan, we established a development subgroup with representatives from health and care partners, the voluntary and community sector and Healthwatch. We used recent surveys and reviews carried out during the pandemic response period, together with the results of an online survey to inform the updated plan.

Overall, the findings from this engagement indicate that the people who responded to the online survey support the refreshed health and care plan for Kingston.

People wanted to see more specific detail around how the priorities would be achieved and implemented, and how the plan would be funded. They also wanted to see included more specific actions about active travel and green infrastructure, particularly supporting school streets and encouraging cycling; support for Long Covid; wider communications and not just relying on digital; and a focus on the wider determinants of health including housing, along with addressing health inequalities.

The final version of the Health and Care Plan was approved by the Health & Wellbeing Board in November 2021.

Read the Kingston Health and Care Plan at www.southwestlondonics.org.uk/kingston

## MERTON

The Covid-19 pandemic exacerbated health inequalities in Merton with a negative impact on mental health and child welfare. Disadvantaged groups had significantly higher mortality rates during the pandemic.

During 2021, we consulted people on our existing health and care plan, seeking their input into a new plan for 2022 to 2024.

More than 100 people attended virtual workshops in September 2021. We also held discussions with specific community organisations such as Merton Centre for Independent Living, and Covid-19 Community Champions.

Themes cropped up regularly during the consultation:

- the need to listen to communities in their own environment, investing in and empowering them and understanding their needs;
- the need to be culturally sensitive and make communities part of the planning and delivery of services;
- the importance of mental health and emotional wellbeing across start well, live well and age well and the impact it has on other life courses – for example, how parental mental health affects children.

As a result, we have a new, collective vision for Merton – "Working together to reduce inequalities and provide truly joined-up health and care services with and for all people in Merton, so they start, live and age well in a healthy place."

Following the success of the consultation, we will continue to work with communities, and trusted leaders, such as the Polish Family Association and BAME Voice, to ensure that

local voices shape the development of the borough's health services. To help us do this we will develop a communications and engagement strategy for Merton Health and Care Together by July 2022. With ongoing quarterly reporting, this will ensure an active dialogue about partnership work across Merton.

Read the Merton Health and Care Plan at www.southwestlondonics.org.uk/merton

## RICHMOND

During the year we refreshed Richmond's health and care plan which describes our vision, priorities, and actions to meet the health and care needs of local people to create a two-year plan (2022/2024). By working together, we believe health, social care and the voluntary sector can deliver quality health and care services that support local people.

Working with our health and care partners we ensured a focus on hearing from communities disproportionately affected by Covid-19, experiencing health inequalities and underserved communities by reviewing local insight collated in response to the pandemic. This included Healthwatch Richmond's Covid-19 experiences report; Youth Out Loud! Young People's Wellbeing during Covid-19 Crisis; JSNA refresh and the CCG's own Covid-19 vaccination behaviours and attitudes insight results.

During November and December 2021 local people had an opportunity to share their views on our refreshed priorities through a mix of face to face discussions at local forums, via an online survey and written feedback. Overall those who shared their views with us support the refreshed health and care plan for Richmond.

People asked for further information or clarification on several areas including:

- more actions to support unpaid carers;
- greater emphasis on travel as wider determinant of health;
- more about the impact of the pandemic on health inequalities;
- greater emphasis on the role of schools in developing a healthy lifestyle;
- that exercise resources and activities should be equally available to everyone; and
- ensuring services remain accessible to all as a result of increase in online access to services and digital support.

Health and care partners considered the key themes from the feedback to inform the final version of the health and care plan which was approved by the Richmond Health and Wellbeing Board in March 2022.

Read the Richmond Health and Care Plan at www.southwestlondonics.org.uk/richmond

## SUTTON

We reviewed Sutton's Health and Care Plan by reviewing the core themes in each life stage – start well, live well and age well – where we can make the greatest impact by working in partnership to improve health and wellbeing.

Engagement on the plan took place between October 2021 and February 2022 and incorporated a wide range of feedback from across the borough.

As a system, we spoke to over 600 people at 26 listening events, webinars and interviews led by Sutton's CCG engagement team, with support of Sutton PCN Clinical Leaders, St Helier Hospital, Sutton Council and Community Health Champions to ensure they were involved in shaping the Sutton Health and Care Plan priorities.

Key engagement already undertaken with local partners included:

- Sutton Integrated Care Partnership Board - 13 October 2021
- Sutton Voluntary Sector Forum – 10 November 2021
- Sutton Health and Wellbeing Board – 6 December 2021
- Sutton Plan Partnership Event – 1 February 2022

Engagement also included:

- Advocacy for All - engagement on the Learning Disability Strategy consultation;
- Healthwatch Surveys on Covid-19 Experience;
- The Stronger Sutton Conversation: Residents' Survey (findings relevant to the health and care plan); and
- Covid-19 Listening events.

In addition, quotes and reflections from 11 local leaders of grassroot organisations who were interviewed as part of engagement for the Sutton Health and Care Plan.

People told us that:

- they are concerned about access to medical support, such as routine NHS appointments and face to face contact with GPs
- they are concerned about the impact of Covid-19 and recovery
- they need support with mental health issues such as depression, isolation and anxiety

We also received positive feedback for the model of engagement used during the Covid-19 Listening Events.

We will use this feedback to start in-depth conversations with residents, communities and stakeholders on how best to partner with them to address the health and care challenges facing Sutton.

The plan was adopted and approved by the Sutton Health and Wellbeing Board on 1 March 2022.

Read the Sutton Health and Care Plan at www.southwestlondonics.org.uk/sutton

## WANDSWORTH

Between August and December 2021, we spoke to 120 people to hear how we could work together to improve health and wellbeing in Wandsworth. We held workshops where local people could reflect on the previous plan and share their experiences and expertise.

Within each life stage – start well; live well; age well - we identified three core themes where we can make the greatest impact by working collectively to improve health and wellbeing. These were:

- Integration (a holistic approach to supporting the whole person)
- Health Inequalities (reducing barriers to access and tailoring provision to local needs)
- Prevention (taking a proactive approach to jointly improving the health and wellbeing of Wandsworth residents

In practical terms, we will target our actions at key areas of concern. For example on childhood obesity, we will aim to address young people's BMI, improve diet, and increase physical activity. Other areas of focus include improving mental health and inequalities.

For working-age people, we will address ethnic inequalities in mental health. We will take a local approach, working with

community-led health clinics and the Health and Wellbeing Hub – part of the Ethnicity and Mental Health Improvement Project (EMHIP). We will also focus on tackling diabetes and cardiovascular and respiratory disease.

Wandsworth has London's sixth highest rate of emergency admissions due to falls in people aged over 65. A key priority for the age well strand of our plan is working with the voluntary sector on falls prevention. We will also focus on integrating services with care and nursing homes and social prescribing services which address this age group.

Read the Wandsworth Health and Care Plan at www.southwestlondonics.org.uk/wandsworth

### 1.2.1.2.2 Primary care developments in 2021/22

General Practices and Primary Care Networks (PCNs) continued to lead the transformational agenda in South West London in 2021/22, successfully delivering a range of work programmes. PCNs rapidly mobilised the Covid-19 vaccination response, through a combination of fixed vaccination sites being staffed by PCN teams, and roving models being jointly delivered with community services to vaccinate care home and housebound residents, and other vulnerable groups. PCNs delivered a rapid, efficient and responsive service model to allow them to meet the needs of their local populations. You can read more about the vaccination programme in section 1.2.1.1.

With money from the NHS Winter Access Fund to support the urgent care system, the South West London Primary Care Provider Alliance provided additional primary care capacity on weekends and bank holidays from 18 December 2021 until 30 January 2022. This gave patients a local phone number to call, which directed them to a clinical triage when their practice was closed, and from there into local access hubs if they needed to be seen.

The service answered 10,579 calls with 87% of patients getting advice and care via a telephone consultation and the remainder being seen face to face.

A patient survey showed that the service was well used and valued across South West London. While the service was active, it also supported a reduction in attendances at emergency departments.

Due to its success, we are considering using the service to support further busy periods.

**Primary Care Networks (PCNs)**

PCNs continued to develop during 2021/22, especially in developing the workforce and making use of an NHS England scheme that funds recruitment to new roles including:

- Clinical Pharmacists
- First Contact Paramedics
- First Contact Physiotherapists
- Mental Health Workers (employed by the mental health trust and deployed to PCNs).

South West London CCG has at least 470 additional roles in place and there has been a large increase in recruitment. We are on track to have the largest additional workforce across London.

To support the recruitment and retention of the primary care workforce, the South West London training hubs provided support with training, workforce development and education. Schemes implemented in 2021/22 include:

- Recruitment and Retention Programmes
- CPD and training for multi-professional workforce

- Health and Wellbeing Coaches Peer Support
- Multi Professional Faculty Groups

**Clinical pharmacists in Wandsworth**

Clinical pharmacists are playing an increasingly important part in the care GP practices are offering their patients.

As well as detailed reviews of medication, they talk to people about their overall health and welfare and advise them on living healthier more fulfilling lives through social prescribing.

At Brocklebank Primary Care Network (PCN) in Wandsworth PCN Lead Clinical Pharmacist, Ryan Benbow and his team of four clinical pharmacists serve 30,000 local people across three sites. Typically, they see around 500 people each week, particularly people taking multiple medications, people with medications for long term conditions and those on drugs that require regular safety monitoring.

A recent patient satisfaction survey found that 100% of the people surveyed were happy to be consulted again by the clinical pharmacist.

**Social prescribing in Richmond**

Social Prescribing in Richmond is carried out by RUILS which offers a holistic service that supports individuals to be more independent and active in their local community. There are now 16 link workers and a manager carrying out the service which has gone from strength to strength in the last year. Approximately 250 different services were referred to in the first six months of year two. New services are being added continuously to the social prescribing service database and the team has stretched out geographically beyond the borough. The top reasons for referral currently include social isolation (949), mental health support (693), weight management (514) and social needs (383). In addition to these referrals, some of the link workers have been working on patients lists, contacting patients such as carers; those on the housebound register; and people aged 90 and over. This has proved to be a good way of unearthing hidden needs and supporting harder to reach patient populations.

**Integrated working across primary care and community health and care services**

Across Kingston and Richmond we have been working with our partners and local people to define a more developed, collaborative, local way of working aligned with our developing Primary Care Networks (PCNs). Bringing together resources (personnel, estates, digital) in smaller local areas such as those covered by PCNs enables better relationships and instills a more local and focused approach to population health and how we deliver care. In a series of workshops, staff and patients/community partners have acknowledged the work done so far such as Proactive Anticipatory Care, staff working in multi-disciplinary teams and the collaborative working across organisations during the pandemic. From this they started to form a picture of what a future locality model in our boroughs would look like.

Working with people and communities in a meaningful way to identify and address what matters to them has been identified as key to this new way of working. We started the conversation about working in smaller local areas with our patient and community partners in our community involvement group and Patient Participation Group network in Richmond and our patient and public forum in Kingston. Our next step

will be to build on existing work with our partners to develop an integrated approach to working with people and communities, so we all have a clear understanding and can fully understand what matters most to local people about their health and wellbeing. Demonstrating this understanding and working with our communities will build trust in local health and care so that our communities know that their views are listened to and that they can inform the health and wellbeing priorities for their area.

**Sutton Primary Care Network led Community Virtual Ward**

The Sutton Primary Care Network (PCN) led Community Virtual Ward was established on 2 February 2021 as part of the local NHS response to the Covid-19 pandemic. It is a partnership between Sutton Primary Care Networks, Age UK Sutton, Sutton Council Adult Social Care, Sutton Health and Care Community Services and Epsom & St Helier University Hospitals NHS Trust.

Virtual wards support patients, who would otherwise be in hospital, to get the acute care, remote monitoring and treatment they need in their own home, including care homes.

Initially established to support the safe discharge of coronavirus patients from St Helier Hospital back into their own homes, the Virtual Ward has been expanded to care for patients with long term conditions, such as heart failure and chronic obstructive pulmonary disease and frailty, who are well enough to recuperate at home - with the support of PCN clinical directors; frailty and respiratory consultants from Epsom and St Helier University Hospitals NHS Trust; social prescribing link workers; the medicines optimisation team; adult social care; and multidisciplinary clinicians and coordinators.

The virtual ward service offer includes a virtual ward round three times per week, pulse oximetry, wellbeing checks (day two and seven following discharge) and the management of complex cases through PCN-aligned Community Response Teams. Patients are also able to self-monitor their vital signs using remote monitoring technology supplier by the Virtual Ward.

**Primary and urgent care in one service at Queen Mary's Hospital**

After the urgent treatment centre at Queen Mary's Hospital needed to close temporarily, we launched an innovative pilot service, offering people same-day access to GPs and emergency practitioners for minor illnesses and injuries. This urgent care hub operates from 8am to 8pm, seven days a week, and is delivered by St George's University Hospitals NHS Foundation Trust, Wandsworth GP Federation and out-of-hours provider SELDOC.

Changes to the pilot from April 2021, meant people could call a dedicated number for emergency practitioner appointments to treat wounds, sprains, broken bones, and earaches. GP and emergency practitioner slots have since been near capacity. Surveys reveal high levels of patient satisfaction and that, without the hub, many respondents would have gone to A&E.

We conducted detailed engagement in the Roehampton area to ensure the future service model is influenced by insights from patients and the public most impacted by any changes. The service team also captured patient experience information and staff views through a survey, which were used to evaluate the pilot service.

The engagement team in Wandsworth has been talking to informal and formal leaders from communities in and around Queen

Mary's Hospital since February 2021. We used our regular attendance of Roehampton Response Network meetings, engagement at community-led event and articles in community-owned newsletters to keep people updated on developments.

Our engagement activities generated strong relationships and significant goodwill, which gave us the ability to recruit local people to partner with us as paid advisers in the design, recruitment of participants, and analysis and interpretation of data as part of the pilot service evaluation.

Our engagement work aimed to understand how well the hub was meeting the local community's health and care needs. Specifically, this research explored how much the local community are aware of the hub, how they use the hub and if they feel any healthcare needs are not being met. A diverse group of eight people who live and work in the Roehampton area were recruited to work alongside them as paid advisors. The group met virtually using Zoom three times over the course of six weeks.

Exploration labs and focus groups were formed to allow participants to share their experiences, views and ideas. Thirty-six Roehampton residents took part in these groups, with a broad representation including recent migrants, those aged 18 to 30, people from areas of high deprivation and the over 60s. Those taking part have included people who have not used the hub before.

The key findings were:

- Awareness – nearly half (43.9%) of the residents who registered to take part told us they had not heard of the urgent care hub before this project. Gaps exist in awareness and understanding of the hub.
- Understanding – residents agreed that they needed more understanding of what to expect from the service and how their needs would be met. The service needs promoting, particularly via offline methods and via existing community links.
- Trust – residents tend to use healthcare services that they trust and where they have the assurance they will be seen.
- Access – routes to access different types of healthcare services vary slightly across age groups and for those who have English as an additional language. Information about the hub and how to access it is not accessible to everyone. Residents were keen to reconsider a walk-in element.

As a result the pilot has been extended until September 2022 and the service model is being developed to respond and a communications campaign is being developed to raise awareness.

**Optimising electronic referral system for advice and guidance**

In Kingston and Richmond, GPs have begun using the electronic referral system (e-RS) to encourage GPs and specialists to make the most of the advice and guidance functionality within it. This is a move away from the use of existing Kinesis software where variable access by GPs and specialists reduced its benefits. By referring through e-RS, GPs are prompted to access the latest information about care pathways so they can make better informed decisions about whether a referral to a hospital outpatient appointment is essential or whether further primary care work may be more appropriate. It also provides an opportunity for dialogue between primary and secondary care clinicians which facilitates mutual

understanding and development of more effective pathways, thus improving care for patients.

### 1.2.1.2.3 Service recovery and improving access following Covid-19

**Hospitals collaborate to reduce long waits**

Normal health services were severely disrupted during the Covid-19 pandemic as they were affected by a range of issues that reduced capacity including infection prevention and control measures; staff sickness; patient fears about visiting health sites and a wish to reduce the burden on health services by some people. This means more patients than ever before are waiting to be seen and treated in hospitals.

Locally, our four acute trusts – St George's, Epsom and St Helier, Kingston and Croydon Health Services – worked together to help reduce the number of people waiting and continue to do so.

This work, which is led by our clinical networks of GPs and hospital doctors and nurses, includes giving people the option to move to another site for surgery if this would be quicker.

At Epsom Hospital, regional hubs were established for eye care and orthopaedic treatments such as hip and knee surgery. Patients needing simple surgeries such as cataract and knee replacement, could be seen quicker and discharged home, in most cases on the same day, resulting in a better patient experience.

By December 2021 Epsom Hospital's ophthalmology team had carried out cataract surgery on 1,000 extra patients from neighbouring hospital trusts. As a result, at the start of 2022, waiting times in the region were returning to normal levels seen before the pandemic began.

South West London Elective Orthopaedic Centre – known as SWLEOC – expanded its capacity to include an additional operating theatre, allowing an additional 125 patients a month – or 1,500 extra a year – to be treated.

St George's Hospital also worked with other local hospitals to build a new surgery treatment centre at Queen Mary's Hospital in Roehampton. The centre has four operating theatres and a recovery area providing surgical teams across South West London with theatre time to ensure patients waiting for routine procedures get the treatment they need.

By March 2021, South West London had the lowest number of patients waiting over 52 weeks for what is known as 'high volume, low complexity surgical specialties' – important, but not urgent operations, like cataract surgery or a knee replacement

Fewer than 900 patients were waiting longer than 52 weeks for care at St George's, significantly down from the peak of 2,671 in February 2021 when Covid-19 was putting the NHS under unprecedented pressure.

At Queen Mary's Hospital Surgery Treatment Centre, more than 2,500 operations or procedures had been carried out since opening in June 2021, meaning significant progress had been made in reducing the backlog, particularly in plastics and urology.

Croydon Hospital's elective centre – a Covid-19 secure 'hospital within a hospital' – also helped to ensure planned care is above pre-lockdown levels. The centre was constructed within the existing hospital footprint and was sealed off from other areas, with its own separate entrance, operating theatres, inpatient wards and a

catheter lab, and strict infection prevention and control measures to keep it protected.

By the end of this January, some 2,000 patients had been referred from neighbouring trusts to Croydon's elective centre as part of the co-ordinated approach to reducing backlogs.

Between July 2020 and January 2022, over 18,500 people had safely received planned care in Croydon despite the pressures of the pandemic, with Croydon Hospital providing care to around 300 patients a week for routine surgery or planned treatment – more than a 10% increase since pre-lockdown levels.

**New 'one stop shops' to speed up diagnosis and save lives**

In 2021/22, we invested £10 million in developing a community diagnostic centre or 'one stop shop' at Queen Mary's Hospital, offering a large range of tests and scans.

This means local people can start treatment sooner for serious conditions like cancer and heart problems or get the all-clear and peace of mind.

As well as making services more convenient for local people, the new 'one stop shop' will increase our testing capacity to help manage the backlog created by the pandemic.

The service at Queen Mary's will also be supported new and expanded 'satellite' sites in areas of greatest need, for the greatest benefit to local people.

To help us understand what is important to patients who need diagnostic services we undertook significant engagement with patients and staff. You can read more about this in chapter 1.2.2.

### 1.2.1.2.4 Improving access to cancer services

The number of people seen after an urgent referral to diagnostics for suspected cancer during 2021 was higher than pre-pandemic levels. However, there is still a backlog of people who have been referred to treatment, and we would have expected more people to come forward to start treatment during the pandemic than have done so.

Throughout the pandemic, the NHS in South West London has been the highest performing system in London for the number of patients treated within 62 days of referral, demonstrating good resilience and continued provision of cancer treatments. Our aim now is to build on this and to return to pre-pandemic rates of access to treatment, whilst also meeting the increased number of referrals.

During 2022/23 we will focus on achieving the Faster Diagnosis Standard (FDS), which aims to make sure that nobody waits more than 28 days from referral to finding out whether they have cancer. We are also focusing on making sure people wait no more than 31 days between the meeting with their doctor at which a treatment plan is agreed and the start of treatment.

### 1.2.1.2.5 Urgent and emergency care – access to the right care, at the right place, at the right time

During the year, we worked hard with our partners to expand capacity in our hospitals to help ensure critical services could be maintained if there was a surge in the number of people becoming very unwell due to Covid-19 particularly as we prepared for winter.

We put measures in place to prevent the urgent and emergency care services being overwhelmed, so hospital doctors and nurses, GPs as well as social care colleagues, could continue to focus on those who most needed care. These included:

- Extended primary care services, offering all patients access to pre-bookable and same day appointments in the evenings, weekends and Bank Holidays, from 8am to 8pm
- Increased local 111 capacity, with more call handlers to provide advice and signposting to the right services, as well as increased clinical support
- Same Day Emergency Care at all our hospitals, providing rapid care for emergency patients who would otherwise be admitted to hospital
- Remote monitoring to enable people to stay in their home, care home, or be discharged from hospital more quickly
- Community based services provided care within two-hours to help prevent someone going into hospital
- Working with local authorities and our 350 care homes to prevent residents needing to go to hospital and supporting faster and safe discharge when they were ready to leave hospital
- A 'Bed Bureau' to manage additional community beds, which people could be discharged into if they were not ready to go home but no longer need hospital care.

We also focused on providing mental health support through community-based services but with inpatient beds available if needed.

To help residents to get to the right services, we put into action a comprehensive communication and engagement plan to help raise awareness and signpost people to the appropriate setting, whether that was their GP, a pharmacist, 111 or an urgent treatment centre.

### 1.2.1.2.6 Making mental health services more responsive

We know people's mental health and emotional wellbeing continues to be impacted by the pandemic and demand has increased, especially for children and young people's mental health services.

Specifically, demand for children and young people's mental health services has grown by as much as 30% this year, with many children and young people presenting with greater acuity and complexity than before. We have also seen referrals to our children and young people's eating disorders service almost double that of pre-pandemic levels. Both issues reflect the national picture that clearly indicates the pandemic's impact on our children and young people's mental health.

As a result, we have been reviewing the needs of our communities and our existing transformation plans to meet the demand. We have worked with mental health service providers to focus on prevention and early intervention and develop the capacity we need to support people including support for people who are waiting for treatment.

We have also delivered interventions and projects this year aimed at preventing suicides in middle-aged men and children and young people. This has included offering all our secondary schools and further education colleges the opportunity to access specialist suicide awareness and prevention training through a nationally recognised organisation dedicated to preventing suicides in children and young people. We have also continued to support the development of a Men's Shed in each of our boroughs, where

men can socialise and take part in activities such as woodworking or playing football while, at the same time, providing an opportunity to pass on messages of support for mental wellbeing.

We continued to support the South London Listens community listening campaign launched by the three south London mental health trusts in 2019. In June 2021, the trusts launched a two-year plan based on what the community asked us to do. The plan sets out how we will deliver across four priority areas:

1. Loneliness, social isolation and digital exclusion
2. Work and wages
3. Children, young people and parental mental health
4. Access to services

You can read more about the programme at www.southlondonlistens.org

Below, we highlight some examples of our work over the past year, delivered in the boroughs, to meet local need. In 2022, we will be developing a South West London mental health strategy.

### Support for those in mental health crisis

We have been working across south west London to establish services that provide support to people in mental health crisis as an alternative to attending an Emergency Department.

### Sutton Crisis Café

Working with the voluntary sector has enabled us to provide safe spaces for people in mental health crisis but who don't need a medical intervention. In August 2021, we supported Sutton Mental Health Foundation (SMHF) to open a new Crisis Café in Sutton.

The Café is a community mental health support service for anyone over the age of 18 living in the borough of Sutton. Open 365 days a year it is a safe, calm and supportive non-clinical place for people who feel they are in, or might be moving towards, a mental health crisis that doesn't require medical intervention. It is an alternative to attending A&E.

Staff have experience of mental health issues and SMHF has strong links with other mental health services in the borough, so anyone using their services can access all the support they need.

Since its launch in August 2021, over 150 people have been supported by the Café and over 350 one to one crisis support sessions have been held. 73% of visitors to the Café are self-referred.

### Croydon Recovery Space

A new Recovery Space in Croydon opened in April 2021, from 6pm to 11pm, seven days a week receiving 715 referrals between April 2021 and January 2022. Hosted by Mind in Croydon, the pilot has now been extended for another year with additional crisis support workers to ensure alternative crisis support from 10am to 11pm, seven days a week.

### 24/7 crisis line

During the pandemic, a dedicated 24/7 mental health crisis line was set up, which has continued in 2021/22 across all boroughs. In addition to this, we supported the creation of the Coral Crisis Hub at South West London and St George's Mental Health NHS Trust in June 2021, which brings together the mental health crisis line, the crisis assessment team, street triage and the crisis assessment unit at Springfield Hospital in Tooting. Working with partner agencies,

such as the police, NHS 111 and London Ambulance Service, this multi-disciplinary team ensures patients presenting in crisis receive timely, accessible, safe, effective, high-quality care. It provides same day urgent assessments for those over 18 and telephone support to children and young people. People can be seen at home or in a community setting by the assessment team or in the unit at Springfield Hospital if they cannot be safely assessed in the community.

**Addressing inequalities in mental health linked to ethnicity**

The NHS Race and Observatory report Ethnic Inequalities in Healthcare: A Rapid Evidence Review found that black and ethnic minority groups were less likely to refer themselves for talking therapies, or to be referred by a GP. Even when people are referred, they are less likely to receive treatment.

The Ethnicity in Mental Health Improvement Programme (EMHIP), a partnership between South West London and St George's Mental Health Trust, NHS South West London CCG and voluntary and community groups from Wandsworth, sets out to tackle unequal treatment in mental health care. Based in Wandsworth, and co-designed by users of these services, its first action was to open a wellbeing hub at the New Testament Assembly Church, Tooting, a Pentecostal church with strong roots in the area. Community mental health workers at the hub support people in a trusted setting. EMHIP aims to launch new ways of supporting people – family placements for those in crisis, for example. It will also look at limiting use of restraint and making hospitals feel like an extension of the community. Read more about EMHIP in section 1.2.2.4.

**Croydon Health and Wellbeing Space**

Based in Croydon's Whitgift Centre in partnership with Croydon BME Forum and Mind in Croydon, the Health and Wellbeing Space aims to provide an inclusive and safe space to transform the health and wellbeing of Croydon residents. The free service provides a safe space for those aged 18 years+ to connect and gain advice from support workers, a psychologist and a mental health nurse. Since its launch in January 2022 the hub has supported nearly 100 people. This is the first of three hubs to open across the borough.

**New autism services in Wandsworth**

Children with autism struggled during the pandemic. After listening to families talk about the major difficulties they faced, we have put in place new services to support their needs. These include an autism advisory service, psychodynamic therapy in schools, autism key workers and behaviour analysts, who provide guidance to families on living positively and avoiding situations that trigger anxiety. Dramatherapy is proving popular for younger children too, boosting their social communication skills. And we have developed a buddying programme for teenagers with autism.

We work closely with Wandsworth Council and South West London St George's Mental Health Trust on the roll out of these new services, helping children at an early stage, often without the wait for a diagnosis.

We took onboard detailed feedback from parents and carers of autistic children in mental health crisis. This included the numerous services parents experienced over the years, some that had rejected the referral and others that had intervened with limited impact and where their child continued to

deteriorate. Consistent key messages came out of these discussions, which have helped shape our approach.

Feedback has included the need for consistency and for clinicians and professionals to keep their commitments and timescales promised. Parents want not just any support that happens to be available, but the right support. They want professionals who are able to visit their child in their home (given that many of these children are demand avoidant and can't attend appointments at Springfield Hospital). They want a family centred approach, including someone they can speak to out of hours and during period of crisis.

### 1.2.1.2.7 Transforming care and joining up services

Our programmes to transform care and join up services focused on new needs generated by the pandemic and to prioritise those at greatest risk of health inequalities. We were able to make faster progress in some areas as a result and we will build on these.

**Talking to men about urology**

A Merton project got men talking about urology using informal drop-in sessions. After a fall in people coming forward with symptoms during the pandemic, the sessions demystified the bladder and prostate problems that can be a sign of cancer, urging people to seek early diagnosis and treatment. It also helped people access care in an area of east Merton, which has high rates of health inequalities.

The first event, aimed at men from the area's African and Caribbean communities, took place at Pollards Hill Baptist Church where worshippers were invited to stay after the service to hear a presentation from a local specialist, before opening the floor for questions. More than 50 Merton residents have taken part in the events at the church and through a stall at a community fun day in Pollards Hill.

The project was led by Ben Ayres, Consultant Urologist at St George's Hospital and Dr Vasa Gnanapragasam and Dr Mohan Sekeram, from Mitcham's Wideway GP Practice.

Mr Ayres said: *"What was different here was that, in addition to a group presentation and discussion on urology and health promotion, we offered patients the chance to have a one-to-one consultation with a specialist about something urological that was on their mind – on a Sunday. The idea was that the presentation might jig some thoughts in their heads, like 'Oh yes, I have seen blood in my pee, maybe I should talk to the doctor about that'. But the focus wasn't just on cancer. We covered difficulty passing urine, incontinence, testicular pain – all sorts of urology conditions. I was amazed at the number of questions afterwards – it all seemed very natural."*

Dr Gnanapragasam, Merton clinical chair and urology GP lead for South West London NHS, said the project drew inspiration from the Covid-19 vaccination programme. He said: *We didn't want people to think we only come to them when we need them to do something. So, it was like going back to say thank you, we are here and we will carry on engaging, with topics you want to talk about and issues which are important to you and your communities."*

**Integrated Community Networks**

We continued to work together to join up services available to focus on the prevention of ill health as well as treatment.

In the north-east of Croydon, one of our most deprived areas, our pilot of Integrated Community Networks plus (ICN+) has brought health and care teams together to connect residents with support services around them. Local people now have access to a multidisciplinary team including GPs, social care workers and mental health specialists. Last year, this helped more than 600 residents access help with housing, benefits, social isolation, and mental health. 31% of people reported an increase in health and wellbeing within a year of being referred with 28% reporting an increase in movement, mobility and physical ability.

Building on this success, we rolled out the model across Croydon in 2021 and now over 3,000 Croydon residents have been supported by the ICN+ teams since the pilot was launched in 2020.

As part of this work, we introduced the 'Stay Steady, Stay Well clinic' to improve the health and wellbeing of older adults and to help people live independently for longer. Personal Independence Coordinators (PICs) employed by Age UK Croydon have also been introduced to enable older people to stay well and enjoy a better quality of life. Community hubs - which were held virtually during the pandemic - tackle social isolation, provide links to benefits, drugs and alcohol support, and improve access to mental health support.

To support the work of the ICN+S weekly GP led 'huddles' are held. These are confidential meetings in a GP practice with a multiagency team to discuss the care planning of people with complex health and care needs. This reduces duplication and delays and means that teams can target those patients with escalating needs.

**Long Covid**

In South West London, multidisciplinary teams working across the NHS, local authority and the voluntary sector have come together and established services to support people suffering with Long Covid, which is a term used to describe signs and symptoms that continue or develop after an acute infection of Covid-19. To get a greater understanding of the impact of Long Covid on our local population in South West London, Healthwatch in each of our boroughs worked in partnership to undertake local surveys to gather the experiences of those affected by Long Covid, and to explore the needs identified by them. We will be using this insight to inform the ongoing development of local Long Covid services.

Working across Kingston and Richmond, we have established services for local people and have promoted these on our website, so people are sign-posted to reliable sources of self-help, and other services readily available in the local community to support recovery. We have also done focused work to promote services for health and care staff who have been adversely affected by Covid-19 infection, and the longer-term impact of Long Covid.

The community engagement projects undertaken by Healthwatch Kingston and Healthwatch Richmond during summer 2021 have provided valuable insight and recommendations to inform the development of services in both boroughs. Common themes from these projects include:

- Provide a comprehensive screening process which provides seamless referral pathways to care and support beyond the traditional health and

care to address financial, social and domestic needs

- Improve integrated and coordinated care and support
- Develop peer-led support groups (clinician-aided) to alleviate isolation, provide better information and self-care advice.

We are continuing to work with our Healthwatch colleagues and to use the Living with Long Covid insights to develop a comprehensive communications and engagement plan to inform residents about the self-care options and range of services available for those with Long Covid or those at risk of developing it after Covid-19 illness. This includes providing a toolkit for local groups and our partners that they can use to support discussions about Long Covid; having a focus on our underserved communities by exploring how we integrate Long Covid information into our wider work with these communities. For example, providing accessible information and advice on Long Covid alongside vaccination and other local services at our health and wellbeing days for those experiencing homelessness and refugees and asylum seekers.

### 1.2.1.2.8 Maternity care – equitable, accessible, safe and personalised maternity care for all

Despite the challenges South West London Local Maternity and Neonatal System (LMNS) continued to deliver maternity and neonatal care services throughout the pandemic; there was no 'pause' on births. The restrictions and prioritisation of resources resulted in some services such as carbon monoxide monitoring and homebirths being paused to reduce adverse outcomes for women and babies.

We were able to put assurance measures in place which included:

- Most maternity services remaining open.
- Putting in place remote antenatal and postnatal appointments, depending on gestation and risk assessments.
- Breastfeeding support via telephone from Epsom & St Helier NHS Trust.
- Delivering care to women and birthing people with complex health needs by providing specialist care close to home.
- Providing continuity of carer (midwife known to woman/birthing people) to an average of 40% of women/birthing people who delivered in South West London.
- Recruiting a Darzi Fellow - focusing on engagement with ethnic minority groups.
- Implementing the recommendations following the review of maternity services at Shrewsbury and Telford Hospitals NHS Trust. You can read about these on the NHS England website.

We successfully bid for funds to increase the uptake of immunisations and the use of e-Redbook for pregnant women; develop perinatal pelvic health services; and improve technology through the Digital Unified Tech fund.

Equity, Equality, Diversity and Inclusion is a golden thread for us to focus on as we develop plans for 2022/23. By using population health data, we'll improve access to information for people for whom English is a second language and those living in areas of deprivation - supporting our vision to deliver equitable, accessible, safe and personalised care.

### 1.2.1.2.9 Improving care and outcomes for people with long term health conditions

One of the impacts of the Covid-19 pandemic was to disrupt care for people with long term health conditions. Access to and uptake of health checks, regular diagnostics and annual review appointments were greatly reduced. We know that prevention is best. However, early identification and regular review and continuous management of long term health conditions is essential to reducing health inequalities and ensuring that patients have the best quality of life and to reducing health risks arising from their condition.

In 2021, we were still able to run some innovative programmes to improve outcomes for people with long term health conditions. These were in addition to the existing support services such as expert patient programmes and the outreach screening programmes that identify people with or at risk of one or more long term health conditions. Looking ahead, we will build on these to address the variation in services and health outcomes across South West London.

In South West London, nearly 500,000 people have a diagnosed long-term health condition with 185,000 of these people having more than one long-term health condition. About one third of patients with one or more long-term conditions are not yet diagnosed. Many people have a range of other factors in their life which have a negative impact on their health. So, we are working to shift to 'treating people, not diseases'.

We know that other factors such as housing and income (called wider determinants of health) contribute to poor health and premature death. Therefore, using population health management data is a key enabler in developing and rolling out our support offer to ensure that we work with those people in our communities who are most in need. We are committed to working with system and community partners, to empower people to co-produce and co-deliver services that address their specific healthcare needs, factoring in wider determinants of health and known health inequalities. Practically, this means that we are working to co-produce with community members to deliver services in the communities that have the largest health risks but lowest engagement with prevention and primary care services.

#### Managing complex diabetes care in the community

Technology is helping GPs in Merton and Wandsworth identify the diabetes patients most at risk of complications. Working in partnership, Central London Community Healthcare (CLCH), GPs, diabetes and practice nurses, and dietitians have come together for the project.

Practices use specially designed software to identify and prioritise patients with more complex needs, reviewing their treatment plans to control their diabetes well. Each patient's current medication is monitored, with checks on kidney function and other long-term conditions, before their care plan is updated.

The team have strong links with a diabetes consultant at St George's Hospital who runs a weekly clinic at a GP practice in Roehampton with a diabetes specialist nurse and dietician. This also enables patients who need referral for more specialist support to be easily referred into secondary care and transferred back to primary care when clinically appropriate.

The work illustrates how technology is helping GPs to identify patients most at risk of complications arising from diabetes and how care is improved by working in partnership.

Dr Sachin Patel, Wandsworth Federation Diabetic Clinical Lead said: "I value the opportunity we have in primary care in Wandsworth to have a specialist diabetic team to see our patients closer to home and away from the busy acute trust."

**Kingston and Richmond community-led health and wellbeing programme**

In January 2020, we were awarded £65,000 by NHS England and Improvement to address health inequalities across both boroughs as part of the Health Equality Partnership Programme. The project sits under the local long term health conditions programme and focuses on the prevention, detection and self-management of long-term health conditions in the community. The project aims to address poorer health outcomes by working with local communities to co-produce early interventions, giving people the knowledge and confidence to manage their own health.

The current focus is on Type 2 diabetes and hypertension with links to mental illness as well. Our data tells us that approximately 9,000 people across both boroughs have Type 2 diabetes and 20,000 people have hypertension but don't know. Without an early intervention, these people may end up in emergency services with preventable heart attacks and strokes causing both a high human as well as financial cost. People mostly affected are those living in deprived communities who are often underrepresented in preventative services.

Based on our data and local insights we have identified four communities to work with in Kingston: South Korean, North Korean, Tamil and Kingston Mosque and four areas in Richmond: Castelnau, Hampton North, Ham and Petersham and Heathfield. We have held community engagement events with some of these communities to understand their priorities and to promote the programme. From these events we have recruited 22 community volunteers to date, to deliver health checks, health coaching advice, to signpost people to services and ensure that people visit their GP, or if necessary, urgent care services such as A&E.

Our volunteers are currently receiving training from local health and care professionals before taking part in local community health and wellbeing events. We will be planning several health and wellbeing events over the next year in partnership with local community groups, our primary care networks and our community health volunteers.

The long-term vision is to develop community-led health and wellbeing hubs in both boroughs that are connected to the local primary care networks.

### 1.2.1.2.10 Preventing the causes of ill health

**Healthy Communities Together**

In Croydon, the voluntary and community sector, NHS and Croydon Council are working together through the Healthy Communities Together programme. In 2021 the programme developed the Local Voluntary Partnership Programme to explain the core principles of proactive and preventative care to ensure shared understanding and action across health and care.

The programme has supported more than 70 initiatives to connect residents to neighbourhood groups and services around them to reduce social isolation and support people to stay well as an active part of our community. This has been extended to improve access to mental health support services with a specific pot of funding supporting a further eight groups.

A series of events called 'Building Community Partnerships' have been run, where voluntary and community sector partners come together in geographic localities to discuss issues and challenges affecting their local neighbourhoods. These local partnerships provide the opportunity for organisations to build relationships with health professionals, and other statutory partners such as social workers and housing workers.

**Carers Crisis Prevention Service (CCPS)**

In January 2022, One Croydon in partnership with Croydon's Carers Information Service and Croydon Council launched the Carers Crisis Prevention Service (CCPS). The service, for adult carers aged 85+ caring for adults, offers free proactive support to alleviate carer stress and prevent the carer role collapsing. Engaging with 320 eligible residents, CCPS have created a tailored service to proactively identify and assess people who may need support. Working together with the carer and the cared for, CCPS alongside other social services create a package of care to reduce the stress from the carer.

**Kingston and Richmond Proactive Anticipatory Model (PAC)**

Based on the national anticipatory care model, PAC helps patients to stay healthier for longer, reduces the need for reactive health care and supports actions to address wider determinants of health. It also joins up all parts of the health system and the voluntary and social care sectors.

At the centre of the model is a weekly multi-disciplinary team meeting which includes GPs and professionals from community services, social care and hospital services to provide more proactive and coordinated care. This approach works best for people with escalating risks ensuring they can be better supported at home, harnessing the strengths within local communities.

Working across two PCNs, the pilot launched in May 2021, with GPs referring suitable patients into the team. Patient feedback is crucial. Since January 2022, we have been working to engage patients and their families and/or carers to find out the impact the project has had so far. Due to the complex nature of patients, we worked with frontline staff to create a set of generic interview questions to enable us to understand their experience of PAC, and agreed the engagement model which is telephone call based. The interview questions were then tailored to each individual based on their health and care needs. This allowed us to focus on the health and care support offered through the PAC, rather than general experiences of healthcare.

Those patients that have been interviewed told us they feel more confident to manage their own care and that they have confidence that the MDT team has their interests at heart and work together with them, or family members to come up with a plan of action. We are creating a short film that demonstrates the positive impact PAC is having on patients and are using the feedback from patients to inform the PAC steering group.

**Learning disability strategy for Sutton**

In partnership with the London Borough of Sutton we have developed a five-year learning disability strategy, which sets out how young people and adults with learning disabilities, and their families, can be supported to improve their quality of life and outcomes. We want to offer the best possible services and support to people with a learning disability whilst encouraging independence and offering choice and control. The strategy was co-developed with local people and communities. Involvement activities included: attending public meetings and speaking to key stakeholders; conducting a survey with people with a learning disability and their carers; conversations with advocacy organisations. We also shared the final strategy widely across the borough for six weeks, inviting comments from the public and stakeholders, to ensure that it met the expectations and needs of the wider public and received positive responses and feedback. The learning disability strategy was approved at the London Borough of Sutton's People Committee in December 2021.

**Improving health check uptake for people with learning disabilities**

In Sutton, there are over 1,000 people on the learning disabilities register. We were concerned that the uptake of annual health checks (AHC) was low during the pandemic and established a project to:

- increase uptake of AHCs to 67% in 2020/21 and 75% for 2021/22;
- assess the use and quality of health action plans; and
- investigate the barriers people faced getting their AHC.

The team of two nurses and the LD strategic health facilitator, started by addressing the biggest barrier for people in accessing their AHC which had been identified as anxiety around Covid-19 and visiting their GP because of the risk of infection. The team set up a service where most AHCs were carried out at two clinics or offered at home.

The nurses have completed over 200 AHCs and patient feedback has been very positive stating that the nurses are patient, kind, understanding and caring. The team is regularly awarded five-stars in the Friends and Family Test.

By March 2021, the team achieved the target of 67% for uptake of AHCs and at the time of writing were on course to achieve their target of 75% by the end of March 2022. The project has been extended to March 2023 and will also include increasing uptake of AHCs in 14 to 19-year-olds in special needs schools.

In September 2021, the team was also awarded NHS England's learning disabilities exemplar funding. The funding will be used to focus on those people with a learning disability that have not had an annual health check in over 13 months and those from communities that are harder to reach or have more negative health outcomes.

### 1.2.1.2.11 Care for vulnerable people and at the end of life

Working with care homes continued to be a priority as residents include patients with the some of the highest health and care needs. In the last year we introduced several initiatives to improve support to residents and staff. These included introducing a multi-disciplinary team model which is helping to improve the care of people with complex conditions by making full use of the

knowledge and skills of team members from a range of disciplines. We also continued to work with a range of organisations such as the Prince's Trust, the Health Innovation Network (the HIN) and Skills for Care, to ensure that care home staff have the right skills and support to deliver the highest quality care that is needed in the sector.

The Pioneer's Programme provided by the HIN, offers training and enhanced skills to care home managers. Eighteen places have been offered to care homes in South West London to attend the programme in 2022.

Red Bags and e-Red Bags are used to ensure that important information about care home residents can be easily accessed if they need to go into hospital. In 2021 we relaunched the Red Bag scheme with improved systems to reduce the loss of the bags and to ensure Information Governance compliance of residents' property and information.

Four coordinators recruited in 2021 are supporting the Red Bag and e-RedBag schemes to improve the efficiency and effectiveness of conveying, admitting and discharging care home residents. The coordinators are also working with staff in the four hospital trusts in South West London to ensure that care home residents receive safe co-ordinated and efficient care when they go to hospital in an emergency.

**A new early warning system to improve care**

We have rolled out RESTORE2 – an early warning system that helps care staff identify whether a care home resident is at risk of becoming unwell – across South West London.

RESTORE2 is a tool that helps staff recognise and manage physical deterioration to improve outcomes for care home residents, reduce 999 calls and prevent hospital admissions. It works on the principles of 'right care, right place, right time' and helps staff decide if someone is just 'under the weather' or is becoming unwell and in need of medical attention.

Since it was first introduced in November 2020, we have given training in 332 homes across the six South West London boroughs. This has helped to improve staff's knowledge and confidence – and ultimately the care of their residents – with evaluation suggesting almost nine in 10 reporting a better understanding of the first signs of a decline in a resident's health.

Following on from the success of RESTORE2 training, remote monitoring of residents is also being rolled out so people's vital signs can be checked. Already, 75 South West London care homes are using Bluetooth-enabled technology, which features a digital dashboard to allow healthcare professionals to review residents' conditions and provide tailored advice when not in the home.

## 1.2.2 Engaging people and communities

We work on behalf of every resident in South West London and it is therefore vital that we understand what is important to local people and include people and communities in our planning and decision making.

Insight from engagement work helped the success of our vaccination programme both in shaping how it was delivered and helping us to forge new relationships with different communities. Examples of the role and impact of engagement in specific programmes and projects are given throughout this annual report.

In this chapter we look at the engagement that we led across South West London in the past year and the infrastructure and governance around it.

### 1.2.2.1 Governance and assurance

We have several mechanisms to support good practice engagement across our work.

At a South West London level:

**Community Engagement Steering Group**

We run a Community Engagement Steering Group comprising local Healthwatch organisations, Local Infrastructure Organisations and our borough Patient and Public Engagement (PPE) leads. It is chaired by the lay member for PPI. The purpose of the group is to ensure best practice community engagement is at the heart of our work across South West London. The group has been instrumental in shaping our communications and engagement work. Examples of work include:

- Reviewing our communications and engagement plans for renal services.
- Informing and influencing the development of our ICS people and community's engagement strategy and approach.

- Shaping our engagement work on Long Covid and agreeing to take forward local insight activities across each borough to feed into local developments.

**Patient and public voice in governance**

To support patient and community voice at a strategic level we have both Healthwatch and voluntary sector representation on the Programme Board, Primary Care Commissioning Committee and Governing Body. These representatives are supported by pre-meets to go through papers and offered debrief meetings where needed.

**South West London PPE Network**

We also support the borough PPE leads to meet as a network. Our patient and public engagement professionals from across South West London meet on a regular basis to: discuss and advise on shared engagement work and challenges; shape South West London engagement strategy and approach; progress professional development; offer peer support and share opportunities across their networks. The group were instrumental in developing the ICS people and communities engagement strategy – ensuring that the lessons learned during Covid-19 have influenced how we work moving forwards.

We have been meeting since August 2018 and discussed, reviewed and refined a number of engagement activities – drawing from local learning and practice. Moving into the ICS we will be building an additional network to include patient experience colleagues in provider trusts – with a focus on improving the quality of care and outcomes for our local people and communities.

At a borough level:

**Borough communications and engagement groups**

In each borough we bring together communications and engagement professionals working across the NHS, councils, Healthwatch and the voluntary sector. They meet regularly to work on local joint projects, share knowledge, map stakeholders and coordinate plans for involving local people.

**Local patient and public engagement forums and groups**

**Croydon** – Healthwatch, the voluntary sector and local people are involved on a number of strategic groups and committees including: Local Strategic Partnership; Local Voluntary sector partnership; health and wellbeing board; localities board and Preventative and Proactive Care Board; One Croydon Service users and Carers specialist pecialist and Engagement Group. Each locality has a community partnership group comprising VCSE and active citizens. Croydon has continued to role out small grants through the Local Voluntary Partnerships and this year has extended its reach to mental health grants. Our virtual health network has been invaluable in sharing information throughout the pandemic and we have been able to respond to new developments swiftly and efficiently by working together to share resources and networks to delve deeper into the heart of the community.

This type of representation is replicated in the other boroughs. In addition:

**Merton** – have a Patient Engagement Group which meets every six weeks and contributes to the continuous improvement of services in Merton, ensuring that the South West London Clinical Commissioning Group (CCG) is responsive to the needs and wishes of Merton residents.

**Wandsworth** – run a Thinking Partners Group to help assure their approaches to addressing health inequalities. And they run a Patient and Public Involvement Reference Group - to ensure that the voice of the Wandsworth community is at the heart of our commissioning. Both groups meet every 6 weeks. The borough also ran its 10th year of the Community Grant Scheme which has funded seven small voluntary sector programmes this year. It supports relationships between Community groups and the local NHS, increasing mutual understanding, community resilience and enabling groups to increase their understanding and potential as organisations. The groups interact with the Voluntary Sector Forum, gain support from the Voluntary Sector Co ordination Service and attend Thinking Partners group at NHS Wandsworth.

**Kingston** – host a patient and public forum which meets every 8 to 10 weeks and is open to anyone living in Kingston to attend to hear updates about and share their views on local healthcare services with the CCG. We are currently undertaking a review of this forum to ensure that it is effective, has impact and is aligned to the new governance at Place.

**Richmond** – run a Community Involvement Group which acts as an engagement and equalities reference group for the borough. We also run a regular PPG network which provides PPG reps the opportunity to network and share information and give feedback on primary care and wider healthcare services and initiatives. We are currently undertaking a refresh of the CCG forums to ensure that they are effective, have impact and are aligned to the new governance at Place. Richmond CVS coordinates several forums with local voluntary and community organisations and people with lived experience of services which the CCG takes part in to maintain ongoing engagement with local communities and patient groups. We also run a regular PPG network which provides PPG reps the opportunity to network and share information and give feedback on primary care and wider healthcare services and initiatives.

**Sutton** – Healthwatch and the voluntary sector are involved in several strategic groups such as the Sutton System Leaders, Sutton ICP board, and Sutton Health and Wellbeing Board. We also have a patient reference group which meets every six weeks and it represents the voice of the patients across all 23 GP surgeries in Sutton. We also hold monthly meeetings with Sutton Health Champions to ensure the voice of residents across all 18 wards in Sutton is heard. As a result of the Covid-19 pandemic, over the last two years NHS Sutton has improved the way we engage with local communities and residents. We have developed a successful engagement model based around community Health Champions - local residents who live or work in all 18 wards in Sutton – who have played a key role in our community engagement in Sutton.

Building on that model, a new reference group *"Community Voice"* has been established for Sutton. The group is co-chaired by a PCN Clinical Director and a community leader and members include community connectors, health champions

and representatives of organisations who work with vulnerable residents. We plan that, over time, Community Voice will provide the core infrastructure for engagement activities at a Sutton level and at the PCN neighbourhood level. This approach will help us to consolidate community engagement activities relating to the Sutton Health and Care Plan and broader health hand care priorities agreed by the Sutton ICP Board.

We are currently undertaking a refresh of all our borough groups and forums – to ensure that they are effective, have impact and aligned to the new governance in our ICS.

### 1.2.2.2 Participation principles

Following the development of our ICS people and communities engagement strategy, our principles for participation have been updated in line with NHSE and are as follows:

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.
3. Understand your communities: their relevant social histories, their experiences and their aspirations for health and care. Engage to find out if change is having the desired effect.
4. Build relationships with excluded groups, especially those affected by inequalities.
5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.
6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
7. Use community development approaches that empower people and communities, making connections to social action (bottom up) – what local people determine are community priorities.
8. Use co-production, insight and engagement to achieve accountable health and care services. By working jointly with people – accountable to local people.
9. Co-produce and redesign services and tackle system priorities in partnership with people and communities (top down).
10. Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.

### 1.2.2.3 How we enable and support people to get involved

We know there are unjustifiable differences in outcomes for people who experience health inequalities. Our Core 20 plus 5 work has supported our understanding of the people we need to reach in order to progress our work to achieving health equity. We actively seek out affected communities and understand their current situation and past histories. Informed by EHIAs, JSNAs, BI and local insight, each borough has worked with local authority leads and VCSE partners to develop a map of key areas/communities to focus on. IMD data was overlaid with information about health inequalities including identifying communities from Black, Asian and Minority Ethnic backgrounds. Informed by data intelligence, in collaboration with councils and public

health, we are identifying those residents that are experiencing Health Inequalities and target engagement accordingly (see 1.2.1.1.1. Delivering the Covid-19 vaccination programme for examples).

We have developed multiple ways to ensure that local people and communities have a voice and are heard. Over the last year, the balance of our work has focused on far more community driven approaches – building on our local assets and investing in our VCSE sector.

We ensure that local people and communities are aware of how to get involved by circulating opportunities via our networks; community connectors and VCSE and Healthwatch partners. We also ensure that information is available on our website.

**Working with Healthwatch**

Our relationship with Healthwatch has been an essential and valued element of our engagement approach. Not only do they provide critical friend challenge and expert advice, guiding our engagement work – on our SWL Community Engagement Steering Group and at Place level committees - they also champion the voice of local people and communities on key strategic groups such as our Governing Body and Programme Board. Their own insight work provides us with additional sources of data to help ensure that our work is informed by the needs and aspirations of local people. They are uniquely placed to ensure that this insight is followed up with decision makers – holding us to account. Their work is either driven by Healthwatch – for example a recent survey of over 3000 people conducted by Healthwatch Sutton into use of primary care services during the pandemic. Or commissioned by us, such as Healthwatch Kingston's support to our End of Life Care programme running focus groups to understand the many different needs of people experiencing grief after bereavement. Other examples of how we work with local Healthwatch organisations can be found in section 1.2.1 2021 – 2022 highlights.

Some of our main methods to involve people and communities are detailed below.

**Broad community engagement** – working with the voluntary and community sector to host 'community conversations', to hear and respond to feedback, answer questions and gather insight. We champion 'every contact counts' supporting staff to have 'confident conversations' with local people and patients. Signposting people to our 'single source of truth' SWL CCG website.

**Community champions and influencers** – Working with key local influencers (faith leaders, community champions, health care professionals, GPs and their practices) to lead and host conversations for us building trust and confidence within our diverse communities.

**Grassroots grants programme** – In order to improve our reach into health inclusion communities we funded a £160,000 grassroots grant programme to facilitate and intensify meaningful, respectful and culturally appropriate activity in our local boroughs. This model of engagement has been centrally agreed and locally developed, working with our voluntary sector to reach communities experiencing health inequalities. Delivery models and groups have been prioritised and agreed locally in response to local data and insight.

**Surveys and questionnaires** – Working with our 'People's Panel' (a virtual group of 3,000 people who broadly reflect the population of South West London) we have conducted a number of surveys to

understand more about people's view and attitudes towards our work and services. These surveys have led to deeper dives into specific areas and have informed the operational delivery of our work.

**Targeted focus groups and one-to-one interviews** – We have conducted a number of focus groups and one to one interviews (for those who are digitally excluded) to help inform and shape pathway redesign work.

To complement these methods we have recently commissioned an online engagement platform 'Bang the Table – Engagement HQ' which will enable us to reach more people and provide additional ways for people to share their views with us.

### 1.2.2.4 Examples of impact – borough

We have described how engagement influences our work throughout this report. You can read more examples where engagement has played an important role in the sections listed below:

| Section | Page | Examples of engagement impact |
|---|---|---|
| 1.2.1.1 Delivering the Covid-19 vaccination programme | 16 - 18 | South West London vaccination programme |
| 1.2.1.2 Our other priorities in 2021/22 | 23 - 28 | Health and care plans |
| | 35 - 36 | South London Listens |
| | 36 | Wandsworth – autism services |
| | 37 | Merton – men's urology services |
| | 38- 39 | Healthwatch insights into Long Covid |
| | 41 | Kingston and Richmond-community-led health and wellbeing hub |
| | 41 | Co-producing services with people who have long term conditions |
| | 41 | Croydon – Healthy communities together |
| | 42 | Kingston and Richmond – proactive anticipatory care model |
| | 29 | Kingston and Richmond – integrated working |
| | 29 | Wandsworth – QMH primary care hub |
| 1.2.3 Reducing health inequalities | 57 | Sutton – population health management pilot |
| | 56 | Merton – population health management pilot |
| | 56 | Merton – Mitcham health and wellbeing hub |
| | 57 | Outreach with Sutton Housing Partnership |
| | 58 | Kingston and Richmond health and wellbeing days |

### 1.2.2.5 South West London led work – examples of impact

#### 1.2.2.5.1 Renal – improving kidney care for local people

Following the Improving Healthcare Together consultation in 2020, leading renal clinicians from St Helier and St George's Hospital put together a proposal to improve kidney care for patients. Under the new plans, six major services including surgery and intensive care would move to the new Specialist Emergency Care Hospital (SECH) to be built in Sutton. Inpatient renal care would be moving with these services.

The new proposal was to improve the outcome and experience for renal patients who need inpatient care and more specialised support. The services would be brought together into a single brand new unit at St George's Hospital. It would affect 5% of renal patients' contact with kidney services – with no changes to existing dialysis services and renal clinics in local hospitals, units or at home.

Early engagement with patient representatives, clinicians and stakeholders helped to shape the overall engagement approach and materials. The engagement plan was shared with a range of stakeholders prior to the launch of engagement.

The plan was shared with and scrutinised by the Committees in Common on 22nd July and Joint Health Overview & Scrutiny Committee (JHOSC) on 7th July 2021. The JHOSC agreed to support proceeding with an extensive period of engagement with patients, the public, and staff members however, shared recommendations that should be included in the Decision Making Business Case.

Engagement activity on the Improving Kidney Care Programme launched on 27th July 2021 and ran until 7th September 2021.

Informed by the Equalities Impact Assessment, activities were split into three areas, those:

- directly affected by the proposals, such as kidney patients and their families and carers and staff working for, or aligned to, kidney services
- who might be interested by proposals - wider NHS staff, community groups and stakeholders
- with a wider interest - the general population with an interest in health.

To ensure we captured patients, staff, families and stakeholders views on the proposals, an engagement questionnaire was shared online, hard copy format and translated into Tamil, Urdu, Polish and Easy Read.

During the engagement period, we:

- Wrote directly to 3,369 kidney patients to share information about the proposals
- Spoke to 750 kidney patients via 25 visits to 10 kidney clinics and units
- Worked closely with the Kidney Patient Associations for both Trusts
- Held 10 independently run focus groups with equalities groups and 14 telephone interviews with those who are digitally excluded
- Held drop in sessions with staff working at both trusts
- Shared regular updates with key stakeholders and engaged with local groups

- Held two independently chaired listening events on 9th August and 3rd September
- Shared information on social and traditional media including an animation, vox pops and images of the proposed new unit
- Had a dedicated space on our SWLCCG website for information relating to the improving kidney care proposal.

We received 400 responses to our questionnaire. 81% of those responses were directly from kidney patients. The independent research analysis report is available on our website at www.southwestlondon.icb.nhs.uk/get-involved/consultations. There were high levels of support overall from patients however, the most common concerns was around travel and transport, specifically parking and continuity of carer.

The South West London and Surrey CiC met in public on 18 November 2021 to consider the Decision Making Business Case. The CiC noted the strong support from patients, carers and the public. The CiC agreed that the proposal can be taken forward to the next stage, a Full Business Case developed by the trusts with St George's University Hospitals leading with recommendations of further actions to be taken to address the issues raised during engagement including the JHOSC recommendations.

### 1.2.2.5.2 Community Diagnostic Hubs/Centres

Community Diagnostic Centres (CDCs) were proposed to reduce the backlog that arose during the pandemic, and to improve waiting times and patient experience of diagnostic services going forward. Engagement activities were conducted to inform a business case to fund the centres. A summary of this engagement is as follows:

- **London-wide patient experience survey** by Imperial College Health Partners and Ipsos MORI, commissioned by NHSE/I. Looked at what matters most, must dos and red lines. Participants recruited from across all 5 ICSs, with spread across demographics and professions.
  - 2 x 3-hour workshops with 40 people
  - 15 x 1-hour depth interviews
  - 2 x 2-hour workshops with 30 diagnostic staff
- **South West London survey:** testing themes arising from London engagement via a survey distributed to the People's Panel. This survey was also shared by Healthwatch and Voluntary Sector organisations. 722 respondents.
- **Focused South West London engagement:** Phone interviews and focus groups were conducted to delve further into patient experiences.
  - Three advisory group meetings
  - 10 phone interviews
  - Six online Exploration Labs
  - Four in-person Labs (held in Kingston, Merton, Richmond and Sutton.)
  - In total, 72 participants engaged.
- **Mapping existing insights:** examining data from hospital Friends and Family tests for diagnostic services.
- **Site specific engagement:** speaking with people in Roehampton, Sutton and Croydon about proposed sites. Considering issues such as access and transport. Methods included presentations at community groups and talking with patient representatives.

**Key findings from engagement activities:** Throughout engagement, there was consensus amongst patients about poor communication and lack of co-ordination of services. This included communication between GP practice and diagnostic teams, diagnostic teams and the patients and within the NHS teams such as diagnostic teams and specialist treatment teams. Overall, people want clarity and a diagnostic process that they can follow that is reliable and effective. Following on from the engagement report, several recommendations were made including encouraging health professionals to ask patients about their preferred mode of communication and to develop a pathway so that patients can understand what will happen next in terms of their treatment.

### 1.2.2.5.3 Development of the ICS People and Communities Strategy

To shape our approach to developing the people and communities engagement strategy for the ICS we held discussions with more than 40 groups and over 550 people including:

- Community Engagement Steering Group (Healthwatch, Local Infrastructure Organisations and PPE leads from each borough)
- Communications and engagement colleagues – SWL NHS Providers and Local Authorities & Borough Communication & Engagement Groups
- Borough patient engagement groups in each borough
- Place Leaders Group
- Borough Transition Teams
- ICS Delivery Group
- Chief nurse meeting and trust patient experience leads and directors of quality
- NHS Provider Chief Execs and NHS Provider Chairs
- Collaborative Leadership Group

We developed the strategy over two phases.

**During phase 1** we tested our vision for what it should be; sought views on the supporting companion documents and asked for feedback on key governance questions including assurance, resourcing and delivery. We also mapped how engagement works at place and within provider collaboratives.

**During phase 2** we went back to review the themes that came out of phase 1, and which informed our aims, and discussed our recommendations about assurance, resourcing and delivery.

There was positive support for ensuring that this strategy is informed by the lessons learned from engaging with local people over the last 18-24 months. We discussed these lessons during phase 1, adding and amending them so they reflect what we learned across the system. Please see diagram below.

The strategy sets out our approach to making sure that the voice of people and communities is heard and influences how we plan and deliver health and care services in south west London. It shows the principles that we can be held to; the ways we involve people; and the processes ensure that their views influence decision making and the systems in place to provide assurance that this happens. A key tenet is ensuring that engagement is everyone's responsibility. To this end we will be developing a framework for assessing the level of input needed from PPE colleagues; a toolkit to support transformation colleagues and programme managers to conduct engagement and a training package to embed the practice. Work is now under way to implement the strategy – including co-developing local delivery plans; developing a people's charter, setting out what the engagement strategy means for local people and co-designing an evaluation framework to evaluate the impact of our work.


## 1.2.3 Reducing health inequalities

One of our key objectives and priorities is to continue to tackle health inequalities and race disparities across our population and workforce. Across our six boroughs and all our transformation programmes, colleagues have worked with communities, the voluntary care sector, public health, and social care to improve outcomes for our disadvantaged communities. One example of this is how we implemented the Covid-19 vaccination programme for all communities including those communities who were most adversely impacted by the pandemic. It is also evident in our approach to recovering services post pandemic.

In 2021, we established the South West London Health and Care Partnership Health Inequalities Board and the Health Inequalities Delivery Group. Both partnerships bring together key leaders across the system to drive forward the efforts to tackle inequalities including to raise the profile of work done for several years by partners and ensure it's a golden thread across everything we do.

We have also been developing plans to tackle inequities focusing on the top 20% of our most deprived communities using a national programme called Core20PLUS5, which helps the NHS prioritise efforts for their most disadvantaged communities. We were successful in our bid to become a Wave 1 national Core20 Connectors NHS site, received funding from the NHS to recruit community connectors to support individuals, families and communities to achieve better health and social outcomes.

We also agreed with partners our core priorities to tackle health inequalities:

- Implement the CORE20PLUS5 programme and improve access, experience, and outcomes for our most deprived and disadvantaged population.
- Develop and deliver our South West London equity strategy aligning to Place health and care plans and the Mayor of London's strategy.
- Enable proactive co-production with people with lived experience including increased board presence to inform decision making.

- Develop our Anchor Institutions' structures and programmes of work at Place and system to tackle and reduce socio-economic inequalities.
- Improve health outcomes through embedding Population Health Management insights and intelligent data evaluation.
- Improve diversity and inclusion of our workforce through our Equality, Diversity and Inclusion strategy and development of a SWL anti-racism framework in line the NHS Observatory report of Health and Race 2022.

**Key programmes in 2021/22**

- Using Population Health Management with system partners with local knowledge to find the most vulnerable communities and patient cohorts as well as potential digital exclusion in SWL.
- Using asset-based community development methodology to educate and empower the most vulnerable regarding their health and to co-produce and co-deliver culturally sensitive health checks and prevention programmes in local communities.
- Building physical health and wellbeing hubs to provide patients with mental health, physical health and advice and advocacy support.
- Working with patients with lived experience and local community and volunteer partners to co-produce improved, personalised health care.
- Developing methods to evaluate projects aimed at reducing health inequalities.

**Public Sector Equality Duty**

The PSED consists of general and specific duties for public authorities to meet under the Equality Act 2010. We continued to work hard to ensure we comply with our duties in 2021/22 ensuring that all projects commissioned by NHS South West London CCG were required to complete an equality analysis prior to implementation. This allows us to understand the impact a project or programme will have on the communities it affects and take action to mitigate any potential inequities.

In 2022/23 the Equalities, Diversity and Inclusion and Health Inequalities Board will be focusing on improvement plans to strengthen our approach to impact assessments and the Equality Delivery System.

**Reducing health inequalities in action**

Here are some examples from 2021/22 of projects and programmes aimed at reducing health inequalities.

**Developing our approach to population health management:**

As part of the NHS England and Improvement Population Health Development Programme we developed pilot projects in Sutton Place and five Primary Care Networks in South West London. The pilots demonstrated that through good use of data we can identify unmet need and consider the wider determinants of health, working with our local partners and specific groups in our communities to develop targeted interventions. These pilots are models for the future working of the ICS and support the shift in behaviour and thinking that will help tackle heath inequalities.

The Sutton Place pilot used co-production with patients and local communities at a very early stage. Data analysis enabled a specific cohort (group) to be identified; these were people with a chronic musculo-skeletal condition and a diagnosis of high blood pressure or obesity or depression, living in areas of high deprivation. We gathered insight through in-depth interviews to understand patients' experience of specific services and the barriers to accessing these. We used the information to develop and plan a new health and wellbeing intervention. This is a three stage process to guide and support an individual through changes they want to make and to feel more confident in leading a healthy lifestyle and managing their conditions. Work will continue into the implementation phase in 2022.

The East Merton PCN pilot enabled us to bring together lived patient experience, professional experience, and data analysis to identify people with Severe Mental Illness (SMI) and to work with them to increase their participation in and uptake of their annual SMI health check. We have started work on an emerging model for a holistic health and wellbeing hub in a community setting, and will be co-designing the health checks drop in space with patients and partners.

**Health and wellbeing hub for Mitcham**

Mitcham is an area of unacceptable health inequalities. Life expectancy for men in Cricket Green ward is 78 – in Wimbledon's Merton Park it's 85.

In response, we have been working with community organisations on plans for a health and wellbeing hub in Mitcham. Progress on the hub stalled during lockdown, but partners have been working to move the project forward and engage with people.

Rather than a place to get treatment when someone is ill, the hub will be about connecting people, helping them stay healthy and signposting to support. It will have outdoor community space and bookable rooms for activities.

We involved community representations and stakeholders as part of the process to determine the site for hub, including Merton's Young Inspectors, the Polish Family Association and BAME voice. Due to national guidance around developing Business Cases, we had to reassess all potential options for the location.

The Wilson Hospital site on Cranmer Road, Mitcham was verified as the preferred option. However, all participants indicated that the project should: improve accessibility to The Wilson; improve lighting and security for walkers and cyclists; and improve ability to use electric vehicles. These recommendations will be addressed as the project develops.

**Wandsworth – addressing inequalities in mental health linked to ethnicity**

NHS statistics show that if you are black, you are four times more likely to be subject to a restrictive mental health intervention than if you are white. There are health inequalities in access to mental health support and treatment too. The Ethnicity and Mental Health Improvement Project (EMHIP) seeks to transform this landscape of mental health care in Wandsworth. It follows decades of campaigning by the community, led by Malik Gul, Director of Wandsworth Community Empowerment Network, and writer and academic, Dr Colin King. It has been developed in partnership with South West London and St George's Mental Health Trust and South West London Clinical Commissioning Group (CCG).

The first initiative is a health and wellbeing hub in the New Testament Assembly Church, Tooting, which brings mental health support to the heart of the community. It is a safe space that cares for people who aren't accessing services through traditional NHS routes, enabling them to have conversations about life's challenges and find support. In keeping with the hospitable nature of the hub, service users are referred to as guests. Services include mental health and wellbeing clinics; diabetes checks; smoking cessation and weight management sessions; couple and family support. It also provides advice on debt, housing, welfare benefits and drugs and alcohol dependency. Rather than moving the location of existing services, this hub is about creating completely new ones, which are culturally adapted, as well as offering a bridge to other NHS and community services.

The work is also about empowering and offering training to members of the community in having conversations about health and wellbeing. Known as 'community embedded workers', they encourage people to access the hub and can be anyone with a local role – church pastors, or Imams, or local hairdressers and barbers, for example.

Even during an ongoing pandemic, the hub is supporting people who may not have received help otherwise. GPs have started to refer to the service and it has already held multiple clinics. It will host its first mental health outpatient clinic with a psychiatrist in April, and with the lifting of Covid-19 restrictions, begin welcoming more guests.

The project is working with service users to coproduce an evaluation criteria tailored to the project, as a robust methodology to monitor a demonstrate reduction in ethnic inequalities in mental health.

EMHIP is now embarking on its second year in Wandsworth, which will see the introduction of more new initiatives. Other boroughs in South West London – Croydon and Merton – have also committed to develop similar projects. The other elements of the plan are set out in the EMHIP key intervention report.

**Sutton Housing Partnership – health and wellbeing events**

A new initiative for us in 2021/22 was our work supporting vulnerable Sutton residents, living in social housing, by collaborating with Sutton Housing Partnership.

We have held events, in local community-based facilities, offering health and wellbeing advice, with the Covid-19 vaccine also available if required.

The events have been well received by residents, particularly those who are used to accessing community-based support (for example at the St Helier Community Food Shop at Hill House). This work will continue in 2022/23.

This collaboration also helped us to develop new links with the Gypsy Roma Travelers' community in Sutton. We joined forces with Sutton Housing Partnership (SHP), Cognus and Sutton Council, to help increase vaccination uptake within the traveller community in the borough.

The joint team liaised with the traveller community on the Pastures site in Banstead and arranged an on-site information session about the vaccine.

The vaccine was offered to anyone who was eligible on-site who wanted it and community members were able to ask the clinicians present questions about the vaccine.

We have offered Covid-19 vaccinations to over 90% of the residents at Sutton's Travelers sites. We will continue to work with this community to help meet their health and wellbeing needs going forward.

This approach has increased trust within communities and shown that we are working to address wider healthcare concerns in Sutton. It is a great example of how we can work together with our borough partners to ensure the safety of everyone living in Sutton.

**Kingston and Richmond health and wellbeing days**

Partnership working is at the heart of the two Health and Wellbeing Days held in Kingston and Richmond this year, aimed at supporting people experiencing homelessness, refugees and those seeking asylum in South West London.

Both events, held at venues in Twickenham and Kingston town centre saw colleagues from health and care organisations, local authority and the voluntary sector working together to provide a range of useful services.

Over 140 attendees came along to the events and were able to access Covid-19 and flu vaccinations, testing for HIV and Hepatitis, a chance to have an appointment with a GP and access to support for any worries they might have around addiction and their mental health. There was also a healthy lunch available, haircuts and a chance to pick up clothes from the Spear Clothing Bank.

A homeless man at the Kingston event visiting the blood testing van said 'I had an appointment at West Middlesex Hospital for this but can't afford the bus fair to get there. I wouldn't have got these tests done if you weren't here today'.

Working with the voluntary organisations who directly support these communities including Spear, Refugee Action Kingston and Kingston Churches Action on Homelessness we were able to engage and support people to attend the event, through providing transport and interpreters. Speaking to attendees issues such as accessibility, travel and language are barriers they face in accessing health services. Events like this overcome these barriers.

Dr Naz Jivani, said of the Kingston event: *"During the pandemic, more than ever, we have realised that there are certain communities and parts of the population that can be really isolated, particularly those who are experiencing homelessness. Working together across Kingston has been shown to be effective at supporting these populations. Today is a perfect example.'*

### 1.2.3.1.1 Addressing equality for CCG staff through NHS Workforce Race Equality Standard (WRES)

The NHS Workforce Race Equality Standard (WRES) is used across the NHS to narrow the gap between the treatment of ethnic minority and white staff through collection, analysis and acting on specific workforce data. In addition, the WRES aims to improve diversity of leadership and the experience of staff from ethnic minorities within an organisation.

There are nine indicators, all of which draw a direct comparison between white and ethnic minority staff experience. Four focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator considers whether the governing body membership is broadly representative of the overall workforce.

This is the second year that the CCG's performance against the WRES indicators are published. This data allows us to take action to improve against these indicators.

**We have seen improvements across:**

**Recruitment:** white staff are 1.3 times more likely to be appointed compared to the 19/20 figure of 1.8. This is a significant improvement from last year. The CCG is now below the London average. This area has seen a reduction due to all the work that has taken place to ensure our recruitment panels for roles at band 8 and above have an inclusion champion.

**Disciplinary Processes:** staff from ethnic minorities are now 0.4 more likely to undergo a disciplinary process than white staff. Any figure under 1 is considered as no difference. This is a significant improvement from the previous year's date of 1.59. In the last year, we focused on resolution and working differently.

**Percentage of staff experiencing harassment and bullying/abuse from other staff:** This indicator has seen no improvement. 23.6% of white staff report experiencing harassment and bullying (below London average) and 35.5% of staff from ethnic minorities report experiencing harassment and bullying.

**Percentage of staff believing the organisation provides equal opportunities for career progression and promotion:** The 2021 staff survey shows that 79.3% of white staff in the CCG believe the organisation provides equal opportunities for career progression and promotion compared to 37.5% of ethnic minority staff.

**Percentage of staff experiencing discrimination at work from managers/ team leader:** 11.5% of staff from ethnic minorities report experience of discrimination at work from managers. This is an area that we will continue to focus on.

We continue to deliver our action plan to address our performance against the WRES indicators. We hold monthly listening events to give staff the opportunity to be part of the work and to feed in to the Inclusion and Belonging work stream. The action plan focuses on four key themes and links to the NHS People Plan and the Race Plan for London:

- Culture and leadership
- Recruitment
- Development
- Education

Although we have seen improvements on the WRES indicators it is clear there is still more work to be done, particularly on the staff survey indicators. Achieving real change in equality, diversity and inclusion takes time and effort and we are committed to the development of this work.

Contact Melissa Berry, Programme Director of Equality, Diversity and Inclusion confidentially on melissa.berry@swlondon.nhs.uk

## 1.2.4 Assuring delivery of performance and constitutional standards

NHS England assesses the performance of each CCG through a national Improvement and Assessment Framework. The metrics for oversight and assessment purposes include the headline measures described in the NHS Long Term Plan Implementation Framework.

These performance indicators help us to measure and assess the quality and productivity of the services we commission. They also tell us where we need to work with our partners to improve the care our patients receive.

Over this financial year we have worked well with our partners in responding to the Covid-19 pandemic. We have also made significant progress together in helping services recover, with our goal to increase activity levels so that they exceed pre-pandemic levels.

### 1.2.4.1 Referral to Treatment (RTT)

The operational standard is that 92% of patients should be waiting no more than 18 weeks for elective treatment.

At the end of March 2022 our performance against the standard was 75.7%. This is a slight decrease on previous month's performance (of 76.3%), but reflects both seasonality and the impact of the Omicron variant on bed availability in hospitals and staffing levels. This is also an improvement on the 75.4% rate at the beginning of the financial year.

We have maintained our position as the highest performing CCG in London for the Referral to Treatment standard this year and are again significantly ahead of both London and national performance outcomes.

Throughout 2021/22 our focus has been on restoring services impacted by Covid-19 and reducing the numbers of patients waiting more than 52 weeks for treatment. We have reduced the number of people waiting over 52 weeks for treatment from 2,781 in April 2021 to 1,177 in March 2022. The South

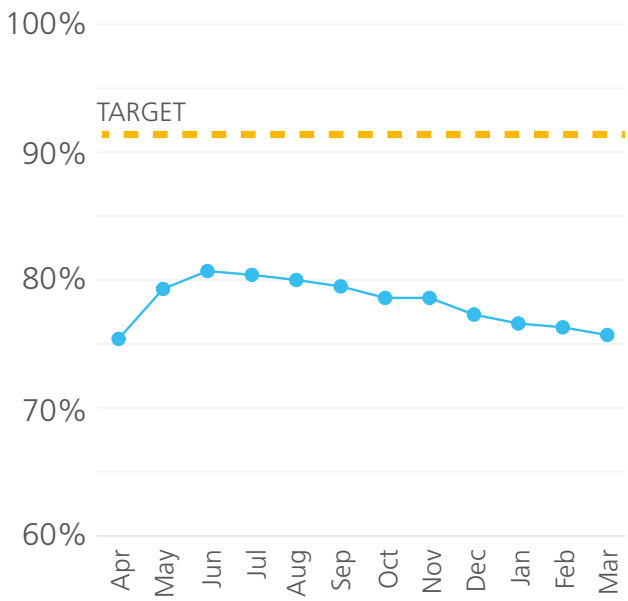
West London CCG has the lowest number of patients waiting over 52 weeks and 104 weeks for treatment in London.

In April 2021, following the partial lifting of the third national lockdown restrictions, clinical services were able to increase capacity. Elective capacity had been reduced between January and March 2021 to maximise resources available in hospitals to deal with rising Covid-19 rates and winter pressures. Our hospitals continued to follow the guidance from Royal College of Surgeons for prioritising patients waiting for treatment. These clinical priority categories were based on the condition and treatment requirements and included a timeframe for each surgical procedure whilst safeguarding patient care.

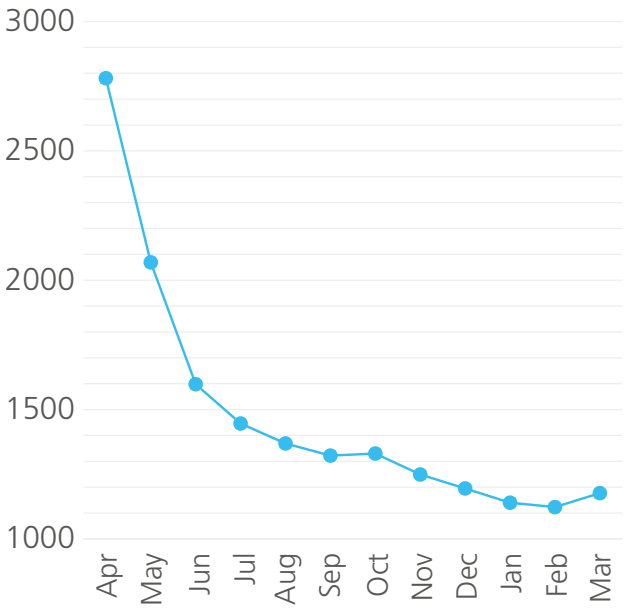
With the improving Covid-19 situation between April 2021 and November 2021, we were able to use the increased capacity within our hospitals to treat the patients who had been waiting the longest. This allowed us to reduce the number of people who had waited over 52 and 104 weeks for treatment.

Across South West London our partners have worked together to reduce waiting times and inequalities, sharing capacity and waiting lists to make sure that patients get the treatment they need, wherever they live. We have also commissioned additional services from independent sector providers to add capacity through both insourcing and outsourcing arrangements.

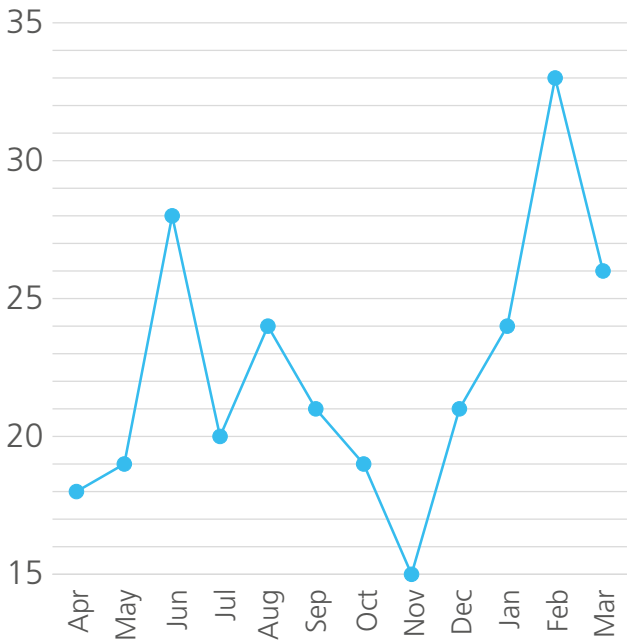
RTT Performance




SWL 52 Week waits 2021/22



SWL 104 Week Waits 2021/22




### 1.2.4.2 Diagnostic test waiting times

The operational standard is that no more than one per cent of patients should be waiting more than six weeks for a diagnostic test.

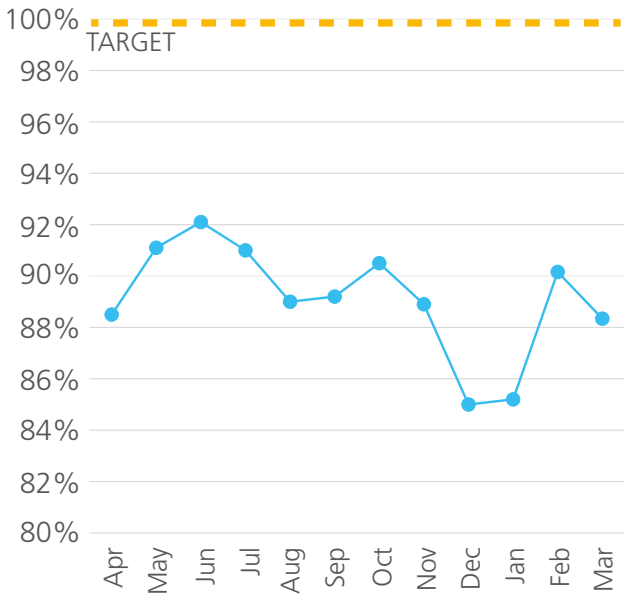
This year our performance has ranged from a high of 92.1% in July 2021 to 85.0% in December 2021 and we finished the year with an outcome of 88.2% in March 2022, similar to 88.5% at the beginning of the financial year. No CCG within England has achieved the 99% standard this year. Our performance has exceeded the non-compliant London and national performance outcomes, and we are the fourth highest performing CCG within London for March.

In South West London, echocardiography, non-obstetric ultrasound and MRI scanning services had a higher number of patients waiting more than 6 weeks. This is consistent with diagnostic services waiting times across the country.

All of our provider partners have continued to face workforce challenges throughout year due to staff absences which were deepened by the emergence of the Omicron variant.. Every Trust has plans in place to address these staffing issues. Each Trust has also created additional capacity in the evenings and weekends, as well as using independent services where possible.

The South West London Elective Recovery Board oversees the Endoscopy Network and Diagnostic Board, which underpin the Diagnostic System Recovery Plan and includes a number of task and finish modality workstreams supporting focused delivery of recovery.

SWL Diagnostic Performance



### 1.2.4.3 Estimated diagnosis rate for people with dementia

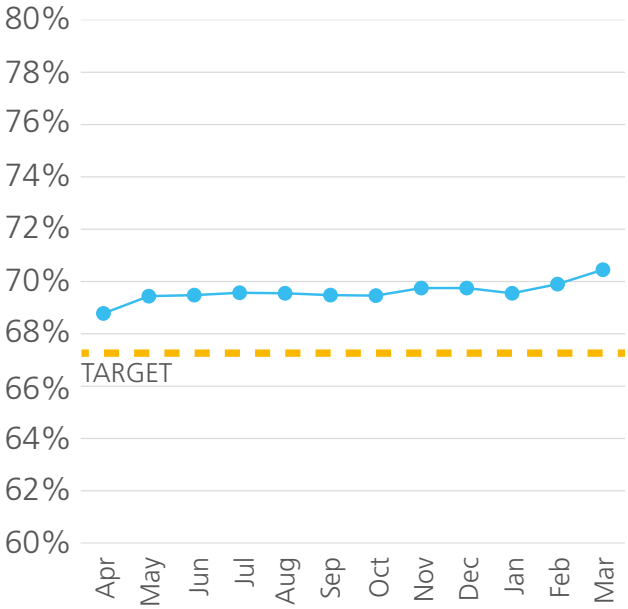
A timely diagnosis enables people living with dementia, and their carers and families to access treatment, care and support, and to plan in advance in order to cope with the impact of the disease; it also helps primary and secondary health and care services to anticipate needs. Working together with people living with dementia, they can plan and deliver personalised care plans and integrated services and improve outcomes.

In 2021/22 our performance levels have exceeded the national threshold of making sure that over 66.7% of patients with dementia are diagnosed, and by March 2022, we had achieved our ambition of achieving over 70% with an outcome of 70.5%.

Workstreams which aim to maintain and improve diagnosis rates include:

- Promoting third sector support services to general practice
- Information exchange about service changes in GP and the MAS (Memory Assessment Service)
- Undertaking virtual assessments when appropriate for patients, with home assessments also performed when necessary.
- Exploring screening opportunities for people in nursing homes and residential accommodation to make sure they are being assessed in a timely manner.

SWL Dementia Diagnosis




### 1.2.4.4 Improving Access to Psychological Therapies (IAPT)

Around one in six adults in England suffer from a common mental health problem like depression or an anxiety disorder. The effectiveness of local IAPT services is measured using this indicator and the IAPT recovery rate, which focuses on the recovery of patients completing a course of treatment.

We have continued to meet national standard for waiting times for first treatment for IAPT services:

- 97.2% of people start treatment within 6 weeks (75% standard)
- 99.2% of people start treatment within 18 weeks of referral (95% standard)

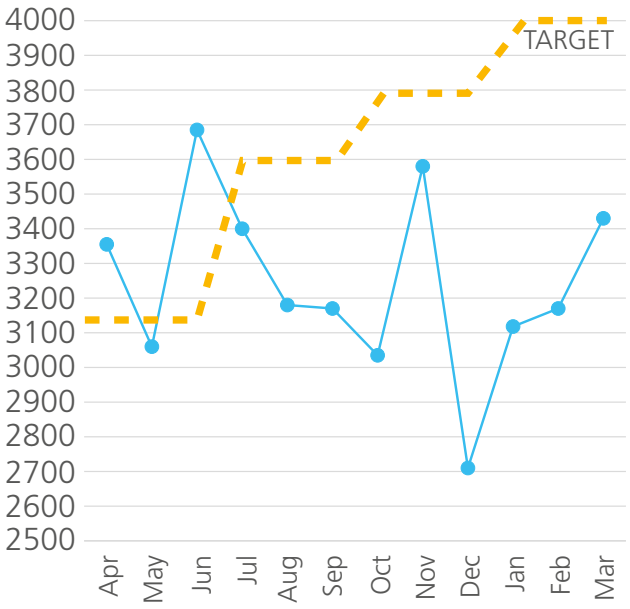
By March 2022 38,905 people started treatment during 2021/22, which is below the intended trajectory of 43,620 clients for this reporting period.

Access levels to IAPT in South West London have been affected by the reduced capacity of our service providers due to staff vacancies

and difficulties recruiting to these posts. This situation is reflective of regional and national staff shortages.

We are working closely with our IAPT service providers and are reviewing options to improve access levels through a series of escalation and touch-point meetings. South West London and St George's Mental Health NHS Trust, our largest IAPT service provider, has launched a number of improvement workstreams which we expect to improve access levels to IAPT services in 2022/23.

SWL IAPT Access 2021/22

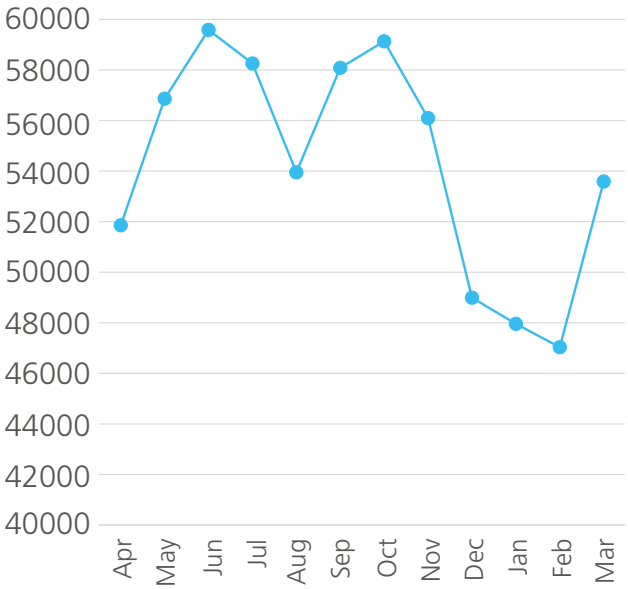



## 1.2.4.5 A&E four hour wait standard

The national standard is that 95% of patients should have their treatment completed, or be admitted, within four hours in an Emergency Department.

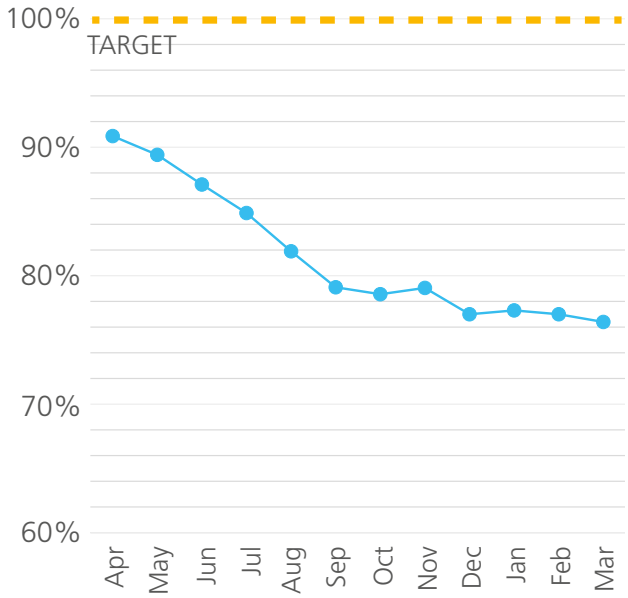
The numbers of patients arriving in Emergency Departments in South West London rose from 51,857 attendances in April 2021 to 53,588 attendances in March 2022, peaking at 59,853 in June 2022.

SWL A&E All Type Attendances




Our performance against the 4-hour target has also decreased since April 2021, reducing from 90% in April 2021 to 76% in March 2022.

SWL A&E Performance All type

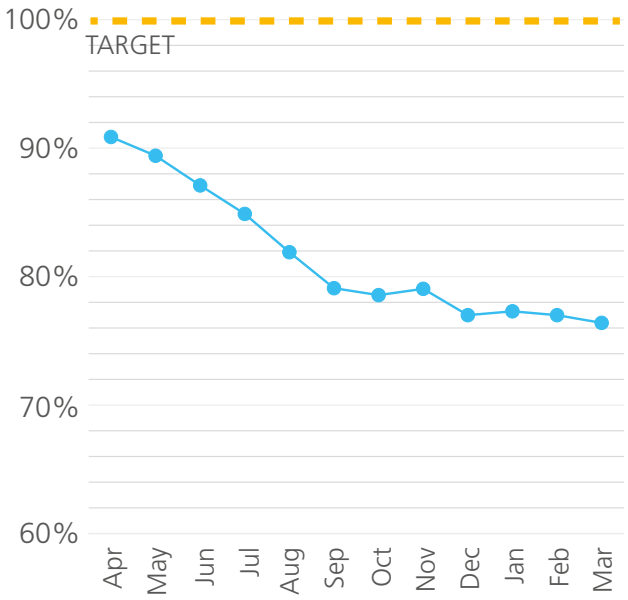



This means that 23.6% of people waited longer than 4 hours for a decision to admit to a hospital bed or to be discharged. However, this performance is better than the London average and is better than most CCGs in the country.

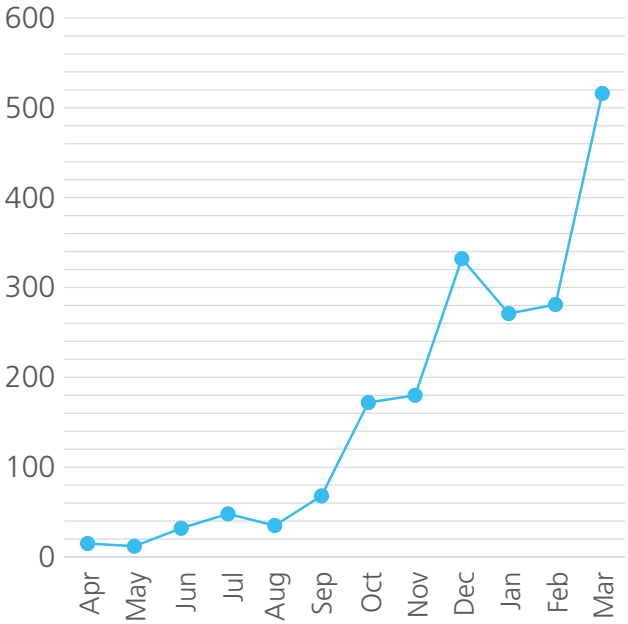
The number of patients waiting over 12 hours to be admitted to a bed has increased steadily since September 2021, however there has been a decrease in March, with 665 patients waiting over 12 hours for admission, down fro 854 in February. We had the second lowest number of 12 hour breaches in London in March 2022. The cause of long waits is primarily down to slow patient flow and discharge through our hospitals, particularly after the emergence of the Omicron variant. This has resulted in longer lengths of stay and significant pressure on capacity in our hospitals.

Slow flow and discharge within a hospital means that the Emergency Department must hold patients it is treating whilst waiting for beds to become available, meaning ambulances are unable to offload their patients. This is seen in the low percentage of patients handed over within 15 minutes of arrival at hospital and the increasing number of patients waiting over 60 minutes in an ambulance after arrival at hospital.

SWL % Ambulance handover within 15 minutes




SWL 60 minute Ambulance breaches




Trusts further report that complexities in multiple pathways for Covid-19 and non-Covid-19 patients leads to further inefficiencies, with patients grouped by Covid-19 status rather than presenting condition.

To help improve the situation in South West London, actions we have taken with our partners include:

- Supporting discharge with increased brokerage to create onward packages of care over winter.
- Effective use of Discharge to Assess.
- The implementation of 2-hour community rapid response services.
- Developing a virtual ward whereby people with certain conditions are discharged and monitored at home. This programme has the potential to significantly increase the number of timely discharges.

We are also working with the London Ambulance Service to reduce ambulance handover delays. We have established several short-term plans that build on existing pathways and protocols, alongside medium-term plans aimed at identifying new or innovative approaches to managing patient handover from ambulance staff to hospital staff. Other medium-term actions include focused demand management and implementing and piloting innovations and behaviour change goals aimed at reducing pressure on Emergency Departments.

### 1.2.4.6 Transforming care for people with learning disabilities

The annual standard for 2021/22 is to provide annual health checks to 75% of people on the Learning Disability (LD) register who are aged 14 or older.

The number of annual health checks delivered by the end of January was 3.5% below planned trajectory. This is reflective of the wider pressures in primary care, as well as the wider governmental advice resulting from the emergence of the Omicron variant, which may have discouraged people from attending their annual health check.

We remain committed to improving the provision of learning disability health checks across South West London. Our learning disabilities clinical leads in each borough are working with individual GP practices to help them to maximise the uptake of annual health checks. This includes making sure that continuous training and support is provided to GP practice staff.

### 1.2.4.7 Physical health checks for people with severe mental illness

This indicator monitors the proportion of the people on the Severe Mental Illness (SMI) GP register receiving six physical health checks within the last 12 months.

The national standard is that 60% of SMI patients receive all six annual health check elements. We did not meet this standard, but performance improved through the year, from 28.5% (4,593 patients), to 32.8% of SMI patients (5,363 people) in Quarter 3 and 39.0% of SMI patients (6,295 people) in Quarter 4.

To support performance improvement on this standard, a number of workstreams are underway which include more detailed data being provided by the borough GP mental health leads which can be used to case-find individuals who have only one or two checks remaining.

Additional incentives are being provided to practices to support the additional administrative or clinical time necessary to make phone calls to complete the alcohol or smoking questions. Point of Care Testing kits have been delivered to 13 PCNs to support delivering health checks outside of a practice where deemed appropriate. These kits will help provide blood tests for people who may have faced delays due to the blood tube shortage in 2021. The additional pieces of kit will be rolled out in the next financial year.

As with the annual health checks for people on the learning disabilities register, the health checks for those on the SMI register have also been adversely impacted by the pandemic and associated reduction in face-to-face GP appointments and the challenges posed by social distancing and shielding.

### 1.2.4.8 Cancer waiting times

There are four cancer waiting time standards:

- week waits (93% standard)
- 31 days first and subsequent treatments (96% standard)
- 62 days referral to treatment (85% standard)
- 28 day faster diagnostics standard

We have delivered strong performance against the cancer waiting times standards in South West London compared to the rest of London and England.

We continue to work in partnership with RM Partners (the West London Cancer Alliance) which includes NHS Acute trusts, community services, primary care, commissioners, public health and the voluntary sector to maintain and improve access to cancer services across South West London.

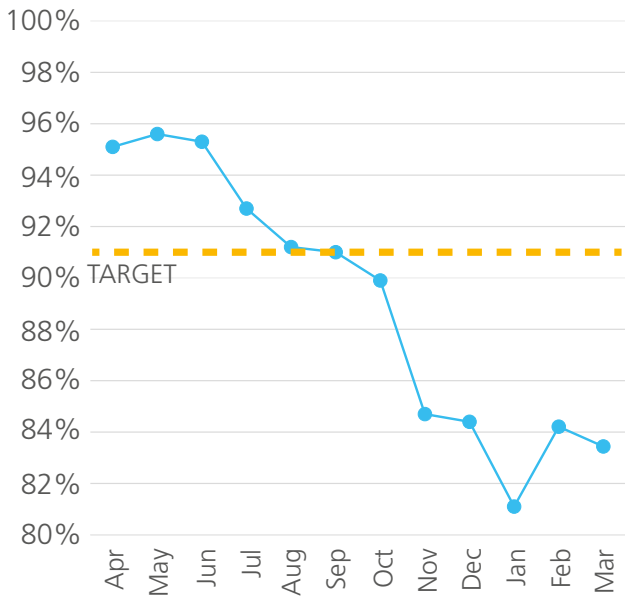
Although our providers have maintained services throughout the pandemic, like all clinical services have faced workforce challenges due to the Omicron variant in recent months, with patient choice and reduced capacity also impacting on performance.

**Recovery Performance**

The 2021 NHS Operating Plan demands cancer services recover above business as usual (BAU) activity levels for 2 week waits, cancer treatments and reduce patients waiting above 62 days on the cancer patient tracking lists to pre-pandemic levels.

**2 week waits**

SWL Cancer 2WW

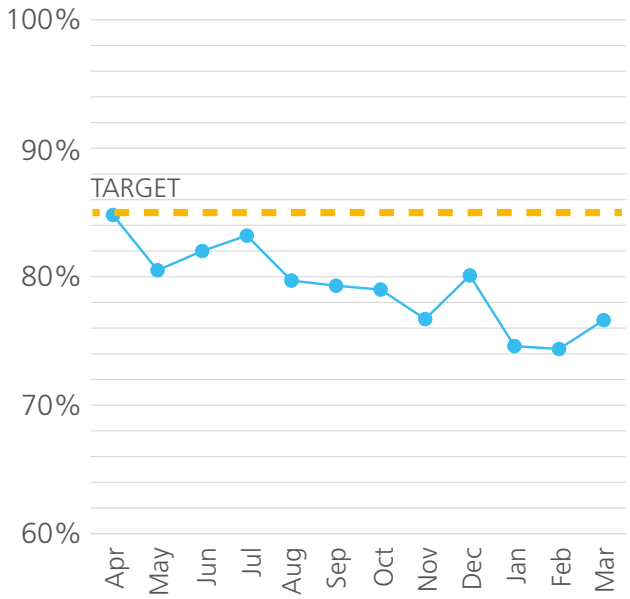



We were the third highest performing CCG in London for 2 week waits in March 2022, with a performance outcome of 83.4%. This was above the London and National outcomes for the month but did not meet the standard of 93%. The overall numbers of patients referred into the 2 week wait pathway in March 2022 increased by 19% compared to March 2019. This is above the London average, which saw a 14% increase across the same period.

Our providers have seen an 18% increase in 2 week waits referral activity in March 2022 in comparison to March 2019, the highest in London and above the London position of 13%. St George's University Hospitals NHS Trust have reported an increase in referral activity which is impacting the Breast Service in particular, and St Georges have implemented a recovery plan to increase capacity as well as working with other providers in South West London to treat patients.

### 62 days to treatment

SWL Cancer 62 Day GP referral

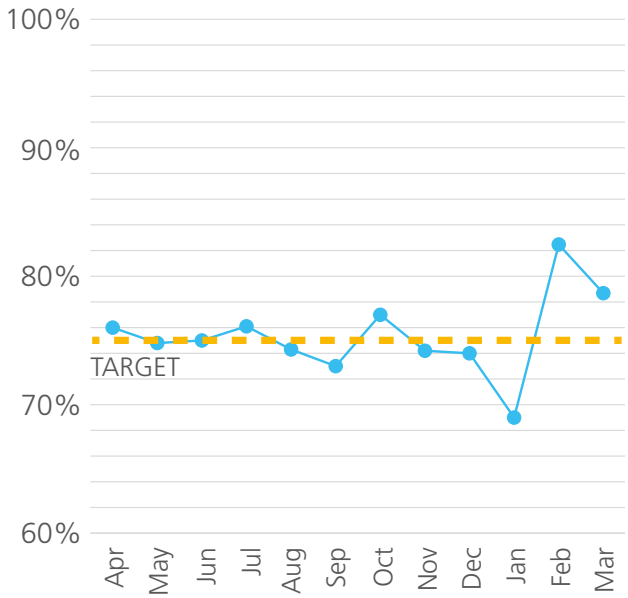



We were the highest performing CCG in London against the 62 Day performance standard for March, with an outcome of 76.6%, This was above the London and National CCG level performance, which were also non-compliant. Trusts cite main drivers for performance are the sustained increase in referrals and the impact on diagnostic and treatment turnaround. SWL Performance has been affected by patient choice and reduction in diagnostic and treatment capacity due to workforce challenges caused by the Omicron variant surge.

We are ahead of our recovery plan as of March 2022, with 320 patients waiting more than 62 days for treatment, against a plan 410 patients.

### Faster diagnostics standard (FDS)

SWL Cancer 28 Day FDS 2021/22




This is a new standard introduced in April 2021 aims for 75% of patients to receive their result within 28 days. All ICSs are expected to meet this standard from quarter 3 2021/22 for all urgent suspected cancers, breast symptomatic and screening referrals.

Our aggregated FDS performance for March 2022 was 78.7%, which is above the target of 75% for the second consecutive Month. We were the second highest performing ICS in London and exceeded both the London and national CCG level performance. Performance outcomes were above the expected target at four of the five SWL provider trusts. Two trusts are implementing actions from their respective recovery plans to support sustained compliance. The Trusts have recruited two FDS Champion Managers who are supporting the development and delivery of the action plans. All five SWL trusts were within the top 15 performing

trusts in London, with one trust in the top five performing London trusts for the sixth continuous month.

Our screening services are meeting the relevant standards as outlined below.

**Breast screening**

The South West London Breast Screening Service continues to be RAG rated green and continues to project backlog clearance will be achieved by March 2022.

**Bowel screening**

The South West London Bowel Cancer Screening Service meets all NHS Bowel Cancer Scope Screening Programme standards and guidelines, including pathology turnaround times at 95% to 100%. The service also successfully introduced age extension screening for patients above 56 years of age, with no issues reported.

**Cervical screening**

The South West London Cervical Screening Service maintains business as usual services, with backlogs cleared and maintained since April 2021. South West London colposcopy services are achieving all national quality standards. All services met the 2 week standard for high grade referrals. RM Partners funded extended access cervical screening continues to be available, and from Quarter 2 2021/22 will focus on out-of-hours extended provision to women across South West London.


## 1.2.5 Improving quality and safety

In 2021/22, we continued to transform our system to achieve better outcomes for patients and we created a plan for how the Integrated Care Board will develop a system wide approach across to quality improvement.

Our nursing and quality team continued to deliver core functions alongside supporting the system response to Covid-19 - including volunteering as vaccinators for the booster programme.

In 2021/22, we worked with our ICS partners to establish governance arrangements and a framework for overseeing quality and launched a Quality Surveillance Group and System Quality Council. These groups bring together partner organisations from across South West London; patient partners; lay members; and external partners such as Care Quality Commission (CQC), NHS England, Health Education England, to collaborate towards improved quality of care. The governance arrangements will enable proactive oversight of quality of our services across the system.

In South West London, we define, deliver, improve, and measure quality under the following domains:

For people who use our **health and care services**, that services are:

- Safe
- Provide a positive experience (leading to improved outcomes)
- Effective

For those planning for and providing services, that services are

- Equitable
- Well led and
- Sustainable

These domains are underpinned by South West London Health and Care Partnership outcomes to start well, live well and age well.

### 1.2.5.1 Improving the safety of care

NHS England published its Patient Safety Strategy in July 2019 and an updated version February 2021. Several initiatives set out in the strategy will result in significant system and cultural change in our approach to patient safety.

Over the last year, South West London successfully:

- Engaged with all sectors so they are aware of the patient safety strategy initiatives and national patient safety priorities.
- Started work supporting the implementation of Learning from Patient Safety Events.
- Launched patient safety training, an "involving patients" framework and recruited Patient Safety Partners (PSP).
- Engaged with our patient safety collaboratives to support the roll out of a Medical Examiner role in the community.

Priorities for 2022/23 include:

- Embedding a safety culture across South West London Integrated Care Board.
- Implementing insight, involvement, and improvement initiatives from NHS patient safety strategy.
- Making South West London ICS a 'safety learning system'.
- Agreeing patient safety improvement areas to focus on for the next 3-5 years and supporting improvement programmes which proactively engage on health inequalities and patient safety.

**Preventing Serious Incidents**

There have been no serious incidents or never events relating to services provided by the CCG during 2021/22.

We are responsible for managing serious incidents that take place in any NHS or independent provider that we commission services with. This allows us to quickly identify any recurring themes and trends. Incidents are managed in line with the National Serious Incident Framework. It is vital that we learn lessons from serious incidents to help reduce patient harm in the future.

We have begun preparatory work to develop our systems in the CCG for the introduction of a new Patient Safety Incident Response Framework (PSIRF) in 2022/23.

**Reducing Mortality**

We continued to support all system partners to ensure that opportunities for learning are identified and where appropriate, action is taken to achieve improvements in line with the Learning from Deaths framework and other mortality learning platforms such as Child Death Overview Panel (CDOP). We began discussions about system-wide central mortality monitoring processes with a remit for monitoring mortality, gathering themes, learning, and identifying safety improvement areas. We are working to strengthen our improvement approach in the CCG through other data sources such as safeguarding and relevant local authority data.

## Make A Difference (MkAD)

The Make A Difference (MkAD) system is a quality alert, management and monitoring system designed to implement the recommendations of the Francis Inquiry (2013). The system is a simple, user-friendly online form for health and social care professionals to report any quality concerns (usually relatively minor ones), issues, compliments, and good practice that they have become aware of through contact with their patients.

In 2020/21 a total of 1,192 alerts were raised across South West London CCG. All alerts are reported to the relevant provider, who is responsible for investigating the concern, and responding to the healthcare professional that reported the alert providing assurance of any immediate or long-term actions.

MkAD is intended to act as an early warning/ feedback system, providing intelligence that can be used to address any wider quality issues, facilitate shared learning, inform the commissioning process and service improvements, and most importantly improve outcomes for our patients.

Priorities for 2022/23, include:

- The transition of the MkAD service to the ICS model promoting collaborative working and engagement to establish and sustain relationships with partner agencies across South West London.
- Using the intelligence from alerts to improve patient experience and safety but also use this to inform wider learning and improvement across the system.
- Promoting MkAD across Social Care Partners, by working with the Enhanced Healthcare in Care Homes (EHCH) initiative to increase awareness and uptake of MkAD across Care Homes, facilitated through a programme of engagement and collaboration with the Local Authority partners, and Care Home Leads.
- Using the MkAD to implement the national patient safety strategy.

## Infection and Prevention Control

All South West London healthcare providers have a governance framework in place to manage infection prevention and control (IPC), working in line with the Health and Social Care Act (2008, guidance updated in 2015).

Building on the approach in 2020/21, we continued to lead a weekly South West London IPC provider forum. The forum reviewed learning from previous waves of the Covid-19 outbreak and incorporated this into strategies to support staff, patients and visitors to services.

The IPC medical and nursing teams undertook a programme of work that included updating IPC policies and procedures and adapting testing for staff and patients in line with the most recent guidance.

During the second and third wave of the pandemic, we tailored our IPC training package to support working safely in care homes and we offered this training to all 366 care homes in South West London.

During the spring of 2022/23 the IPC forum has been developing strategies to support our elective recovery programme in South West London.

The NHS Learning from Deaths Framework and the Serious Incident Framework support NHS organisations to learn from incidents relating to patients. Each of the South West London hospital trusts reviewed the impact of Covid-19 on patients, and during autumn and winter discussed and approved sending duty of candour letters in relation to patients who may have died as a result of acquiring Covid-19 while in the hospital.

**The Learning Disability Mortality Review (LeDeR)**

The Learning Disability Mortality Review (LeDeR) programme supports local areas to review the deaths of people with learning disabilities (deaths include from age 4 and above), helping to promote and implement the review process, and providing support to local areas to take forward lessons learned in the reviews to make improvements to service provision. The LeDeR also collates and shares anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements. Following on from the publication of the NHSE LeDeR policy and NHSE recommendations, the CCG is now working towards setting up a small in-house team of reviewers and local area contact, that will coordinate and undertake reviews and support the Integrated Care System across South West London to identify and implement learning from all reviews.

**Safe and wellbeing reviews**

In November 2021, South West London CCG was notified as part of the NHS response to the Safeguarding Adults Review (SAR) concerning the deaths of three individuals at Cawston Park, and a plan to undertake a national review was confirmed by Claire Murdoch, National Director for Mental Health. Reviews were to be undertaken to check the safety and wellbeing of all people with a learning disability and autistic people who are being cared for in a mental health inpatient setting.

The CCG has established an oversight panel to scrutinise the reviews including a range of senior clinical staff and a core group of people with lived experience. The work of the group is due to finish at the end of the March 2022 and will report in early 2022/23 covering the findings, themes and actions to be taken as a result of the reviews.

**Improving positive experiences**

One of our core objectives is to continue to improve the quality of people's experiences of care. As part of this objective, a work programme has been developed to bring together all patient engagement leads across South West London to collaborate at scale on how we improve experiences and outcomes for users of our services. A requirement for Integrated Care Boards from the national patient safety strategy will be to ensure the voice of people with lived experiences are embedded across patient safety, quality functions and decision making, we are recruiting two patient partners to support the CCG and ICB to implement better experiences of care for patients.

**Continuing Health Care and Children's Continuing Care**

We continued to develop an integrated approach to Continuing Healthcare (CHC) across the six boroughs of South West London, despite the challenges of doing so during a global pandemic.

Rapid discharges from hospital into longer term care has led to significant changes in the volume and type of clients being supported by the CHC teams. We expect this level of need to continue and we will need to adjust our resources and processes accordingly.

During 2021/22 we developed several areas of work across South West London to improve quality of data; ensure that contracts meet quality requirements; and agree shared principles across the services we deliver in the boroughs. We also continued as the lead commissioner for the London wide Any Qualified Provider programme.

One impact of the pandemic was to reduce the availability of clinically qualified staff and all our local teams faced difficulties in ensuring that suitably skilled assessors were in place to carry out assessments. We addressed this through use of agency staff. The focus of the team was to ensure that assessments were carried out in a timely way to enable public resources to be appropriately managed while also ensuring that all necessary care is provided effectively and in a timely way.

In 2022 we will focus on bringing together continuing care services to meet the new national All Age Continuing Care model of care.

**Children and Young People**

In 2021/22, we successfully established our Children, Young People and Maternity System Board, bringing together a network of system leaders across health, care and education to share learning to improve outcomes for babies, children, young people and their families.

Priorities for 2022/23:

- Increase the voice of children and young people in shaping services.
- Improve asthma care.
- Develop the Strengthening Communities Programme working with local authorities to establish opportunities for care leavers to have employment opportunities in the NHS.

**Reduce health inequalities; deliver equitable care**

Everybody should have access to high-quality care and outcomes, and those working in systems must be committed to understanding and reducing variation and inequalities.

As part of our equalities agenda, we are adopting Quality Improvement methodologies to deliver better outcomes. Our quality strategy ensures that equality is a golden thread across everything we do. You can read more about reducing health inequalities in section 1.2.3.

**Well-Led Services**

The CCG is working towards developing a system peer review framework that allows partners across the local system to provide mutual benefit, reduce variation and improve outcomes. As social care moves towards CQC regulation, South West London ICB will be providing support to social care services based on our experience of inspections and working with the CQC.

### Sustainable services

The success in developing our quality strategy and improving outcomes for our population is that quality is embedded in our services and that these are sustainably resourced. We continue to use tools such as logic models and a quality management system to evaluate impact and sustain quality improvement.

## 1.2.5.2 Safeguarding Children and Adults

Safeguarding aims to support adults, young people and children to live a life that is free from abuse and neglect. It involves a range of measures to protect people in the most vulnerable circumstances.

As seen last year, the pandemic and lockdowns have meant increased reporting of violence and abuse. We continued to work closely with our partners in policing, education, social care and local authority departments to do risk assessments and protect the most vulnerable children and adults.

We do everything we can to make sure the services we commission are safe and compliant with all statutory safeguarding regulations. We also have procedures to help us recognise, report and respond to safeguarding issues promptly. Through good partnership working with local authorities, we have supported care homes to allow greater access for visitors to care homes in line with the changing national guidance.

### Domestic Violence

Since the start of the pandemic there has been an increase in incidents relating to domestic violence and abuse. Local boroughs adopted new ways of working and increased the frequency of the Multi Agency Risk Assessment Conference (MARAC) to ensure oversight of domestic violence and abuse. The MARAC is a regular strategic partnership meeting chaired by the police public protection lead, and includes representatives from the NHS, local authority social services and education departments. All partners review and provide an update on the status of identified risks and raise new risks and concerns.

Our designated safeguarding leads worked collaboratively across the statutory partnership with local domestic abuse services to share updated guidance and represent the CCG at all commissioned domestic homicide reviews.

### Modern slavery and human trafficking

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for several reasons, including sexual exploitation, forced labour, domestic servitude and organ harvesting. We are committed to ensuring that there is no modern slavery or human trafficking in any part of our business activity and, in so far as is possible, to hold our suppliers to account to do likewise.

**Prevent**

Prevent safeguarding duties include the Prevent strategy, which aims to protect vulnerable individuals from being groomed into terrorist activity or supporting terrorism. All our safeguarding mandatory training now includes Prevent.

## 1.2.5.3 Complaints & PALS

Between 1 April 2021 and 31 March 2022, we received 363 formal complaints

Of these, 233 related to issues for which the CCG was responsible for investigating and responding to. We also received 130 complaints relating to issues which we are not directly responsible for, which were forwarded to the appropriate organisation for investigation and reply. These included complaints for NHS provider Trusts, GPs, dentists and community pharmacies.

Of the complaints we received in 2020/21, one has been referred to the Parliamentary and Health Service Ombudsman.

For those complaints that were within the CCG's remit, the areas most commonly complained about were:

- Continuing Healthcare (assessment for eligibility process, payment) 75 complaints.
- Covid-19 vaccine - 39 complaints
- Mental health commissioning (access to services, availability and funding) - 18 complaints
- General commissioning - 16 complaints
- Assisted conception (eligibility criteria) 9 complaints
- Medicines Management - 8 complaints
- Primary Care - 7 complaints
- Individual Funding Requests - 7 complaints

We very much value the views of patients and other people who experience the services we commission. We consider any complaint or enquiry about these services as a vital part of reviewing and, where necessary, improving them. We are putting together a 'learning from complaints' framework that will allow us improve the experiences of our patients.

**Patient Advice and Liaison Services (PALS)**

Members of the Patient Advice and Liaison Service (PALS) always listen carefully to the concerns raised by patients and their loved ones, and provide advice or make recommendations, where possible, as to the best way forward for the patient or member of the public.

Whilst it is not always possible to resolve a concern to the service user's satisfaction, the PALS team can give information about support services and voluntary organisations that may be able to help.

We believe that a successful PALS service helps reduce anxiety for those who use our services and helps people navigate the health and care system, whilst also reducing the number of issues that go on to become formal complaints.

The Complaints and PALS service also deal with a significant number of enquiries and informal concerns, from the public and MPs.

During 2021/22 there were 2026 such contacts.

The areas giving rise to most contacts were:

- Covid-19 vaccine – 1,043 contacts
- Primary care (GPs, NHS dentists, community pharmacies) – 179 contacts
- Continuing healthcare (assessment for eligibility process, payment) – 73 contacts
- Other NHS organisations – 2121 contacts
- General commissioning – 29 contacts
- Mental health commissioning (access to services, availability and funding) – 26 contacts
- Individual funding requests (requests for funding for treatment/medication not routinely provided on the NHS) – 25 contacts
- Assisted conception (eligibility criteria, can funding be transferred, freezing of eggs) – 21 contacts
- Compliments to the CCG – 14 contacts

## 1.2.6 Sustainable development

Following the publication of 'Delivering a net-zero National Health Service', we have committed to deliver a range of programmes to make the necessary changes required to help achieve this ambition.

During the development of the first South West London Green Plan, we focused on ensuring stakeholders within the NHS system were engaged and committed to the targets we set.

Our Green Plan will have nine areas of focus:

- Workforce and system leadership
- Sustainable models of care
- Digital transformation
- Travel and transport
- Estates and facilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation

We have already showed evidence of delivery in boroughs. Croydon for example, has reduced CO2 by 18% (around 14K tonnes) since the 13/14 baseline, has rolled out an estate-wide LED replacement programme and has reduced desflurane usage in advance of centrally recommended targets. Kingston will provide the NHS's first battery energy storage solution capex free and have replaced calorifiers with efficient plate heat exchangers.

We've also seen progress made in trusts. At the Royal Marsden, half a tonne of unwanted linen, uniforms and curtains have been recycled and reused, 91% of anaesthesia administered was total intravenous anaesthesia (TIVA), while St George's is one of only two trusts to achieve sustainability accreditation with The Planet Mark. They have also appointed new energy brokers to achieve 100% renewable buy-in from the grid and have updated the green travel plan with detailed work progressing on infrastructure improvements. At Central London Community Healthcare Trust (CLCH), 100% renewable electricity contracts with REGO certificates for its tier 1 sites were

purchased, have switched to 100% recycled paper, and all new vehicle leases were switched to 100% electric.

Another example of how South West London is responding to sustainable solutions to healthcare includes establishing 'virtual wards'. These ‘wards’ allow patients who are well enough to be monitored virtually from their own home resulting in fewer patients travelling to hospitals and freeing up hospital beds.

In Merton, a ground-breaking partnership between South West Merton Primary Care Network and the London Ambulance Service is helping more patients receive key primary care services in their own homes while reducing the impact on the environment. Working between the Nelson Health Centre and Grand Drive Surgery in Raynes Park, Paramedic Matt Kilner responds to acute calls that cannot be dealt with GPs on the phone, zipping through the streets of Merton on his power assisted bicycle carrying essential medical equipment.

But we know we can do more. Across the nine areas of focus, we have agreed the following 2022 priorities at an SWL ICS level:

- Kick-start a focus on our sustainability plans through a series of leadership and staff pledges
- Use only recycled paper in South West London, and reduce total paper usage year on year
- Create recycling points for metered-dose inhalers (MDI) in all GP surgeries and community pharmacies and ensure the provision of clear clinical guidance on appropriate inhaler usage to reduce MDI prescriptions
- Cut out all N2O wastage/leakage by 2023
- Keep desflurane usage to below 3% in 2022
- Go electric for patient, inter-site and courier transport by 2027
- Reduce carbon emissions from building by 20% vs 2020 rates by 2025

## 1.2.7 Financial Review

### 1.2.7.1 Staff Costs

There was a 10% year on year increase in the cost of permanent employees and a 45% increase in the cost of agency staff. The main reasons for these increases are as follows:

- A number of staff were "in-housed" from NHS London Shared Services (formerly known as NEL Commissioning Support Unit) to South West London CCG.
- Additional staff were recruited to the Communications Team to manage the Covid-19 response.
- Temporary IT staff were hired, to assist the with the CYC (Connecting Your Care) project and a number of GPIT projects.
- Temporary staff were recruited for SDF (System Development Fund) projects.
- Because of the CCG's imminent closure, limits were placed on the recruitment of permanent staff in the last few months of the year. Therefore temporary staff had to be hired.

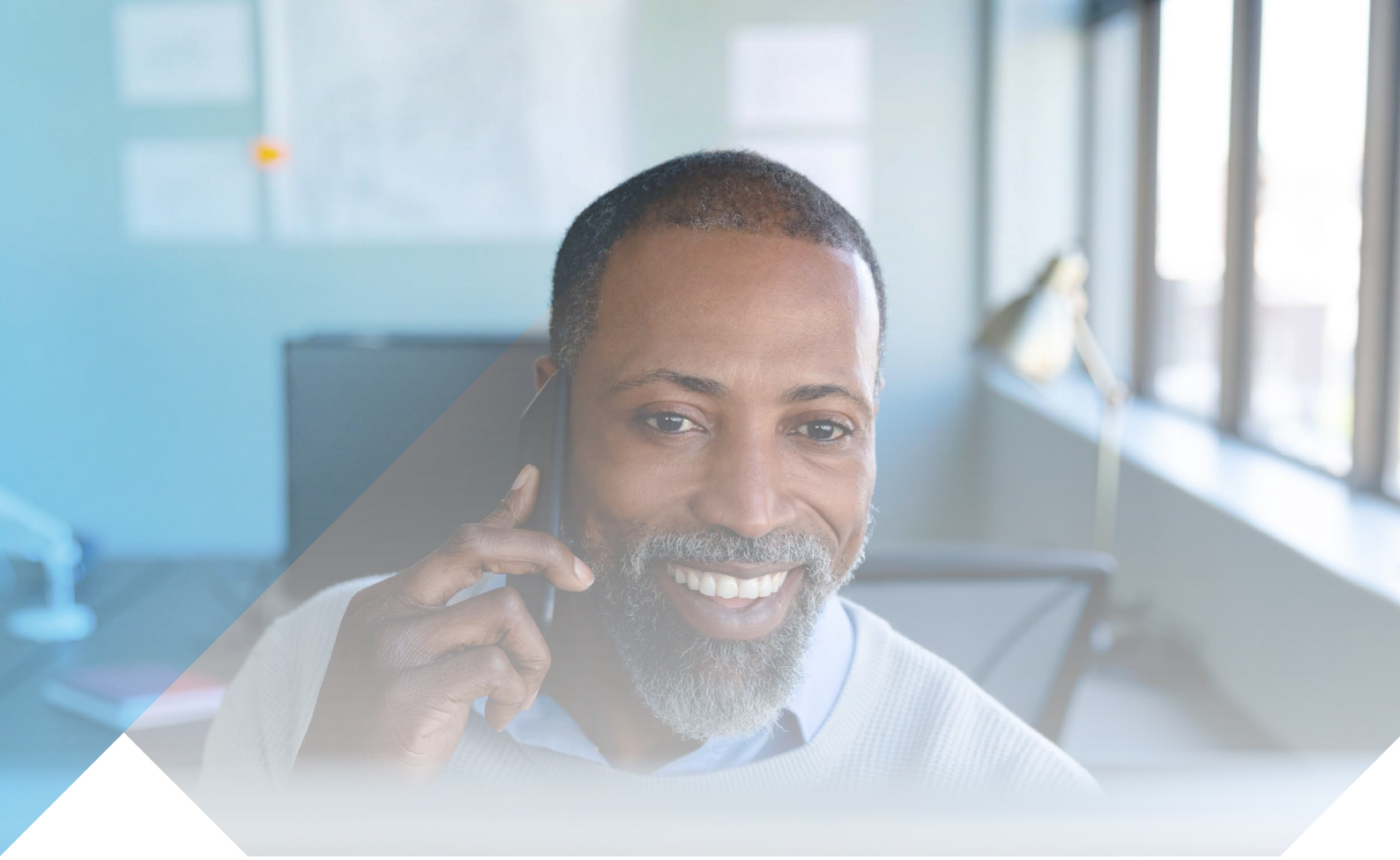
### 1.2.7.2 Balance Sheet

All fixed assets were fully depreciated during the year, and all intangible assets were fully amortised. Therefore the CCG's asset base is now zero.

There was a 12% increase in creditors between 2020/21 and 2021/22. This was predominantly driven by increased accruals for the elective recovery fund with NHS Provider organisations, but also an accrual for the funded nursing care price increase which was backed by an allocation.

Debtors increased by 5% year on year. A key reason for this was that the CCG was owed £870k at year end by a Community Interest Company: the debt related to Paediatric Speech and Language Therapy for Kingston and Richmond.

# 2 Accountability Report



The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during 2021/22, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Sarah Blow
Accountable Officer
20 June 2022

# 2.1 Corporate Governance Report

## 2.1.1 Members Report

NHS South West London CCG is a clinically led member organisation and covers the London boroughs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth. This means that GPs make decisions about local health services by using their local knowledge to improve services and focus resources where there is greatest need.
The CCG is made up of 180 GP practices, which are organised into Primary Care Networks. The CCG's work is overseen by an elected Governing Body which is chaired by Dr Andrew Murray, a GP at the Nelson Health Centre, in Merton. Sarah Blow is the Accountable Officer for NHS South West London CCG. All Governing Body members have specific areas of responsibility and sit on committees of the Governing Body. The members exercise their constitutional rights in respect of the CCG through a membership group. Each member practice has a representative on the membership group.

### 2.1.1.1 Our Governing Body

NHS South West London CCG's Governing Body was established following the merger of the six borough CCGs in April 2020. Under the CCG's Constitution and Standing Orders, the Governing Body's GP representatives either transferred to the new organisation, have been elected by their local memberships or, with local membership agreement, have been extended in their

roles. Our lay members were appointed, from the previous CCGs to the Governing Body via an expression of interest exercise. Our Local Medical Councils, local authorities, Healthwatch organisations and the voluntary sector from across South West London are all represented on the Governing Body.

Our Governing Body met in public six times during the year, and we encourage our community to join us to find out about the work we're doing. Details of public Governing Body meetings, and meeting papers are published on the CCG website at

swlondonccg.nhs.uk/category/previous-governing-body-meetings/

During 2021/22, NHS South West London CCG continued to work under strengthened governance arrangements established in the previous year, within a command and control framework in response to the Covid-19 pandemic, to support the local and national joint decision making model.

Governing Body members and our key stakeholders have continued to be kept informed of the CCG's response to the Covid-19 pandemic throughout the year.

Remote working technologies continued to be embraced, with the live streaming and recording of our public meetings, which helped to ensure the appropriate scrutiny and assurance, and maintain the openness and transparency our meetings.

The role of our Governing Body is to:

Oversee and ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance.

Make sure that decisions about changes to local health services are made in an open and transparent way.

### 2.1.1.2 Governing Body members

#### Dr Andrew Murray, Clinical Chair

Dr Andrew Murray trained at Cambridge and Oxford universities and then moved to South West London in 2000, straight after graduating. He completed his GP training in August 2004 and joined the partnership at The Church Lane Practice in Merton Park and has practised as a GP principal in Merton since then. He oversaw the merger of his practice with Cannon Hill Lane Medical Practice in April 2015 to form the Nelson Medical Practice and now practises out of the Nelson Health Centre.

Andrew was involved in practice-based commissioning, set up and led a local GP provider company, worked as a GP appraiser in Sutton and Merton for five years, was a member of Merton Local Medical Committee for seven years, as well as chairing Merton, Sutton and Wandsworth Local Medical Committees from 2011 to 2013, when he moved from this role to join Merton CCG as Clinical Chair.

He also has an interest in developing world healthcare, education and community development and helped to set up a community health worker training programme in Myanmar which has so far trained nearly 1000 health workers. He served for a number of years as a trustee and chair of the charity supporting this work (Health and Hope) which received the patronage of HRH The Prince of Wales.

In the last couple of years Andrew has co-chaired the South West London Clinical Senate and has led work on Children and Young People's Mental Health. He has overseen the Whole School Approach to emotional wellbeing receiving funding for 14 national trailblazer pilots, covering approximately 50% of pupils in South West London, the largest cluster in the country.

As the previous Merton CCG Chair, Andrew promoted a community-based and holistic approach to health and ensured closer working with the Local Authority, particularly around action on health inequalities through the Health and Wellbeing Board.

Andrew was subsequently appointed Chair of NHS South West London CCG and has provided senior clinical leadership to South West London through the Covid-19 pandemic, chairing the Clinical Leadership Group and the Specialised & Cancer Recovery Programme. Andrew has driven the development of Population Health Management in South West London, overseeing a system-wide stocktake and developing a roadmap to deliver the required infrastructure, system capability and capacity for the future.

## Dr Agnelo Fernandes, GP Borough Lead for Croydon

Dr Agnelo Fernandes has been a GP in Thornton Heath, Croydon for 31 years. His interests include dermatology, quality improvement of health services through innovation and transformation and teaching and training. He is a GP Trainer and a Governor at Royal Russell School, Croydon.

He is also the Chair of the pan-London Integrated Urgent Care Clinical Governance group and Chair of the National NHS Pathways Clinical Governance group involving representatives of the royal medical colleges, and he was previously the National GP Lead for Urgent & Emergency Care for the Royal College of General Practitioners (UK).

Agnelo is also Vice Chair of Croydon's Health and Wellbeing Board and co-Chair of the Health Board in Croydon.

He was awarded the MBE for "services to Medicine and Healthcare" by Her Majesty the Queen (2004) and Fellowship of the Royal College of General Practitioners (2006).

## Dr Naz Jivani, Clinical Vice Chair and GP Borough Lead for Kingston

Dr Naz Jivani has been a GP in Kingston since 1996 and is a partner at The Groves Medical Centre, New Malden. He specialises in musculoskeletal conditions and is currently leading a programme of improvements in this area. He is also Clinical Lead for South West London and Kington Planned Care and MSK Transformation Programmes.

He is currently a Board Member of the NHS Clinical Commissioners, representing London. He also Co-Chairs the Kingston Health and Wellbeing Board.

Naz is the GP Borough Chair for Kingston. In this role he works alongside other GPs, health and care professionals, Kingston Hospital, Kingston Council, and Kingston's local Healthwatch to take forward the

integration of health and social care to better serve the needs of the Kingston community. Naz has played a critical role in the South West London clinical leadership community, and during the pandemic, provided a key link between the South West London Clinical Leadership Group and the acute, elective and critical care work.

## Dr Vasa Gnanapragasam GP Borough Lead for Merton

Dr Vasa Gnanapragasam has been a GP since 1996. He worked for 16 years at the emergency department at St George's Hospital helping to develop his awareness of NHS clinical practice in both primary care and secondary care. He finds the challenge of looking after the diverse population of London intellectually stimulating and personally rewarding. Vasa is a partner at a practice in Merton.

Vasa has an interest in diabetes, cardiovascular disease, frailty and patient engagement. Since 1999 he has held many portfolios in Merton serving as lead for cardiovascular disease, long term conditions, medicines management, community services and planned care. He is currently clinical co-lead for urology and stroke in South West London. Vasa has found leading the discussion and responding to questions at Covid-19 vaccine webinars most fulfilling.

Vasa has been actively involved in education, training, workforce development and quality assurance since 2002. He is a GP trainer and appraiser and is also a Foundation Doctor supervisor. He was a module lead on the pioneering physician associate programme at St George's, University of London for ten years and has been teaching since its founding in 2008. He was promoted to Senior Lecturer in PA education in 2014.

As GP Borough Lead for Merton, Vasa looks forward to supporting the effective integration and delivery of health and care services across South West London to better serve the needs of the people of Merton and South West London.

## Dr Patrick Gibson, GP Borough Lead for Richmond

Dr Patrick Gibson practices at Essex House, Barnes. Patrick has held several board and clinical leadership roles, with particular focus on whole system work, cardiovascular and cancer. He has held liaison roles with Kingston and Queen Mary's Hospitals.

He was a member of Richmond's clinical executive team and chaired the Richmond and Barnes membership engagement group. In 2012, Patrick's thinking on care management was heavily influenced by a whole system leadership programme, supported by the King's Fund, which put relationship building at the heart of transformational work.

Patrick's motivation is to reduce inequalities in health outcomes and to create life-long mental health resilience through attention in the early years.

## Dr Dino Pardhanani, GP Borough Lead for Sutton

Dr Dino Pardhanani graduated from St George's Hospital Medical School in 1999 and has been a GP since 2003. Dino joined Mulgrave Road Surgery as a partner in 2004 and has worked as a GP with a special interest in ear, nose and throat disorders for 15 years and was awarded a Master's in Business Administration in 2016.

Dino joined the NHS South West London CCG Governing Body in October 2020, and previously worked with Sutton CCG from its inception in 2013, and was appointed as Joint Clinical Director in 2018. Dino was elected as Joint Primary Care Network Clinical Director for Central Sutton in 2019. He is Chair of the Epsom and St Helier University Hospitals A&E Delivery Board and is NHS Sutton CCG Clinical Director Lead for the Sutton Joint Financial Recovery plan with Epsom and St Helier University Hospitals NHS Trust.

## Dr Nicola Jones, Clinical Vice Chair and GP Borough Lead for Wandsworth

In addition to supporting the Chair, Nicola's portfolio includes clinical leadership of primary care and the Covid-19 vaccine programme.

Nicola has been a GP at the Brocklebank Practice since 1995. She has been a primary care advisor to the Department of Health and has experience of commercial organisations as well as an NHS background. She gained an MBA from London Business School in 1999 and has developed management expertise in a variety of roles but remains utterly rooted in NHS clinical practice and primary care. She enjoys the challenges of practicing in inner London with its diversity and pathology.

Nicola has an interest in cardiovascular disease and women's health and, as well as seeing patients, is the managing partner of a group of practices in a Primary Care Network in Wandsworth. Having been the Clinical Lead for Cardiovascular Disease in Wandsworth for many years she now co-chairs the South West London Cardiology Network.

## David Smith, Non-Clinical Vice Chair and Finance Chair Lay Member

David Smith is a qualified accountant and member of the Chartered Institute of Public Finance and Accountancy. After more than 42 years working in the NHS, David retired from full-time work at the end of 2017.

David's early career was in finance roles before moving into performance management and commissioning. David has previously served in a joint post as the Director of Adult Social Services for the Royal Borough of Kingston upon Thames and Chief Officer of Kingston CCG. In this role, he led the transformation of the care systems in Kingston, integrating service delivery models, and health and adult social care commissioning. He was also Chief Executive

of Oxfordshire CCG and led the Sustainability and Transformation Partnership covering Buckinghamshire, Oxfordshire, and Berkshire West.

With his experience working in the NHS and with CCGs, David is pleased to be working in NHS South West London CCG, contributing to the strategy of the CCG and the wider system as we strive to deliver consistently high quality of care. David chairs the Finance Committee; chairs the Remuneration Committee and is a member of the Audit Committee.

## Paul Gallagher, Audit Chair Lay Member and Conflicts of Interest Guardian

Paul Gallagher is a chartered accountant and has experience as a lay member on the Governing Bodies for the former CCGs in South West London.

Paul began his career in local government and has since held a number of senior leadership roles in the private sector, managing and supplying IT, professional and support services to both private and public sector organisations. Paul currently works in management consulting and advises companies on finance transformation, strategy and operations.

In his role as Chair of the Audit Committee and Conflicts of Interest Guardian, Paul is committed to ensuring accountable delivery of health and care for the community.

## Susan Gibbin, Patient and Public Involvement Lay Member and Freedom to Speak Up Guardian

Susan has worked in and with the NHS for more than 30 years in an executive, consultancy and more recently in a non-executive capacity. Susan has vast experience of working with commissioning and provider organisations in both Health and Education, offering experience in strategic and critical thinking, governance and partnership working. Susan is also the CCG's Freedom to Speak Up Guardian.

## Pippa Barber, Independent Registered Nurse

Pippa Barber has nearly 40 years' experience in the NHS. She has significant Board experience in a number of Executive roles across a range of Provider and Commissioning Trusts, latterly as the Executive Director of Nursing and Governance at Kent and Medway Social Care Partnership Trust and Executive Nurse at NHS Medway. In addition, she has current Non-Executive Board experience for a Provider NHS Trust Board.

Pippa is currently the Independent Nurse representative for NHS South West London CCG's Governing Body, where she maintains an essential focus on clinical quality, safety and effectiveness and chairs the South West London Quality and Performance Committee.

## Sarah Blow, Accountable Officer

Sarah has over 30 years' of experience in the NHS and has led organisations, systems and programmes across partnerships working collaboratively with staff, clinicians and partners to improve services and deliver sustainability. Sarah has held operational and strategic roles with local authorities, providers and the Department of Health. She has lived in South West London all her life, and values and recognises that a strong collaborative approach delivers better care for our patients and residents.

Sarah has been working in South West London as Accountable Officer for NHS South West London CCG alongside being the Senior Responsible Officer for the ICS (Integrated Care System) known as South West London Health and Care Partnership since February 2017.

In 2020 Sarah oversaw the merger of the South West London Alliance of CCGs and Croydon CCG, into the current, single, NHS South West London Clinical Commissioning Group.

Sarah is responsible for leading the partnership to ensure better outcomes are achieved for local people, as well as being accountable for balancing financial budgets, achieving performance targets, commissioning and overseeing governance and quality, as well as ways of working and communications.

Following a robust process led by NHS England and NHS Improvement, Sarah was appointed as the as Chief Executive of the South West London Integrated Care System (ICS) and designate Chief Executive of the NHS South West London Integrated Care Board.

Sarah holds an MBA, PG Dip in Healthcare Systems Management and a BA (Hons) History and Humanities and is based in Wimbledon. She lives in Sutton with her family and has two grown up sons.

## James Murray, Chief Finance Officer

James has over 30 years' experience working within the NHS across several different organisations, including provider, commissioning and regulatory functions. James was previously the Chief Finance Officer for the South West London Alliance of CCGs, before the merger in 2020 of the six borough CCGs, into NHS South West London Clinical Commissioning Group.Member practices by locality.

### 2.1.1.3 Composition of Governing Body

Members of the Governing Body are as follows:

| Position / Title | Name |
|---|---|
| Clinical Chair | Dr Andrew Murray |
| GP Borough Lead, Croydon | Dr Agnelo Fernandes |
| GP Borough Lead, Richmond | Dr Patrick Gibson |
| Clinical Vice Chair and GP Borough Lead, Kingston | Dr Naz Jivani |
| Clinical Vice Chair and GP Borough Lead, Wandsworth | Dr Nicola Jones |
| GP Borough Lead, Sutton | Dr Dino Pardhanani |
| GP Borough Lead, Merton | Dr Vasa Gnanapragasam |
| **Lay Members** | |
| Non-Clinical Vice Chair & Lay Member, Finance | David Smith |
| Lay Member, Audit Chair | Paul Gallagher |
| Lay Member, Patient and Public Engagement | Susan Gibbin |
| **Independent Members** | |
| Registered Nurse | Pippa Barber |
| Secondary Care Specialist Doctor | vacant |
| **Executive Members** | |
| Accountable Officer | Sarah Blow |
| Chief Finance Officer | James Murray |

Non-voting members and observers, including members of the SWL CCG Senior Management Team, who regularly attend meetings of the Governing Body are as follows:

| | |
|---|---|
| **SWL CCG** | |
| Locality Executive Director, Merton & Wandsworth | Mark Creelman |
| Locality Executive Director, Kingston & Richmond | Tonia Michaelides |
| Place Based Leader, Croydon | Matthew Kershaw |
| Executive Director of Strategy and Transformation | Karen Broughton |
| Director of System Planning, Performance and Delivery | Jonathan Bates |
| Executive Director of Communications & Engagement | Charlotte Gawne |
| Chief Nurse and Director of Quality | Dr Gloria Rowland |
| Chief of Staff | Ben Luscombe |
| **Local Medical Committees** | |
| London Wide LMC | Asiya Yunus |
| Chief Executive, Surrey, and Sussex LMC | Julius Parker |

| | |
|---|---|
| **Local Authority Representatives** | |
| Director, Merton Public Health | Dagmar Zeuner |
| Director of Children's Services | Ian Dodds |
| Strategic Director People Services, London Borough of Sutton | Nick Ireland |
| **Voluntary Sector Representative** | |
| Richmond CVS | Bruno Meekings |
| **HealthWatch Representative** | |
| Kingston, Chair | Liz Meerabeau |

### 2.1.1.4 Committees of the Governing Body

Several sub-committees support our Governing Body to carry out its statutory duties. The extent of authority to act of these committees depends on the powers delegated to them by the CCG, as described in its Scheme of Reservation and Delegation (Appendix 4b of the CCG's constitution), which sets out:

**Decisions that are reserved to the membership as a whole.**

**Decisions delegated to the Governing Body and its committees.**

**Decisions delegated to individual members and employees.**

The CCG remains accountable for all of its functions including those that it has delegated. In discharging their delegated responsibilities, the Governing Body and its committees are required to:

- Comply with the principles of good governance.
- Operate in accordance with the CCG's Scheme of Reservation and Delegation.
- Comply with the CCG's Standing Orders.
- Comply with the CCG's arrangements for discharging its statutory duties.

Where appropriate, ensure that members have had the opportunity to contribute to the CCG's decision-making process through the membership group.

When discharging their delegated functions, the Governing Body and committees operate in accordance with their approved terms of reference.

### 2.1.1.5 Audit Committee

The Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the CCG's activities that support the achievement of the CCG's objectives. A key purpose of the committee is to monitor the integrity of the financial statements of the CCG and assure itself that relevant risks, particularly financial, are appropriately identified and managed within a robust system of internal control. The Committee is also responsible for seeking appropriate assurance functions on relating to ensuring arrangements for counter-fraud and audit work programmes.

### 2.1.1.6 Remuneration Committee

The Remuneration Committee is responsible for advising the Governing Body in meeting their responsibilities to ensure appropriate remuneration, allowances and terms of service for the CCG Chair, Accountable Officer, senior managers remunerated under the Very Senior Manager (VSM) Pay Framework, Governing Body clinical posts, and clinical lead corporate roles; at all times having proper regard to the organisation's circumstances and performance, the provisions of any national agreements and NHS England and Improvement guidance, where appropriate.

With the exception of Lay Members, the Committee also has the power to make recommendations on fees and other allowances for all individuals directly appointed by the CCG as workers or employees.

### 2.1.1.7 Primary Care Commissioning Committee

The Primary Care Commissioning Committee meets in public, and its purpose is to enable the members to make collective decisions on the review, planning and procurement of primary care services in South West London, under delegated authority from NHS England.

The Committee aims to ensure that appropriate primary care services are commissioned to serve the needs of residents and improve the efficiency, effectiveness, economy and quality of services, reduce inequalities and promote the involvement of patients and the public in the development of services. Patients, members of the public and other stakeholders are invited to attend the Committee.

### 2.1.1.8 Quality, Performance and Oversight Committee

The Committee is responsible for overseeing, understanding, reviewing, and ensuring a robust quality strategy is in place and that this maximises the quality and safety of services for the population of South West London. The Committee provides assurance to the Governing Body, that required performance outcomes are delivered with associated risks identified and, where possible, mitigated.

### 2.1.1.9 Finance Committee

The Committee is established to ensure that a robust financial strategy is in place and to oversee the system of financial management, including the review of financial plans and the current and forecast financial position of the CCG and Borough budgets.

The Committee also aims to understand the drivers behind any variances against the plans, ensure any risks have been identified, and mitigating actions have been taken to address these whilst providing assurance to the Governing Body about delivery and sustained performance.

### 2.1.1.10 NHS South West London CCG 'Committees in Common'

The CCG's constitution provides for a mechanism that allows specified functions to be delegated to a designated committee, which may meet with delegated committees of other CCGs in a Committees in Common (CiC) arrangement, with the agreement of the Governing Body.

Membership and attendance at the Governing Body and respective sub-committees is shown in the table below:

| Name | Role | Meetings attended |
|---|---|---|
| **Governing Body** | | |
| Dr Andrew Murray | SWL CCG Clinical Chair | 6/6 |
| Dr Agnelo Fernandes | Croydon, elected GP Borough Lead | 6/6 |
| Dr Naz Jivani | Kingston, elected GP Borough Lead | 6/6 |
| Dr Vasa Gnanapragasam | Merton, elected GP Borough Lead | 6/6 |
| Dr Patrick Gibson | Richmond, elected GP Borough Lead | 6/6 |
| Dr Dino Pardhanani | Sutton, elected GP Borough Lead | 6/6 |
| Dr Nicola Jones | Wandsworth, elected GP Borough Lead | 6/6 |
| David Smith | SWL CCG, Deputy Chair & Lay member Finance | 6/6 |
| Paul Gallagher | Lay Member, Audit Chair | 6/6 |
| Susan Gibbin | Lay Member, Public & Patient Engagement | 6/6 |
| Pippa Barber | Independent Registered Nurse | 5/6 |
| Sarah Blow | SWL CCG Accountable Officer | 6/6 |
| James Murray | SWL Chief Finance Officer | 6/6 |
| **Audit Committee** | | |
| Paul Gallagher | Lay Member, Audit Chair | 6/6 |
| David Smith | SWL CCG, Deputy Chair & Lay member Finance | 4/6 |
| Pippa Barber | Independent Registered Nurse | 5/6 |
| Dr Agnelo Fernandes | Croydon, elected GP Borough Lead | 3/6 |
| Dr Dino Pardhanani | Sutton, elected GP Borough Lead | 2/6 |
| **Remuneration Committee** | | |
| David Smith | SWL CCG, Deputy Chair & Lay member Finance | 4/4 |
| Paul Gallagher | Lay Member, Audit Chair | 4/4 |
| Susan Gibbin | Lay Member, Public & Patient Engagement | 4/4 |
| **Primary Care Commissioning Committee** | | |
| Susan Gibbin | Lay Member, Public & Patient Engagement | 4/4 |
| David Smith | SWL CCG, Deputy Chair & Lay member Finance | 4/4 |
| Mark Creelman | Locality Executive Director Merton and Wandsworth | 4/4 |
| **Quality, Performance and Oversight Committee** | | |
| Pippa Barber | Independent Registered Nurse | 6/6 |
| Susan Gibbin | Lay Member, Public & Patient Engagement | 6/6 |
| Dr Nicola Jones | Wandsworth, elected GP Borough Lead | 6/6 |

| | | |
|---|---|---|
| Dr Patrick Gibson | Richmond, elected GP Borough Lead | 5/6 |
| Gloria Rowland | Chief Nurse/Executive Director of Quality | 6/6 |
| Jonathan Bates | Executive Director Systems Planning Performance and Delivery | 5/6 |
| **Finance Committee** | | |
| David Smith | SWL CCG, Deputy Chair & Lay member Finance, Finance Committee Chair | 13/13 |
| Dr Naz Jivani | Kingston, elected GP Borough Lead | 7/13 |
| Dr Vasa Gnanapragasam | Merton, elected GP Borough Lead | 10/13 |
| Paul Gallagher | Lay Member, Audit Chair | 13/13 |
| Pippa Barber | Independent Registered Nurse | 11/13 |
| James Murray | SWL Chief Finance Officer | 9/13 |

### 2.1.1.11 Register of Interests

The CCG operates a robust policy for the management of Conflicts of Interest.

All attendees are required to declare their interests as a standing agenda item for every Governing Body, Committee or working group meeting before the item is discussed.

To protect the integrity of decision-making, arrangements for managing conflicts of interest and potential conflicts of interest have been established. These include excusing potentially conflicted members from deliberations where appropriate.

The register of interests is available on our website www.swlondon.nhs.uk.

- Personal data related incidents

There have been no Serious Untoward Incidents relating to data security breaches, that required onward reporting to the Information Commissioner.

- Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report;
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

### 2.1.1.12 Modern Slavery Act

SWL CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2022 is published on our website.

## 2.1.2 Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has. appointed the Sarah Blow to be the Accountable Officer of NHS South West London Clinical Commissioning Group.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),

- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

Sarah Blow

Accountable Officer

NHS South West London Clinical Commissioning Group

## 2.1.3 Governance Statement

### 2.1.3.1 Introduction and context

NHS South West London Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2020 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2021, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

### 2.1.3.2 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

### 2.1.3.3 Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

NHS South West London CCG's constitution sets out how it shall fulfil its statutory duties and the primary governance rules for the CCG. It complies with National Health Service Act 2006 (as amended) and relevant guidance issued by NHS England. The CCG is a clinically led membership organisation and is accountable for exercising the statutory functions of the CCG.

The detail, including composition of the Governing Body and its committees are described within the Member's Report.

### 2.1.3.4 UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code and the Corporate Governance in Central Government Departments: Code of Good Practice 2011 (HM Treasury and Cabinet Office) that we consider to be relevant to the CCG. These are especially reflected in this report in describing review of Governing Body effectiveness and the CCG's risk management arrangements.

### 2.1.3.5 Discharge of statutory functions

The arrangements put in place by NHS South West London CCG and explained within the corporate governance framework were developed to ensure compliance with all relevant legislation.

In light of recommendations of the 2013 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

### 2.1.3.6 Risk management arrangements and effectiveness

The CCG has a robust internal control mechanism to allow it to prevent, manage and mitigate risks. The risk assessment section describes our approach to risk management and appetite for risk, explaining the key components of the internal control structure. Alongside the CCG's governance framework, these arrangements underpin the CCG's ability to control risk through a combination of:

- **Prevention** – the CCG's structures, governance arrangements, policies, procedures and training minimise the likelihood of risks materialising;
- **Deterrence** – staff are made aware that failure to comply with key policies and procedures, such as the Standards of Business Conduct Policy or the Fraud, Bribery and Corruption Policy, will be taken seriously by the CCG and could lead to disciplinary action, or dismissal;
- **Management of risk** – once risks are identified, the arrangements for ongoing monitoring and reporting of progress through the Committee structure to the Governing Body ensures appropriate action is taken to manage risks.

The capacity to handle risk section describes the range of systems and processes in place to embed risk management more broadly in the CCG's activities including the requirement for equality impact assessments to accompany papers to the Governing Body and committee reports.

The CCG is fully committed to complying with the public sector equality duty set out in the Equality Act 2010, both as an employer and a commissioner of health services and publishes these arrangements on our website. The Lay Member for Patient and Public Involvement (PPI) assures the CCG's duty to engage the public is given a profile at the Governing Body. Members of the public are also able to attend meetings of the Governing Body and Primary Care Commissioning Committee.

### 2.1.3.7 Board assurance and risk management framework

The Board Assurance Framework (BAF) provides assurance to the Governing Body on the delivery of its corporate objectives.

The BAF has been designed to provide assurance on the delivery and impact of the priority programmes as well as the risks threatening delivery and therefore impact on corporate objectives being achieved. It sets out mitigating actions for the risks and timescales in respect of these actions being completed.

### 2.1.3.8 Capacity to handle risk

The responsibilities of Directors and Committees are set out in the Constitution and the accompanying Scheme of Delegation, as well as the governance reporting lines. Timely and accurate information to assess risk and ensure compliance with the CCG's statutory obligations, is supported by the annual plan of committee work. The Governing Body has rigorous oversight of the performance of the CCG, via formal Governing Body meetings, seminars and through assurances received from committees and audits.

The overall responsibility for the management of risk lies with the Accountable Officer. The Governing Body collectively ensures that robust systems of internal control and management are in place. These arrangements, and the enhancements that have been made to them, are described in the Risk Assessment section of this report.

Risk management capacity continues to be developed across the CCG in a number of ways during the year. The statutory and mandatory training programme includes numerous elements relevant to risk management, including information governance, health and safety, fire safety, safeguarding adults and children and counter fraud.

Governing Body and Committee reporting arrangements prompt authors to consider that key aspects of risk have been reviewed.

Several positive findings were identified in respect of the risk management process, following a review by Internal Audit during the year. This included the risk management framework and the appropriate level of training on risk management across the CCG. In terms of further development, the CCG is in the process of reviewing Borough risk registers to ensure they are more standardised and reflective of the same level of detail and content across the organisation.

### 2.1.3.9 Risk assessment

The Senior Management Team is responsible for oversight of the risk management process, its members review both risk registers and the Board Assurance Framework (BAF) as part of their business cycle, and the management of all CCG corporate risks are overseen by an executive director. It evaluates the status of risks, identifies new risks and monitors effectiveness of the CCG's board assurance and risk management control systems.

The Audit Committee provides scrutiny and independent assurance to the Governing Body on the effectiveness of the CCG's board assurance and risk management processes.

The Governing Body reviews the content of the BAF twice a year as a means of assessing the current level.

All other sub committees of the Governing Body review those risks specific to their area and are made aware of significant changes to the risk register at each meeting.

Operational management of the BAF is provided by the CCG's governance and corporate services team. Regular meetings are held with manager leads to review progress and performance of each of the priority areas and associated risks.

The BAF forms the basis for the Governing Body to assess its position regarding achieving its corporate objectives. It uses principal risks to achieve those objectives as the foundation for assessment. It considers the current level of control alongside the level of assurance that can be placed against those controls.

The BAF has been created from three core areas of the CCG's more detailed Corporate Risk Register:

- Risks with a significant residual score, for example, those that score over 15
- Those risks that we believe are either likely to be growing in significance or that we wish to flag to the Governing Body as posing a risk to delivering essential areas of work.
- Overarching risks that collate and summarise several more detailed risks present on the risk register. For example, finance.

The CCG views risk management as key to the successful delivery of its business and remains committed to ensuring staff are equipped to assess, manage, escalate and report risks. This ensures a comprehensive overview of all the risks affecting the organisation and facilitates decision-making about those risks that need immediate treatment and those that the organisation can tolerate for a specified amount of time.

The CCG uses an NHS standard risk scoring matrix (CASU 2002) to determine the scales of impact and likelihood of adverse events. The scale is scored from 1-25 (with 1 being the least severe and 25 being the most). The risk will continue to be managed at director level with oversight by the committee relevant to the risk as well as oversight from the Audit Committees in Common. This allows:

- The appropriate level of investigation and causal analysis to be carried out.
- Identification of the level at which the risk will be managed, the assigning of priorities for remedial action and determination of whether the risk will be accepted.

Using the residual risk rating (i.e. after controls are taken into account), there are nine risks of significant nature (significant risks are those on the risk register scored at 15 and above or deemed to be of a significant in nature to be included on the BAF):

- RRSWLCCG004 - Integrated urgent care (IUC) contract
- RRSWLCCG008 - Delivering access to planned care
- RRSWLCCG051 - NHS Constitution standards
- RRSWLCCG055 - Provider quality oversight (general)
- RRSWLCCG066 - Achievement of financial balance
- RRSWLCCG106 - Risk of increased nosocomial infection in South West London providers arising from inadequate estates
- RRSWLCCG112 - Workforce capacity wellbeing and availability
- RRSWLCCG115 - Collective corporate risk if South West London fails to deliver ICS activity objectives
- RRSWLCCG118 - Mental health demand in South West London Emergency Departments (all ages)

### 2.1.3.10 Other sources of assurance

- **Internal Control Framework**

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Our governance structures are used to ensure effective oversight of operational and strategic decisions and compliance with the NHS regulatory environment. Details of the Governing Body responsibilities and those of its committees are outlined above and described in further detail within the Constitution.

Ensuring effective risk management, financial management and compliance with statutory duties is high on the list of our priorities. We have implemented policies, systems and processes to reduce exposure in these areas and to ensure that we are legally compliant. Each committee and group oversees risks and policies relating to their area of responsibility. Clinicians and management work in partnership through the commissioning cycle, adding value and delivering outcomes, to ensure the procurement of quality services that are tailored to local needs and deliver sustainable outcomes and value for money.

The CCG has established an effective organisational structure with clear lines of authority and accountability which guards against inappropriate decision making and delegation of authorities enabling the CCG to meet its statutory duties and follow best practice guidelines. Work to ensure that we promote and demonstrate the principles and values of good governance and the review of governance related risks takes place at Senior Management Team meetings and assurance is provided by the Audit Committee to the Governing Body with insight from Internal Audit. The Committee also ensures that, in non-financial and non-clinical areas that fall within the remit of its terms of reference, appropriate standards are set and compliance with them is monitored. We have considered the effectiveness of our governance framework and processes and raised no significant concerns on governance related matters this year.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the CCG, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the CCG for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

- **Annual audit of conflicts of interest management**

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

An internal audit of the CCG's Conflicts of Interest process was carried out during the year. The audit overall provided a positive level of assurance with no high priority actions identified. In terms of further development, the CCG will work to improve the assurance of the Conflicts of Interest process within procurement processes.

- **Data Quality**

The Governing Body regularly receive reports that cover financial, governance, compliance, performance and quality matters for the CCG.

The CCG has a business intelligence and performance function which monitors how local providers are performing against key performance indicators. This information is reported to the Governing Body on a regular basis.

The data contained in the reports is subject to significant scrutiny and review, both by management and by Governing Body committees. The quality of information received to direct decision-making is also assured through the service level specification arrangements with the North East London

Commissioning Support Unit (NELCSU) and the use of contractual arrangements with the commissioned providers. The Governing Body is confident that the information it is presented with has been through appropriate review and scrutiny, and that it continues to develop with organisational needs.

- **Information Governance**

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities. Additionally, and all information governance policies are available on the staff intranet.

There are processes in place for incident reporting and investigation of serious incidents. We continue to develop information risk assessment and management procedures alongside the risk management framework detailed in this report.

- **Business Critical Models**

The CCG confirms that an appropriate quality assurance framework is in place and is used for all business critical analytical models.

- **Third party assurances**

The CCG relies on a number of third party providers (such as NHS SBS, NHS BSA, NEL CSU) to provide a range of transactional processing services ranging from finance to data processing. Our requirements for the assurance provided by these organisations are reviewed every year. Appropriate formal assurances are obtained to supplement routine customer/supplier performance oversight arrangements.

### 2.1.3.11 Control Issues

No significant control issues have been identified at NHS South West London CCG during 2021/22.

### 2.1.3.12 Review of economy, efficiency and effectiveness of the use of resources

The Governing Body, through its meetings, retains primary oversight of the appropriateness of arrangements in place within the organisation to exercise its functions in an effective, economic and efficient manner. The Accountable Officer retains overall executive responsibility for the use of our resources.

The organisation has a number of key processes and internal mechanisms that provide assurance that we are operating within our statutory authority:

- Within our constitution there are clearly defined standards for conducting business, Standing Orders, Scheme of Reservation and Delegation along with Prime Financial Policies that ensure the effective management and protection of assets and public funds.
- Key policies are in operation in respect of contract management and procurement that ensure effective operational and financial performance whilst ensuring we operate within regulatory frameworks and reduce the likelihood and impact of risk.
- There is a clearly defined process for the consideration of business cases and saving opportunities to ensure transparency and value for money is upheld.
- The Commercial Procurement Advisory Group evaluates the robustness of proposed business cases before these are then considered by the Finance Committee.
- The Quality and Performance Oversight Committee is accountable for overseeing a robust, organisation-wide system of quality and performance.
- The Finance Committee ensures that the finances of the CCG are scrutinised to ensure budgets are managed in an appropriate and timely manner. It will ensure that the Governing Body is fully aware of any financial risks which may materialise throughout the year. It works alongside the Audit Committee to ensure financial probity in the organisation.
- These committees have, on behalf of the Governing Body, an overview of all aspects of finances (including capital spend and cash management).

### 2.1.3.13 Counter fraud arrangements

Counter fraud arrangements are in place in the CCG to ensure compliance with standards set by the NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption.

- An accredited Local Counter Fraud Specialist (LCFS) is contracted to undertake counter fraud work proportionate to identified risks.
- The CCG's Audit Committee receives progress reports throughout the year and an annual report against each of the standards for commissioners.
- There is executive support and direction for a proportionate proactive work plan to address identified risks.
- Regular fraud related communications are shared with CCG staff and training is delivered to all staff.
- The LCFS meets with the Director of Finance and Internal Audit to agree tasks to be undertaken as part of the workplan.
- The LCFS also has regular liaison with the Director of Finance to discuss any concerns that come to light throughout the year.
- A member of the Executive Team (the Chief Finance Officer) is proactively and demonstrably responsible for tackling fraud, bribery and corruption.

There have been no assessments from the NHS Counter Fraud Authority but should one occur an action plan would be taken forward following any recommendation made.

## 2.1.3.14 Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued a final independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The opinion is as follows:

This report provides an annual internal audit opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance reporting.

### The opinion

For the 12 months ended 31 March 2022, the head of internal audit opinion for South West London Clinical Commissioning Group is as follows:

Please see appendix A for the full range of annual opinions available to us in preparing this report and opinion.

It remains management's responsibility to develop and maintain a sound system of risk management, internal control and governance, and for the prevention and detection of material errors, loss or fraud. The work of internal audit should not be a substitute for management responsibility around the design and effective operation of these systems.

### Scope and limitations of our work

The formation of our opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee, our opinion is subject to inherent limitations, as detailed below:

- internal audit has not reviewed all risks and assurances relating to the organisation;
- the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. The assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- the opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management;
- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance;
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention; and

- our internal audit work for 2021/22 has continued to be undertaken through the operational disruptions caused by the Covid-19 pandemic. In undertaking our audit work, we recognise that there has been some impact on both the operations of the organisation and its risk profile, and our annual opinion should be read in this context.

## FACTORS AND FINDINGS WHICH HAVE INFORMED OUR OPINION

Based on the work undertaken in 2021/22 there is a generally sound system of internal control, designed to meet the CCG's objectives, and controls are generally being applied consistently.

We have provided either a substantial or reasonable level of assurance in most of the areas reviewed, with the exception of a partial assurance opinion assigned to the review of IT Asset Management and Effectiveness of Training – Remote Working review. This means the Governing Body can take partial assurance that the controls to manage risks were suitably designed and consistently applied, and that action was needed to strengthen the control framework to manage the identified risks.

### IT Asset Management and Effectiveness of Training – Remote Working – Partial Assurance.

### IT Asset Management

For IT Asset Management we identified a lack of oversight by the CCG of corporate IT devices that are being managed by the external providers NEL Commissioning Support Unit (CSU). We also determined the CCG does not request monthly reports from NEL CSU on devices that have been deployed, with no oversight of the user or location of assets and no method in place by which devices can be reconciled to the IT Asset Register on a regular basis to ensure that the same number of devices remain.

For new starters there was no requirement to confirm they have received the equipment upon collection from NEL CSU, and for leavers there was no requirement for the leaver to confirm when devices are returned. However, we acknowledge that the CCG as of April 2022 will no longer be outsourcing to NEL CSU and instead will be bringing management of IT Assets in-house for which an implementation plan has been introduced and an Asset Management Lead hired.

### Effectiveness of Training – Remote Working

We identified certain areas of weakness relating to the lack of oversight in place by the CCG of the complaints raised by staff members in relation to difficulties with completing training as well as the consequences of Line Managers not setting up and removing subcontracted employees from the Workforce system, both of which result in distortion of the MAST training compliance figures that are reported. Additionally, the failure to set up sub-contracted staff members can cause employees to lack essential training which could impact on overall achievement of CCG objectives. The High action relates to compliance ratings keeping up to standard with required CCG completion rates for each module.

We have provided a positive (substantial or reasonable) level of assurance in all other areas reviewed to date. Further detail is provided below.

| Assignment | Opinion issued |
|---|---|
| GP IT Services | Reasonable Assurance |
| Covid-19 Recovery | Reasonable Assurance |
| Financial Management and Budgeting | Substantial Assurance |
| Procurement and Contract Management | Reasonable Assurance |
| Risk Management | Reasonable Assurance |
| Conflicts of Interest | Reasonable Assurance |
| Local Collaborative Arrangements – Draft | Reasonable Assurance |

We issued advisory reports in the following area where there were no significant issues arising.

- CCG Closedown and ICB Establishment Due Diligence Checklist – Stage 1.
- CCG Closedown and ICB Establishment Due Diligence Checklist – Stage 2
- Scheme of Reservation & Delegation and SFI Review

### Topics judged relevant for consideration as part of the annual governance statement

Based on the work we have undertaken to date on the CCG's system on internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS). The CCG may wish to consider the issues raised in the partial assurance internal audit report highlighted above when determining whether anything should be highlighted within the Annual Governance Statement. The CCG should also consider whether any other issues have arisen as well as recognise the challenging environment within which the CCG is operating, including the results of any external reviews.

## THE BASIS OF OUR INTERNAL AUDIT OPINION

As well as those headlines previously discussed, the following areas have helped to inform our opinion. A summary of internal audit work undertaken, and the resulting conclusions, is provided at appendix B.

### Acceptance of internal audit management actions

Management have agreed actions to address all findings reported by the internal audit service during 2021/22.

### Implementation of internal audit management actions

Where actions have been agreed by management, these have been monitored by Internal Audit through the action tracking process in place. During the year progress has been reported to the audit committee, with the validation of the action status confirmed by internal audit on a rolling basis.

Our follow up of the actions agreed to address internal audit findings shows that the organisation had made good progress in implementing the agreed actions. The follow up status as at the 26 May 2022 audit meeting is as follows:

As reported throughout our progress reports during 2021/22, there were a total of 26 actions (3 high, 13 medium and 10 low) which were followed up in 2021/22.

21 actions (2 high, 10 medium and 9 low) were implemented during the year.

There are five management actions (1 High, 3 Medium & 1 low) from final reports which are not yet due for implementation and will be followed up accordingly when they become due. These actions relate to Conflicts of Interest and Procurement/Contract Management. No actions were overdue.

## Working with other assurance providers

We reviewed the Service Auditor Report from the internal auditors of NHS Shared Business Services who provide services to the CCG. Only one exception was identified from the 27 controls reviewed and this was not considered to represent a significant risk to the CCG.

We reviewed the Service Auditor Report from the internal auditors for NHS Digital in regard to GP Payments. Testing for two of the controls identified an exception but there was no significant impact for the CCG on its overall control environment.

We reviewed the Service Auditor Report from the internal auditors for the Business Services Authority – Prescriptions Payments Process. The opinion was qualified in a single area in that controls were not in place to provide appropriate periodic review of user access, and in a number of instances the controls related to timely removal of leavers' access to applications and the network did not operate effectively. No other exceptions were identified and we do not consider this sufficient to impact on our overall Head of Internal Audit Opinion.

We reviewed the Service Auditor Report in relation to Capita and four out of the 17 control objectives were qualified by the service auditor. In each instance, management has set out improvements to controls to help prevent a recurrence and to mitigate the risk going forwards. Whilst noting the exceptions, we do not consider these sufficiently significant to impact on our overall Head of Internal Audit Opinion.

We reviewed the Service Auditor Report from the internal auditors of ESR (Electronic Staff Record Programme) who provide a single payroll and Human Resources management system to the CCG. One qualification to the opinion was noted regarding the controls necessary to ensure that access to the development and production areas of the NHS hub was appropriately restricted for a limited period of the year. This issue was resolved once identified and it does not impact our overall assessment of the controls in operation at the CCG. No other qualifications were noted.

We reviewed the Service Auditor Report from the internal auditors for London Support Services (previously NEL Commissioning Support Unit). Three qualifications to the opinion were identified in areas pertaining to accounts receivable and financial ledger. Other exceptions were identified principally in the failure to have reviewed all financial procedures, with these now scheduled to occur in 2022/23. Where exceptions were identified either by the Service Provider or their auditors, suitable mitigating actions appear to have been identified and overall we do not consider that this should have a material impact on CCG's control environment.

## OUR PERFORMANCE

### Wider value adding delivery

| Area of work | How has this added value? |
|---|---|
| Healthcare Benchmarking | We have shared benchmarking information with the CCG including our annual report on the outcomes of Internal Audit opinions and actions across our NHS client base. |
| 2020/21 internal audit high priority management actions | We have undertaken a review of those areas where we agreed internal audit high priority management actions with our NHS provider clients during 2020/21. The outcomes paper shared with the CCG highlights those key issues and themes coming through from our internal audit reviews. |
| Covid-19 | During 2021/22 Covid-19 continued to have an impact on all areas of the organisation's risk profile, however, we worked closely with management to deliver an internal audit programme which remained flexible and 'agile' to ensure it met the organisations needs in the current circumstances. We also adjusted effectively to homeworking and continued to add value to the CCG. |
| Webinars | We have invited the CCG to various webinars including the following:<br>• Employment and HR update webinar, which focused on employment tax update, HR update and employment law update.<br>• Embracing the future of work webinar, which focused on the key considerations of hybrid working from a people management, employment tax, employment legal and global mobility perspective.<br>• Procurement and contract management network webinar, which provided an update on current developments including new procurement thresholds.<br>• Health Matters Webinars, which explored how organisations can collaborate to deliver change and key considerations for private healthcare businesses for workforce planning in a post Covid-19 economy. |
| Coronavirus Briefings | We have shared regular updates and articles regarding the impact of Covid-19 on organisations. The updates and articles focused on:<br>• Government financial support for employers.<br>• Covid-19 fraud risks with accompanying advice on mitigation.<br>• Guide for Audit and Risk Committees on financial reporting and management during Covid-19. |
| Specialists | Where relevant we continue to use Specialists to support our work. For example, GP IT review was supported by IT auditors to ensure the right people are looking at the areas and allows the CCG to learn from best practice seen and shared by our specialists. |

| | |
|---|---|
| Client Briefings | As part of our client service commitment, during 2021/22 we issued news briefings to each Audit Committee meeting. |
| Audit Committee | We contributed to the discussions at each audit committee on various items on the agenda in order to ensure that the CCG benefits from wider input in further developing its governance arrangements. |
| Progress Meetings | We continue to hold regular progress meetings with the Director of Finance & Company Secretary to discuss internal audit progress and follow up of internal audit actions. |
| ICS Workshop – Leadership and Governance in the ICS | We held our first ICS Workshop in July 2021 some of the key learnings were as follows:<br>• Developing clear lines of accountability and transparency around how and where decisions are made.<br>• Ensuring marginal and smaller bodies will have their voice heard within the ICS.<br>• Maximising the link between health and social care.<br>• Accountability for local capital plans.<br>• Managing conflicting roles and interests of ICS board members.<br>• Working closely with local communities in shaping services and improving population health and wellbeing.<br><br>For our second workshop we explored leadership and governance within ICS. RSM were commissioned by NHSE&I to look at Hospital Discharge Policy and Discharge to Assess Processes across ten Integrated Care Systems in England. We used this project as a case study for exploring the key learnings and best practice on what effective leadership and governance might look like across the ICS and how the NHS and LA can make partnership working more effective.<br><br>We held our third ICS workshop on 3 March 2022 focusing on how partners can work together in collaboration, principles to support local decision-making, identifying shared goals, appropriate membership and governance and alignment of activities with ICS priorities. |
| RSM's NED Network | We have launched RSM's NED Network to provide the non-executive director and interim community a place to network, share ideas, attend insightful and relevant events and read key content. |
| South West London ICB Migration Project Board | We attend the meetings of the SW London ICB Migration Project Board, supporting from an assurance perspective and the South West London Governance Oversight Group. |

## Conflicts of interest

RSM has not undertaken any work or activity during 2021/22 that would lead us to declare any conflict of interest.

## Conformance with internal auditing standards

- RSM affirms that our internal audit services are designed to conform to the Public Sector Internal Audit Standards (PSIAS).
- Under PSIAS, internal audit services are required to have an external quality assessment every five years. Our risk assurance service line commissioned an external independent review of our internal audit services in 2021 to provide assurance whether our approach meets the requirements of the International Professional Practices Framework (IPPF), and the Internal Audit Code of Practice, as published by the Global Institute of Internal Auditors (IIA) and the Chartered IIA, on which PSIAS is based.

The external review concluded that RSM 'generally conforms* to the requirements of the IIA Standards' and that 'RSM IA also generally conforms with the other Professional Standards and the IIA Code of Ethics. There were no instances of non-conformance with any of the Professional Standards'.

* The rating of 'generally conforms' is the highest rating that can be achieved, in line with the IIA's EQA assessment model.

## Quality assurance and continual improvement

To ensure that RSM remains compliant with the PSIAS framework we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews are used to inform the training needs of our audit teams.

Resulting from the programme in 2021/22, there are no areas which we believe warrant flagging to your attention as impacting on the quality of the service we provide to you.

In addition to this, any feedback we receive from our post assignment surveys, client feedback, appraisal processes and training needs assessments is also taken into consideration to continually improve the service we provide and inform any training requirements.

## APPENDIX A: ANNUAL OPINIONS

The following shows the full range of opinions available to us within our internal audit methodology to provide you with context regarding your annual internal audit opinion.

| Annual opinions | Factors influencing our opinion |
|---|---|
| | The factors which are considered when influencing our opinion are:<br>• inherent risk in the area being audited;<br>• limitations in the individual audit assignments;<br>• the adequacy and effectiveness of the risk management and / or governance control framework;<br>• the impact of weakness identified;<br>• the level of risk exposure; and<br>• the response to management actions raised and timeliness of actions taken. |

## APPENDIX B: SUMMARY OF INTERNAL AUDIT WORK COMPLETED FOR 2021/22

All of the assurance levels and outcomes provided above should be considered in the context of the scope, and the limitation of scope, set out in the individual assignment report.

| Assignment | Executive lead | Assurance level | Actions agreed H M L |
|---|---|---|---|
| GP IT Services (1.21/22) | Karen Broughton, Deputy Chief Executive/ Director of Transformation and People (Designate) | Reasonable Assurance | 0 2 1 |
| Covid-19 19 Recovery (2.21/22) | Ben Luscombe, Chief of Staff | Reasonable Assurance | 0 1 0 |
| Financial Management & Budgeting (3.21/22) | Neil McDowell, Director of Finance | Substantial Assurance | 0 0 0 |
| Procurement & Contract Management (4.21/22) | Neil McDowell, Director of Finance | Reasonable Assurance | 0 4 4 |
| Rick Management (5.21/22) | Ben Luscombe, Chief of Staff | Reasonable Assurance | 0 1 1 |
| CCG Close Down and ICB Establishment Due Diligence Checklist – Stage 1 – Advisory (6.21/22) | Ben Luscombe, Chief of Staff | Advisory | 0 0 0 |

| Assignment | Executive lead | Assurance level | Actions agreed H M L |
|---|---|---|---|
| IT Asset Management and Effectiveness of Training – Remote Working (7.21/22) | Karen Broughton, Deputy Chief Executive/Director of Transformation and People (Designate) | Partial Assurance | 2 2 2 |
| Working with the Council – Local Collaborative Arrangements (DRAFT) – **joint review with Croydon Health Services** | Ben Luscombe, Chief of Staff – joint with Mike Sexton (CHS) and Neil Goulbourne (CHS) | Reasonable Assurance | 1 5 0 |
| Conflicts of Interest (9.21/22) | Ben Luscombe, Chief of Staff | Reasonable Assurance | 1 3 2 |
| Scheme of Reservation & Delegation and SFI Review (10.21/22) | Ben Luscombe, Chief of Staff | Advisory | 0 0 0 |
| CCG Close Down and ICB Establishment Due Diligence Checklist – Stage 2 – Advisory (1.22/23) | Ben Luscombe, Chief of Staff | Reasonable Assurance | 0 0 0 |

## APPENDIX C: OPINION CLASSIFICATION

We use the following levels of opinion classification within our internal audit reports, reflecting the level of assurance the board can take:

Taking account of the issues identified, the board can take minimal assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective.

Urgent action is needed to strengthen the control framework to manage the identified risk(s).

Taking account of the issues identified, the board can take partial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective.

Action is needed to strengthen the control framework to manage the identified risk(s).

Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).

Taking account of the issues identified, the board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

## APPENDIX D: LOOK FORWARD 2022/23

This section provides an overview of work scheduled for completion from April 2022 to 30 June 2022 along with the status and timing of the reviews.

| Assignment area | Status | Original Planned Start Date | Audit Committee |
|---|---|---|---|
| Continuing Healthcare – Adults | Draft Report being Q&A – Report to be issued shortly in draft | January 2022 | September 2022 |
| Additional Roles Reimbursement Scheme<br>This scheme entitles Primary Care Networks to access funding to support recruitment across 5 reimbursable roles – clinical pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics. | APS issued to Management with a Provisional Start Date 6th June 2022. | Requested by Management | September 2022 |
| CCG Close Down and ICB Establishment Due Diligence Checklist – Stage 3 | Agreed Start Date 9th June 2022 | June 2022 | September 2022 |
| Safeguarding | APS issued to Management with a Provisional Start Date 16th June 2022 | July 2022 | September 2022 |

| Assignment area | Status | Original Planned Start Date | Audit Committee |
|---|---|---|---|
| **ICB PLAN – July 2022– March 2023** | | | |
| Medicines Management | APS issued to Management with a Provisional Start Date 1st July 2022 | July 2022 | September 2022 |
| Financial Feeders | Planning – Provisional Start Date 11th August 2022 | October 2022 | January 2023 |
| Primary Care Commissioning | Planning – Provisional Start Date 12th September 2022 | September 2022 | January 2023 |

## YOUR INTERNAL AUDIT TEAM

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## 2.1.4 Remuneration Report

### 2.1.4.1 Remuneration Committee

A summary of the duties and the membership of the remuneration committee is included within the governance section of the Annual Report.

### 2.1.4.2 Policy on the remuneration of senior managers

Remuneration for Governing Body members, including the Accountable Officer and Chief Finance Officer, is determined on the basis of reports to the Remuneration Committee, taking into account national guidance on pay rates, any independent evaluation of each post and national and market rates.

### 2.1.4.3 Remuneration of Very Senior Managers (audited)

The CCG has one director on a VSM grade who is paid more than £150,000 per annum. Their remuneration takes into account national guidance on pay rates, an independent evaluation of their post and national and market rates.

#### 2.1.4.3.1 Senior manager remuneration (including salary and pension entitlements) 2021/22 (audited)

The table on the next page discloses salaries and allowances paid by the CCG to Directors of significant influence.

| Name and title | Salary (bands of £5,000) £000 | Expense payments (taxable) (rounded to the nearest £100) £000 | Performance pay and bonuses (bands of £5,000) £000 | Long-term performance related bonuses (bands of £5,000) £000 | All pension related benefits (bands of £2,500) £000 | TOTAL (bands of £5,000) £000 |
|---|---|---|---|---|---|---|
| Agnelo Fernandes - Elected GP Lead Croydon Borough | 90 to 95 | N/A | N/A | N/A | N/A | 90 to 95 |
| Andrew Murray - SWLCCG Chair | 100 to 105 | N/A | N/A | N/A | N/A | 100 to 105 |
| Charlotte Gawne - Director of Communications and Engagement | 120 to 125 | N/A | N/A | N/A | 27.5 to 30 | 150 to 155 |
| David Smith - Governing Body Deputy Chair & Lay Member Finance | 10 to 15 | N/A | N/A | N/A | N/A | 10 to 15 |
| Dino Pardhanani - Elected GP Lead Sutton Borough | 95 to 100 | N/A | N/A | N/A | N/A | 95 to 100 |
| Gloria Rowland - Chief Nurse and Director of Quality | 115 to 120 | N/A | N/A | N/A | 35 to 37.5 | 150 to 155 |
| James Murray - Chief Finance Officer | 145 to 150 | N/A | N/A | N/A | N/A | 145 to 150 |
| Jonathan Bates - Executive Director Systems Planning Performance and Delivery | 120 to 125 | N/A | N/A | N/A | 27.50 to 30 | 150 to 155 |
| Karen Broughton - Executive Director Strategy and Transformation | 140 to 145 | N/A | N/A | N/A | 32.5 to 35 | 170 to 175 |
| Mark Creelman - Locality Executive Director Merton and Wandsworth | 110 to 115 | N/A | N/A | N/A | 35 to 37.5 | 145 to 150 |
| Matthew Kershaw - Placed Based Leader for Health Croydon | 115 to 120 | N/A | 10 to 15 | N/A | N/A | 125 to 130 |
| Naz Jivani - Elected GP Lead Kingston Borough | 80 to 85 | N/A | N/A | N/A | N/A | 80 to 85 |
| Nicola Jones - Elected Governing Body Member Wandsworth Borough | 145 to 150 | N/A | N/A | N/A | N/A | 145 to 150 |
| Patrick Gibson - Elected Governing Body Member | 80 to 85 | N/A | N/A | N/A | N/A | 80 to 85 |

| Name and title | Salary (bands of £5,000) £000 | Expense payments (taxable) (rounded to the nearest £100) £000 | Performance pay and bonuses (bands of £5,000) £000 | Long-term performance related bonuses (bands of £5,000) £000 | All pension related benefits (bands of £2,500) £000 | TOTAL (bands of £5,000) £000 |
|---|---|---|---|---|---|---|
| Paul Gallagher - Lay Member for Audit and Conflicts of Interest Guardian | 10 to 15 | N/A | N/A | N/A | N/A | 10 to 15 |
| Pippa Barber - Independent Nurse | 15 to 20 | N/A | N/A | N/A | N/A | 15 to 20 |
| Sarah Blow - Accountable Officer | 170 to 175 | N/A | N/A | N/A | 30 to 32.50 | 205 to 210 |
| Susan Gibbin - Lay Member Patient Public and Engagement | 10 to 15 | N/A | N/A | N/A | N/A | 10 to 15 |
| Tonia Michaelides - Locality Executive Director Richmond and Kingston | 125 to 130 | N/A | N/A | N/A | 27.50 to 30 | 150 to 155 |
| Vasa Gnanapragasam - Elected GP Lead Merton Borough | 45 to 50 | N/A | N/A | N/A | N/A | 45 to 50 |

**Notes**

1. Mark Creelman is the Locality Executive Director (Merton and Wandsworth) since September 2020 and is on the payroll of NEL CSU, his total annual salary is in the range of £140k-£145k. South West London CCG is responsible for 80% of his costs.
2. Lucie Waters has been excluded from the above table as she was on secondment to the post of Programme Director (Specialist Commissioning), SWLCCG, from 12 April 2021 to 31 March 2022. Her substantive role (Locality Executive Director – Sutton) was covered by Mark Creelman.
3. Matthew Kershaw is the Placed Based Leader for Health Croydon and is on the payroll of Croydon Health Services NHS Trust, his total annual salary is in the range of £225k-£230k. South West London CCG is responsible for 50% of his costs.

## 2.1.4.3.2 Senior manager remuneration (including salary and pension entitlements) 2020/21 (for comparison) (audited)

| Name and title | **Salary and/or fees** (bands of £5,000) £000 | **Taxable benefits** (rounded to the nearest £100) £ | **Annual performance related bonuses** (bands of £5,000) £000 | **Long-term performance related bonuses** (bands of £5,000) £000 | **All pension related benefits** (bands of £2,500) £000 | **TOTAL** (bands of £5,000) £000 |
|---|---|---|---|---|---|---|
| Agnelo Fernandes, Elected GP Lead Croydon Borough | 90 to 95 | n/a | n/a | n/a | n/a | 90 to 95 |
| Andrew Murray, SWLCCG Chair | 100 to 105 | n/a | n/a | n/a | n/a | 100 to 105 |
| Charlotte Gawne, Director of Communications and Engagement | 120 to 125 | n/a | n/a | n/a | 25 to 27.5 | 145 to 150 |
| David Smith, Governing Body Deputy Chair & Lay Member Finance | 10 to 15 | n/a | n/a | n/a | n/a | 10 to 15 |
| Dino Pardhanani, Elected GP Lead Sutton Borough (from October 2020) | 45 to 50 | n/a | n/a | n/a | n/a | 45 to 50 |
| Geoff Croucher, Elected GP Lead Sutton Borough (up to October 2020) | 30 to 35 | n/a | n/a | n/a | n/a | 30 to 35 |
| Gloria Rowland, Chief Nurse and Director of Quality (from January 2021) | 25 to 30 | n/a | n/a | n/a | 35 to 37.5 | 80 to 85 |
| James Blythe, Locality Executive Director Merton and Wandsworth (up to September 2020) | 60 to 65 | n/a | n/a | n/a | n/a | 60 to 65 |
| James Murray, Chief Finance Officer | 145 to 150 | n/a | n/a | n/a | n/a | 145 to 150 |
| Jonathan Bates, Executive Director Systems Planning Performance and Delivery | 120 to 125 | n/a | n/a | n/a | 25 to 27.5 | 145 to 150 |
| Karen Broughton, Executive Director Strategy and Transformation | 135 to 140 | n/a | n/a | n/a | 30 to 32.5 | 165 to 170 |
| Les Ross, Secondary Care Consultant | 10 to 15 | n/a | n/a | n/a | n/a | 10 to 15 |
| Lucie Waters, Locality Executive Director Sutton | 120 to 125 | n/a | n/a | n/a | 127.5 to 130 | 245 to 250 |
| Mark Creelman, Locality Executive Director Merton and Wandsworth (from September 2020) (1) | 60 to 65 | n/a | n/a | n/a | 37.5 to 40 | 100 to 105 |

| Name and title | **Salary and/or fees** (bands of £5,000) £000 | **Taxable benefits** (rounded to the nearest £100) £ | **Annual performance related bonuses** (bands of £5,000) £000 | **Long-term performance related bonuses** (bands of £5,000) £000 | **All pension related benefits** (bands of £2,500) £000 | **TOTAL** (bands of £5,000) £000 |
|---|---|---|---|---|---|---|
| Matthew Kershaw, Placed Based Leader for Health Croydon (2) | 110 to 115 | n/a | 10 to 15 | n/a | n/a | 120 to 125 |
| Naz Jivani, Elected GP Lead Kingston Borough | 115 to 120 | n/a | n/a | n/a | n/a | 115 to 120 |
| Nicola Jones, Elected Governing Body Member Wandsworth Borough | 135 to 140 | n/a | n/a | n/a | n/a | 135 to 140 |
| Patrick Gibson, Elected Governing Body Member | 80 to 85 | n/a | n/a | n/a | n/a | 80 to 85 |
| Paul Gallagher, Lay Member for Audit and Conflicts of Interest Guardian | 10 to 15 | n/a | n/a | n/a | n/a | 10 to 15 |
| Pippa Barber, Independent Nurse | 15 to 20 | n/a | n/a | n/a | n/a | 15 to 20 |
| Sarah Blow, Accountable Officer | 145 to 150 | n/a | n/a | n/a | 32.5 to 35 | 180 to 185 |
| Susan Gibbin, Lay Member Patient Public and Engagement | 10 to 15 | n/a | n/a | n/a | n/a | 10 to 15 |
| Tonia Michaelides, Locality Executive Director Richmond and Kingston | 120 to 125 | n/a | n/a | n/a | 22.5 to 25 | 145 to 150 |
| Vasa Gnanapragasam, Elected GP Lead Merton Borough | 60 to 65 | n/a | n/a | n/a | n/a | 60 to 65 |

## Notes

1. Mark Creelman is the Locality Executive Director Merton and Wandsworth since September 2020 and is on the payroll of NEL CSU, his total annual salary is in the range of £145k-£150k. South West London CCG is responsible for 82% of his costs.
2. Matthew Kershaw is the Placed Based Leader for Health Croydon and is on the payroll of Croydon Health Services NHS Trust, his total annual salary is in the range of £225k-£230k. South West London CCG is responsible for 50% of his costs.

## Pension benefits as at 31 March 2022 (audited)

Where the CCG contributed to pension schemes for senior managers, the benefits are shown in the table below:

| Name and title | Real increase in pension at pension age (bands of £2,500) £000 | Real increase in pension lump sum at pension age (bands of £2,500) £000 | Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000 | Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000 | Cash Equivalent Transfer Value at 1 April 2021 £000 | Cash Equivalent Transfer Value at 31 March 2022 £000 | Real Increase in Cash Equivalent Transfer Value £000 | Employers Contribution to partnership pension £000 |
|---|---|---|---|---|---|---|---|---|
| Charlotte Gawne - Director of Communications and Engagement | 0 to 2.5 | 0 | 40 to 45 | 70 to 75 | 652 | 697 | 42 | 0 |
| Gloria Rowland - Chief Nurse and Director of Quality | 0 to 2.5 | 0 to 2.5 | 30 to 35 | ` | 443 | 487 | 25 | 0 |
| Jonathan Bates - Executive Director Systems Planning Performance and Delivery | 0 to 2.5 | 0 | 45 to 50 | 90 to 95 | 787 | 836 | 45 | 0 |
| James Murray - Chief Finance Officer | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Karen Broughton - Executive Director Strategy and Transformation | 2.5 to 5 | 0 | 45 to 50 | 85 to 90 | 812 | 867 | 31 | 0 |
| Mark Creelman - Locality Executive Director Merton and Wandsworth | 2.5.to 5 | 0 | 20 to 25 | 0 | 301 | 255 | 44 | 0 |
| Sarah Blow - Accountable Officer | 2.5 to 5 | 0 | 45 to 50 | 85 to 90 | 864 | 926 | 32 | 0 |
| Tonia Michaelides - Locality Executive Director Richmond and Kingston | 0 to 2.5 | 0 | 40 to 45 | 75 to 80 | 721 | 770 | 45 | 0 |

1. South West London CCG does not make any employer's pension contribution in respect of James Murray.
2. Lucie Waters has been excluded from the above table as she was on secondment to the post of Programme Director (Specialist Commissioning), SWLCCG, from 12 April 2021 to 31 March 2022. Her substantive role (Locality Executive Director – Sutton) was covered by Mark Creelman.
3. Mark Creelman is the Locality Executive Director (Merton and Wandsworth) since September 2020 and is on the payroll of NEL CSU. South West London CCG is responsible for 80% of his costs, but we are showing the full benefits. The lump sum figure for Mark Creelman is £0 as he is in the 2008 pension scheme.

## Pension benefits as at 31 March 2021 (for comparison) (audited)

| Name and title | Real increase in pension at pension age (bands of £2,500) £000 | Real increase in pension lump sum at pension age (bands of £2,500) £000 | Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £000 | Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £000 | Cash equivalent transfer value at 31 March 2021 £000 | Cash equivalent transfer value at 31 March 2020 £000 | Real increase in cash equivalent transfer value £000 | Employer's contribution to stakeholders pension £000 |
|---|---|---|---|---|---|---|---|---|
| Charlotte Gawne, Director of Communications and Engagement | 0 to 2.5 | 0 | 35 to 40 | 70 to 75 | 652 | 602 | 22 | 0 |
| Gloria Rowland, Chief Nurse and Director of Quality | 2.5 to 5 | 0 to 2.5 | 25 to 30 | 50 to 55 | 443 | 390 | 43 | 0 |
| Jonathan Bates, Executive Director Systems Planning Performance and Delivery | 0 to 2.5 | 0 | 45 to 50 | 90 to 95 | 787 | 732 | 24 | 0 |
| James Blythe, Locality Executive Director Merton and Wandsworth (1) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| James Murray, Chief Finance Officer (2) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Karen Broughton, Executive Director Strategy and Transformation | 2.5 to 5 | 0 | 45 to 50 | 85 to 90 | 812 | 751 | 28 | 0 |
| Lucie Waters, Locality Executive Director Sutton | 5 to 7.5 | 12.5 to 15 | 40 to 45 | 85 to 90 | 765 | 623 | 114 | 0 |
| Mark Creelman, Locality Executive Director Merton and Wandsworth (3) | 2.5 to 5 | 0 to 2.5 | 15 to 20 | 0 to 5 | 255 | 207 | 23 | 0 |
| Sarah Blow, Accountable Officer | 2.5 to 5 | 0 | 45 to 50 | 85 to 90 | 864 | 797 | 32 | 0 |
| Tonia Michaelides, Locality Executive Director Richmond and Kingston | 0 to 2.5 | 0 | 40 to 45 | 75 to 80 | 721 | 670 | 23 | 0 |

### Notes

4. South West London CCG does not make any employer's pension contribution in respect of James Blythe.
5. South West London CCG does not make any employer's pension contribution in respect of James Murray.

1. Mark Creelman is the Locality Executive Director Merton and Wandsworth since September 2020 and is on the payroll of NEL CSU. South West London CCG is responsible for 82% of his costs, but we are showing the full benefits. The lump sum figure for Mark Creelman is £0 as he is in the 2008 pension scheme.

### 2.1.4.4 Cash equivalent transfer values (audited)

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The benefits and related CETVs do not allow for a potential adjustment arising from the McCloud judgement (a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design).

### 2.1.4.5 Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

### 2.1.4.6 Compensation on early retirement or for loss of office

One staff member was made redundant in 2021/22, at a cost of £34k.

### 2.1.4.7 Payments to past directors (audited)

There were no payments to past directors

### 2.1.4.8 Fair Pay Disclosure (audited)

**Pay ratio information**

As at 31 March 2022, remuneration ranged from £6k to £175k (comparing the remuneration of the highest paid director, the top of the range increased by 17% against the 2020/21 figure of £149k). This is based on annualised, full-time equivalent remuneration of all staff. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Remuneration of SWLCCG's staff is shown in the table below:

| | 25th percentile | Median | 75th percentile |
|---|---|---|---|
| 'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) | £39,099 | £52,814 | £68,829 |
| Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) | £39,099 | £52,814 | £68,829 |

It should be noted that, in both years, no employee received any remuneration in addition to their salary

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in SWLCCG in the financial year 2021/22 was £170k to £175k (an increase of 17% against the 2020/21 band, which was £145k to £150k). The rise is due to the CCG's Accountable Officer being appointed as the Chief Executive of the new Integrated Care Board, and her salary being increased from 01/11/21. The relationship to the remuneration of the organisation's workforce is disclosed in the table below, which shows the ratios of staff remuneration against the mid-point of the banded remuneration of the highest paid director.

| Year | 25th percentile pay ratio | Median pay ratio | 75th percentile pay ratio |
|---|---|---|---|
| 2021/22 | 4.41 | 3.27 | 2.51 |
| 2020/21 | 3.83 | 2.83 | 2.21 |

The following table shows the percentage change from the previous financial year in respect of the highest paid director:

| | 2021/22 £ | 2020/21 restated £ | % change £ |
|---|---|---|---|
| Midpoint of band of highest paid director | 172,500 | 147,500 | 17% |

The increase is due to the CCG's Accountable Officer being appointed as the Chief Executive of the new Integrated Care Board, and her salary being increased from 01/11/21.

In 2021/22, no employees received remuneration in excess of the highest-paid director (this was also the case in 2020/21)

The following table shows the average percentage change from the previous financial year in respect of employees of the entity, taken as a whole:

| | 2021/22 £000s | 2020/21 restated £000s | % change |
|---|---|---|---|
| Total salary and allowances for all employees on an annualised basis, excluding the highest paid director | 37,399 | 33,551 | 11% |
| Average FTE number of employees (also excluding the highest paid director) | 473 | 452 | 5% |
| Average salary per FTE | 79 | 74 | 6% |

## 2.1.5 Staff Report

### 2.1.5.1 Number of senior managers

| Pay Band | Employee Headcount | FTE | Basic Annual Pay |
|---|---|---|---|
| Band 9 | 19 | 18.7 | £1,963,643 |
| VSM | 10 | 9.8 | £1,297,800 |
| **Grand Total** | **29** | **28.5** | **£3,261,442** |

### 2.1.5.2 Staff numbers and costs (audited)

| Category | Permanently employed staff | | Other staff (agency) | | Total | |
|---|---|---|---|---|---|---|
| | Cost, £000 | Average WTE | Cost, £000 | Average WTE | Cost, £000 | Average WTE |
| Add Prof Scientific and Technic | 3,680 | 43.72 | 872 | 7.41 | 4,553 | 51.14 |
| Administrative and Clerical | 30,528 | 380.56 | 7,235 | 64.52 | 37,763 | 445.09 |
| Allied Health Professionals | 60 | 0.85 | 14 | 0.14 | 75 | 1.00 |
| Medical and Dental | 1,105 | 5.96 | 262 | 1.01 | 1,367 | 6.97 |
| Nursing and Midwifery Registered | 2,951 | 42.71 | 699 | 7.24 | 3,651 | 49.95 |
| **Total** | **38,325** | **473.81** | **9,083** | **80.33** | **47,408** | **554.14** |

## 2.1.5.3 Staff composition

### Disability

| Disability Flag | Headcount | % | FTE at 31/3/22 |
|---|---|---|---|
| No | 425 | 84.2 | 404.92 |
| Not Declared | 44 | 8.7 | 41.16 |
| Prefer Not To Answer | 15 | 3.0 | 13.92 |
| Yes | 21 | 4.2 | 19.84 |
| **Grand Total** | **505** | **100.0** | **479.84** |

### Ethnicity

| Ethnic Group | Headcount | % | FTE at 31/3/22 |
|---|---|---|---|
| A White - British | 221 | 43.76% | 207.83 |
| B White - Irish | 10 | 1.98% | 9.80 |
| C White - Any other White background | 39 | 7.72% | 37.49 |
| C3 White Unspecified | 1 | 0.20% | 1.00 |
| CA White English | 3 | 0.59% | 3.00 |
| CB White Scottish | 2 | 0.40% | 2.00 |
| CP White Polish | 1 | 0.20% | 1.00 |
| CY White Other European | 1 | 0.20% | 1.00 |
| D Mixed - White & Black Caribbean | 2 | 0.40% | 1.91 |
| E Mixed - White & Black African | 4 | 0.79% | 3.80 |
| F Mixed - White & Asian | 3 | 0.59% | 3.00 |
| G Mixed - Any other mixed background | 8 | 1.58% | 7.40 |
| GF Mixed - Other/Unspecified | 1 | 0.20% | 0.60 |
| H Asian or Asian British - Indian | 51 | 10.10% | 47.19 |
| J Asian or Asian British - Pakistani | 11 | 2.18% | 9.91 |
| K Asian or Asian British - Bangladeshi | 5 | 0.99% | 4.60 |
| L Asian or Asian British - Any other Asian background | 12 | 2.38% | 11.30 |
| LB Asian Punjabi | 1 | 0.20% | 1.00 |
| LF Asian Tamil | 1 | 0.20% | 1.00 |
| LH Asian British | 2 | 0.40% | 2.00 |
| LK Asian Unspecified | 1 | 0.20% | 1.00 |
| M Black or Black British - Caribbean | 25 | 4.95% | 24.90 |
| N Black or Black British - African | 45 | 8.91% | 44.80 |
| P Black or Black British - Any other Black background | 1 | 0.20% | 1.00 |
| PB Black Mixed | 1 | 0.20% | 1.00 |
| PC Black Nigerian | 2 | 0.40% | 2.00 |

| Ethnic Group | Headcount | % | FTE at 31/3/22 |
|---|---|---|---|
| PD Black British | 2 | 0.40% | 2.00 |
| PE Black Unspecified | 1 | 0.20% | 0.90 |
| R Chinese | 10 | 1.98% | 9.71 |
| S Any other Ethnic group | 8 | 1.58% | 8.00 |
| SA Vietnamese | 1 | 0.20% | 1.00 |
| Z Not stated | 29 | 5.74% | 26.72 |
| **Grand Total** | **505** | **100.00%** | **479.84** |

## Sexual Orientation

| Sexual Orientation | Headcount | % | FTE at 31/3/22 |
|---|---|---|---|
| Bisexual | 3 | 0.59 | 3.00 |
| Gay or Lesbian | 10 | 1.98 | 10.00 |
| Heterosexual or Straight | 411 | 81.39 | 391.59 |
| Not Disclosed | 79 | 15.64 | 73.25 |
| Other sexual orientation not listed | 1 | 0.20 | 1.00 |
| Undecided | 1 | 0.20 | 1.00 |
| **Grand Total** | **505** | **100.00** | **479.84** |

## Religion

| Religious Belief | Headcount | % | FTE at 31/3/22 |
|---|---|---|---|
| Atheism | 70 | 13.86 | 68.93 |
| Buddhism | 2 | 0.40 | 2.00 |
| Christianity | 216 | 42.77 | 207.89 |
| Hinduism | 24 | 4.75 | 21.53 |
| Islam | 24 | 4.75 | 22.53 |
| Not Disclosed | 125 | 24.75 | 115.74 |
| Other | 28 | 5.54 | 26.40 |
| Sikhism | 16 | 3.17 | 14.83 |
| **Grand Total** | **505** | **100.00** | **479.84** |

## Age Band

| Age Band | Headcount | % | FTE at 31/3/22 |
|---|---|---|---|
| 21-25 | 6 | 1.19 | 5.60 |
| 26-30 | 35 | 6.93 | 35.00 |
| 31-35 | 56 | 11.09 | 53.51 |
| 36-40 | 60 | 11.88 | 55.95 |
| 41-45 | 86 | 17.03 | 81.19 |
| 46-50 | 70 | 13.86 | 67.53 |
| 51-55 | 86 | 17.03 | 82.43 |
| 56-60 | 77 | 15.25 | 73.60 |
| 61-65 | 27 | 5.35 | 23.04 |
| 66-70 | 2 | 0.40 | 2.00 |
| **Grand Total** | **505** | **100.00** | **479.84** |

## Gender

| Gender | Headcount | % | FTE at 31/3/22 |
|---|---|---|---|
| Female | 380 | 75.2 | 355.04 |
| Male | 125 | 24.8 | 124.80 |
| **Grand Total** | **505** | **100.0** | **479.84** |

## Marital Status

| Marital Status | Headcount | % | FTE at 31/3/22 |
|---|---|---|---|
| Civil Partnership | 6 | 1.19 | 5.80 |
| Divorced | 25 | 4.95 | 23.40 |
| Legally Separated | 4 | 0.79 | 3.80 |
| Married | 256 | 50.69 | 240.60 |
| Single | 163 | 32.28 | 157.37 |
| Unknown | 45 | 8.91 | 43.07 |
| Unspecified | 3 | 0.59 | 2.80 |
| Widowed | 3 | 0.59 | 3.00 |
| **Grand Total** | **505** | **100.00** | **479.84** |

### 2.1.5.4 Sickness absence data

The CCG sickness absence percentage rate is presented regularly to the CCG in the form of workforce reports. Individual sickness absence cases are managed by the line manager with advice and support from HR.

An occupational health (OH) service is available to provide professional clinical advice to line managers within the CCG.

The CCG also has access to an employee assistance programme which offers confidential access to emotional and practical support, including legal and financial advice.

| | |
|---|---|
| Number of days lost in year | 3,531.06 |
| Total staff years | 461.77 |
| Average working days lost in year | 7.64 |

Note that total staff years represents the number of potential worked days across whole of permanent workforce.

### 2.1.5.5 Staff turnover percentages

The staff turnover figure, based on a 12-month average, at 31 March was 12.63%. (it was 12.32% in 2020/21)

### 2.1.5.6 Staff engagement percentages

**NHS Staff Survey**

The CCG commissioned Picker Institute Europe to run an online 2020 National Staff Survey during October and November 2021. The CCG had a score of 6.9 for staff engagement, which was unchanged from 2020. For comparison, the average CCG score was 7.2, the highest was 8.0 and the lowest was 6.5.

A total of 391 of 492 eligible staff took part in the survey, giving a response rate of 79%. This in line with the average response rate for similar organisations. We are grateful to everyone who completed the survey.

The results of the survey were published in March 2022. We are pleased to see there have been significant improvements in several areas. However, there are several areas where we need to act.

Where we're doing well:

| Most improved scores | Trust 2021 | Trust 2020 |
|---|---|---|
| q11e. Not felt pressure from manager to come to work when not feeling well enough | 89% | 80% |
| q9e. Immediate manager values my work | 82% | 73% |
| q9c. Immediate manager asks for my opinion before making decisions that affect my work | 72% | 63% |
| q17b. Would feel confident that organisation would address concerns about unsafe clinical practice | 63% | 54% |
| q17a. Would feel secure raising concerns about unsafe clinical practice | 72% | 64% |

Where we're doing less well:

| Most declined scores | Trust 2021 | Trust 2020 |
|---|---|---|
| q3i. Enough staff at organisation to do my job properly | 39% | 46% |
| q11d. In last 3 months, have not come to work when not feeling well enough to perform duties | 54% | 60% |
| q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation | 56% | 61% |
| q2a. Often/always look forward to going to work | 53% | 56% |
| q22c. I am not planning on leaving this organisation | 52% | 54% |

During April 2022, we held interactive sessions with our teams to review the findings and develop directorate and organisational action plan to address the issues identified.

You can read more about the NHS staff survey on the NHS staff survey website.

### 2.1.5.7 Staff policies

The CCG promotes a working environment in which all parties and procedures relating to recruitment, selection, training, promotion and employment are free from unfair discrimination, ensuring that no employee or prospective employee is discriminated against, whether directly or indirectly on the grounds of age; disability; gender reassignment; pregnancy and maternity; race including ethnic or national origins, nationality; religion belief; sex (gender); sexual orientation; marriage and civil partnership; trade union membership; responsibility for dependents or any other condition or requirement which cannot be shown to be justifiable.

Staff who have a disability are protected under the Equality Act 2010, as disability is a "protected characteristic". The CCG makes sure that the requirements and reasonable adjustments necessary for employees with a disability are considered both during each stage of the recruitment process and during employment.

Our Sickness Absence Policy confirms that where an employee becomes disabled during their employment, we will make any necessary reasonable adjustments required in accordance with the Equality Act to enable the employee to return and remain at work. The types of adjustments may include adjustments to work base, working hours, redeploying the employee to another suitable position and providing any necessary equipment to assist the employee to perform their role.

### 2.1.5.8 Trade Union Facility Time Reporting Requirements

| Table 1 | |
|---|---|
| Relevant union officials | |
| Number of employees (FTE) who were relevant union officials during the relevant period | 3 |
| **Table 2** | |
| Percentage of time spent on facility time | |
| Percentage of time | Number of employees |
| 0% | 0 |
| 1-50% | 3 |
| 51%-99% | 0 |
| 100% | 0 |
| **Table 3** | |
| Percentage of pay bill spent on facility time | |
| Total cost of facility time | £2,551 |
| Total pay bill | £38,324,884 |
| Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100 | 0.01% |
| **Table 4** | |
| Paid trade union activities | |
| Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100 | 2.39% |

### 2.1.5.9 Other employee matters

#### People and Organisational Development Strategy

Our People and Organisational Development Strategy sets out our approach to shaping our organisational culture and supporting our staff. The strategy was developed with insight gathered from staff and our aim is to make NHS South West London CCG a great place to work. To achieve this we work in partnership with our trade union colleagues and focus on:

- Caring for our staff
- Supporting our staff to develop
- Recognising the work and commitment of our staff
- Having the very best employment practices in place
- Working to make sure our staff is representative and inclusive of the populations we serve
- Involving our staff to help us transform and improve the way we work
- Developing compassionate and inclusive leaders

## Caring for our staff

In 2021/22 our staff health and wellbeing network continued to develop organised activities to support staff to maintain their mental and physical health and wellbeing. In addition, we continued to promote free health and wellbeing resources for NHS staff through our staff newsletters and intranet.

Staff can access an Employee Assistance Programme (EAP) which provides personal support, including counselling, and life management and is available 24 hours a day, any day of the year.

We have also supported several staff to complete either the Mental Health First Aider or Mental Health Champion training programmes. These individuals are available to provide support to staff, signposting them to professional help and to challenge mental health stigma in the workplace.

## Supporting staff to develop

Based on the feedback and input of staff and managers across the CCG we have co-designed a new appraisal approach which focuses on the lived experience of people in relation to their job role, workload, colleague relations and managerial relations, as well as improving access to development. The new approach will come into effect from April 2022. We have also developed a range of resources to support managers and staff ahead of, during and after their appraisal discussions.

## Recruitment

Our staff are our most important asset and we want to ensure that we attract and keep the best people. In 2021, we introduced recruitment training to make sure that all recruiters conduct a fair and transparent process. All vacancies and secondment opportunities are advertised through the NHS Jobs system to ensure fairness.

We also trained 15 staff from diverse backgrounds to ensure that we have diverse recruitment panels for staff at band 8b and above.

## Compassionate leaders

We have commissioned a learning partner to support our compassionate and inclusive leadership programme, the aim of which is to explore and build an inclusive and compassionate culture through our most senior leaders. The programme has been developed to inform, challenge, and extend thinking and apply that thinking to the practical ways in which leaders act as cultural influencers in the organisation.

## Inclusive culture

Over the year we have provided many opportunities for staff to talk and learn about diversity, equality and inclusion. We have:

- Worked with our leaders through the leadership forum.
- Trained over 40 members of staff to sit on recruitment panels and be an inclusive recruitment champion.
- Run sessions including writing and talking about ethnicity, including how to be a good Ally, micro-aggression and macro-aggressions, and anti-racism.
- Held a number of drop-in sessions.

We celebrate key events such as LGBT+ History Month; Disability History Month and International Women's Day as well as acknowledging important days for all the main faiths in our internal communications.

All our people policies have gone through the Equality Impact process to ensure there are fair outcomes for our workforce.

### Staff communications and engagement

We aim to support a culture where staff views influence the content of our internal communications and engagement. We do this through different routes including a daily staff update which carries the latest news on staff related matters; a staff intranet, which provides more detail and enables staff to comment and add their own blogs; monthly Team Talk meetings which are led by senior managers and carry important core information for them to discuss with their teams, capturing any questions and feedback; and we hold all staff briefings with the entire organisation roughly every eight weeks. The all staff briefings are led by the CCG Accountable Officer and members of the executive team and encourage staff to ask questions about the matters that are important to them.

### 2.1.5.10 Expenditure on consultancy

The reported expenditure on consultancy was £729k in 2021/22 (£1,261k in 2020/21).

### 2.1.5.11 Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2022 for more than £245* per day and that last longer than six months:

| | Number |
|---|---|
| Number of existing engagements as of 31 March 2022 | 44 |
| Of which, the number that have existed: | |
| for less than one year at the time of reporting | 27 |
| for between one and two years at the time of reporting | 17 |
| for between 2 and 3 years at the time of reporting | 0 |
| for between 3 and 4 years at the time of reporting | 0 |
| for 4 or more years at the time of reporting | |

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

## Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245[1] per day:

| | Number |
|---|---|
| No. of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022 | 193 |
| Of which: | |
| No. not subject to off-payroll legislation[2] | 0 |
| No. subject to off-payroll legislation and determined as in-scope of IR35(2) | 98 |
| No. subject to off-payroll legislation and determined as out of scope of IR35(2) | 95 |
| the number of engagements reassessed for compliance or assurance purposes during the year | 0 |
| Of which: no. of engagements that saw a change to IR35 status following review | 0 |

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

## Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2021 and 31 March 2022:

| | |
|---|---|
| Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1) | 0 |
| Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.[2] | 22 |

## 2.1.5.12 Exit packages, including special (non-contractual) payments (audited)

Table 1: Exit Packages

| Exit package cost band (inc. any special payment element | Number of compulsory redundancies | Cost of compulsory redundancies | Number of other departures agreed | Cost of other departures agreed | Total number of exit packages | Total cost of exit packages | Number of departures where special payments have been made | Cost of special payment element included in exit packages |
|---|---|---|---|---|---|---|---|---|
| | WHOLE NUMBERS ONLY | £s | WHOLE NUMBERS ONLY | £s | WHOLE NUMBERS ONLY | £s | WHOLE NUMBERS ONLY | £s |
| Less than £10,000 | | | | | | | | |
| £10,000 - £25,000 | | | | | | | | |
| £25,001 - £50,000 | 1 | 33,793 | | | 1 | 33,793 | | |
| £50,001 - £100,000 | | | | | | | | |
| £100,001 - £150,000 | | | | | | | | |
| £150,001 - £200,000 | | | | | | | | |
| >£200,000 | | | | | | | | |
| **TOTALS** | **1** | **33,793** | | **Agrees to A below** | **1** | **33,793** | | |

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS National Terms & Conditions (Agenda for Change). Exit costs in this note are accounted for in full in the year of departure.

## **2.2** Parliamentary Accountability and Audit Report

NHS South West London CCG is not required to produce a Parliamentary Accountability and Audit Report. There are no disclosures to report and an audit certificate and report is also included in this Annual Report.


VISITOR
VISITOR

# 3 Annual Accounts

# Independent auditor's report to the members of the Governing Body of NHS South West London Clinical Commissioning Group

## Report on the Audit of the Financial Statements

### Opinion on financial statements

We have audited the financial statements of NHS South West London Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard,

and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

## Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 21 to the financial statements, which indicates that, under the Health and Care Act 2022 the commissioning functions, assets and liabilities of NHS South West London CCG are due to transfer to the South West London Integrated Care Board (ICB) on 1 July 2022.

## Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the CCG to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

## Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

## Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

## Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

## Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

## Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

## Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

## Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

## Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2021 to 2022).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - Journals, management estimates and transactions outside the course of business; and
  - Fraudulent expenditure recognitions, and specifically the completeness of expenditure.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on those meeting a number of specific criteria to identify high risk journals;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the Prescribing Accrual;
  - substantive procedures to confirm the completeness of operating expenditure with a particular emphasis on year end accruals and transactions recorded close to and after 31 March 2022;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimate relating to the Prescribing Accrual for Months 11 and 12 included within the Accounts.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
  - the provisions of the applicable legislation

  - NHS England's rules and related guidance
  - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework.

## Report on other legal and regulatory requirements – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

### Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

Our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the CCG's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2022.

### Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

### Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

# Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for the NHS South West London CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

## Use of our report

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

***Joanne Brown***

Joanne Brown, Key Audit Partner
for and on behalf of Grant Thornton UK LLP,
Local Auditor
Glasgow
Date: 21 June 2022

## NHS South West London CCG - Annual Accounts 2021/22

## Contents

## Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

| | Note | 2021/22 £'000 | 2020/21 £'000 |
|---|---|---|---|
| Income from sale of goods and services | 2 | (19,776) | (20,728) |
| Other operating income | 2 | (13,095) | (13,462) |
| **Total operating income** | | **(32,871)** | **(34,190)** |
| Staff costs | 4 | 47,408 | 40,984 |
| Purchase of goods and services | 5 | 3,074,317 | 2,664,755 |
| Depreciation and impairment charges | 5 | 363 | 1,010 |
| Provision expense | 5 | - | (1,715) |
| Other Operating Expenditure | 5 | 1,347 | 1,015 |
| **Total operating expenditure** | | **3,123,435** | **2,706,050** |
| **Net Operating Expenditure** | | **3,090,564** | **2,671,860** |
| Net (Gain)/Loss on Transfer by Absorption | | - | 142,923 |
| **Total Net Expenditure for the Financial Year** | | **3,090,564** | **2,814,783** |
| **Other Comprehensive Expenditure** | | | |
| **Comprehensive Expenditure for the year** | | **3,090,564** | **2,814,783** |

## Statement of Financial Position as at 31 March 2022

| | Note | 31st March 2022 £'000 | 1st April 2021 £'000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 9 | 0 | 347 |
| Intangible assets | 10 | 0 | 16 |
| **Total non-current assets** | | 0 | 363 |
| **Current assets:** | | | |
| Trade and other receivables | 11 | 20,770 | 19,765 |
| Cash and cash equivalents | 12 | 1,951 | 473 |
| **Total current assets** | | **22,722** | 20,238 |
| **Total assets** | | **22,722** | 20,600 |
| **Current liabilities** | | | |
| Trade and other payables | 13 | (247,790) | (219,954) |
| Provisions | 14 | 0 | 0 |
| **Total current liabilities** | | **(247,790)** | (219,954) |
| **Non-Current Assets plus/less Net Current Assets/Liabilities** | | **(225,068)** | (199,354) |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (225,068) | (199,354) |
| **Total taxpayers' equity:** | | **(225,068)** | (199,354) |

The notes on pages 6 to 30 form part of this statement

The financial statements on pages 1 to 30 were approved by the Audit Committee as delegated by the Governing Body on the 20 June 2022 and signed on its behalf by:

Sarah Blow
Accountable Officer
20/06/2022

## Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

| | General fund £'000 | Total reserves £'000 |
|---|---|---|
| **Changes in taxpayers' equity for 2021/22** | | |
| **Balance at 01 April 2021** | **(199,354)** | **(199,354)** |
| **Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021/22** | | |
| Net operating expenditure for the financial year | (3,090,564) | (3,090,564) |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year** | **(3,090,564)** | **(3,090,564)** |
| Net funding | 3,064,850 | 3,064,850 |
| **Balance at 31 March 2022** | **(225,068)** | **(225,068)** |

| | General fund £'000 | Total reserves £'000 |
|---|---|---|
| **Changes in taxpayers' equity for 2020/21** | | |
| **Balance at 01 April 2020** | 0 | 0 |
| **Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020/21** | | |
| Net operating costs for the financial year | (2,671,860) | (2,671,860) |
| Transfers by absorption to (from) other bodies | (142,923) | (142,923) |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year** | (2,814,783) | (2,814,783) |
| Net funding | 2,615,430 | 2,615,430 |
| **Balance at 31 March 2021** | (199,354) | (199,354) |

The notes on pages 154 to 185 form part of this statement

## Statement of Cash Flows for the year ended 31 March 2022

| | Note | 2021/22 £'000 | 2020/21 £'000 |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Net operating expenditure for the financial year | | (3,090,564) | (2,671,860) |
| Depreciation and amortisation | 5 | 363 | 1,010 |
| (Increase)/decrease in trade & other receivables | 11 | (1,006) | 12,023 |
| Increase/(decrease) in trade & other payables | 13 | 27,836 | 44,957 |
| Provisions utilised | 14 | 0 | (59) |
| Increase/(decrease) in provisions | 14 | 0 | (1,715) |
| **Net Cash Inflow (Outflow) from Operating Activities** | | **(3,063,371)** | (2,615,643) |
| **Net Cash Inflow (Outflow) before Financing** | | **(3,063,371)** | (2,615,643) |
| **Cash Flows from Financing Activities** | | | |
| Grant in Aid Funding Received | | 3,064,850 | 2,615,430 |
| **Net Cash Inflow (Outflow) from Financing Activities** | | **3,064,850** | 2,615,430 |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | 12 | **1,479** | (214) |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** | | **473** | 0 |
| Transfers from other public bodies under absorption | | 0 | 687 |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** | | **1,951** | 473 |

The notes on pages 154 to 185 form part of this statement

# Notes to the financial statements

## 1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

### 1.1 Going Concern

These accounts have been prepared on a going concern basis.

The Health and Social Care Bill was introduced into the House of Commons during 2021/22, please refer to Note 21 (Events after Reporting Date) as to how this affects South West London CCG.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

### 1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

### 1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

### 1.4 Joint arrangements

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

The CCG has a joint operation which are activities undertaken in conjunction with one or more parties which are performed through a separate entity. The clinical commissioning group records its share of the income and expenditure, gains and losses, assets, liabilities and cash flows in its own accounts.

### 1.5 Pooled Budgets

South West London CCG has entered into pooled budget arrangements under Section 75 of the National Health Service Act 2006 with 5 of the Local London Boroughs (Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth), relating to the commissioning of health and social care services within the Better Care Fund. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget arrangement. The Section 75 agreements clearly sets out the accounting, risk share and governance arrangements.

The accountable bodies for the Better Care Fund are the Local Authorities who hold the funds apart from Croydon where the CCG holds the fund. They are managed through a joint management committee.

## 1.6 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the critical judgements, those involving estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- £29.2m Primary Care Delegated Commissioning accruals based on underlying data and assumptions of Practice payments not yet made or received by the CCG.
- £29.1m for the final two months prescribing expenditure has been based on forecast information supplied by NHS Business Services Authority.
- £22.8m as an estimate of additional adult continuing care expenditure based on CCG client databases and trends.

## 1.7 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

## 1.8 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles. Significant terms require that 95% of undisputed, valid invoices should be paid within 30 days.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non- cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

## 1.9 Employee Benefits

### 1.9.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

### 1.9.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

## 1.10 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

## 1.11 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

## 1.12 Property, Plant & Equipment

### 1.12.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost. Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

### 1.12.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

NHS South West London CCG does not own any land or buildings. On the dissolution of former NHS Primary Care Trusts, all land and buildings were transferred to NHS Property Services or Community Health Partnerships.

### 1.12.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written- out and charged to operating expenses.

## 1.13 Intangible Assets

### 1.13.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

### 1.13.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

## 1.14 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

## 1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

### 1.15.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

## 1.16 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

## 1.17 Provisions

The CCG does not hold any provisions as at 31st March 2022.

## 1.18 Continuing Healthcare Risk Pooling

In 2014/2015 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning group contributed to a pooled fund, which is used to settle the claims.

## 1.19 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with South West London CCG. The total value of Clinical Negligence provisions carried by the NHSLA on behalf of the CCG is disclosed at note 14

## 1.20 Non-clinical Risk Pooling

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

## 1.21 Contingent liabilities and contingent assets

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non- occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

## 1.22 Financial Assets

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

### 1.22.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

### 1.22.2 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

### 1.23 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de- recognised when the liability has been discharged, that is, the liability has been paid or has expired.

### 1.24 Value Added Tax

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### 1.25 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation.

By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

### 1.26 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021/22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

• IFRS 16 Leases – IFRS 16 Leases has been deferred until 1 April 2022, but CCGs will still need to provide adequate disclosure on the impact of the new standard. HM Treasury have issued application guidance which will assist entities in assessing the impact and this can be found at IFRS_16_Application_Guidance_December_2020.pdf (publishing.service.gov.uk).

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The clinical commissioning group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group's incremental borrowing rate. The clinical commissioning group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the clinical commissioning group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The impact of IFRS16 is immaterial for 2021/22.

## 2 Other Operating Revenue

| | 2021/22 Total £'000 | 2020/21 Total £'000 |
|---|---|---|
| **Income from sale of goods and services (contracts)** | | |
| Non-patient care services to other bodies | **18,121** | 20,165 |
| Other Contract income | **1,655** | 563 |
| **Total Income from sale of goods and services** | **19,776** | 20,728 |
| **Other operating income** | | |
| Rental revenue from operating leases | **336** | 262 |
| Charitable and other contributions to revenue expenditure: non-NHS | **25** | 1 |
| Other non contract revenue | **12,734** | 13,198 |
| **Total Other operating income** | **13,095** | 13,462 |
| **Total Operating Income** | **32,871** | 34,190 |

### 3.1 Disaggregation of Income - Income from sale of good and services (contracts)

| | 2021/22 | | | 2020/21 | | |
|---|---|---|---|---|---|---|
| | Non-patient care services to other bodies £'000 | Other Contract income £'000 | Total £'000 | Non-patient care services to other bodies £'000 | Other Contract income £'000 | Total £'000 |
| **Source of Revenue** | | | | | | |
| NHS | 2,508 | 148 | 2,656 | 3,799 | 0 | 3,799 |
| Non NHS | 15,613 | 1,507 | 17,120 | 16,366 | 563 | 16,929 |
| **Total** | **18,121** | **1,655** | **19,776** | **20,165** | **563** | **20,728** |

| | 2021/22 | | | 2020/21 | | |
|---|---|---|---|---|---|---|
| | Non-patient care services to other bodies £'000 | Other Contract income £'000 | Total £'000 | Non-patient care services to other bodies £'000 | Other Contract income £'000 | Total £'000 |
| **Timing of Revenue** | | | | | | |
| Point in time | 18,121 | 1,655 | 19,776 | 20,165 | 563 | 20,728 |
| **Total** | **18,121** | **1,655** | **19,776** | **20,165** | **563** | **20,728** |

## 4 Employee benefits and staff numbers

### 4.1.1 Employee benefits

| | 2021/22 | | |
|---|---|---|---|
| | **Permanent Employees £'000** | **Other £'000** | **Total £'000** |
| **Employee Benefits** | | | |
| Salaries and wages | **29,551** | **9,083** | **38,634** |
| Social security costs | **3,416** | **0** | **3,416** |
| Employer Contributions to NHS Pension scheme | **5,178** | **0** | **5,178** |
| Apprenticeship Levy | **146** | **0** | **146** |
| Termination benefits | **34** | **0** | **34** |
| **Gross employee benefits expenditure** | **38,325** | **9,083** | **47,408** |

### 4.1.1 Employee benefits

| | Employees £'000 | Other £'000 | 2020/21 Total £'000 |
|---|---|---|---|
| **Employee Benefits** | | | |
| Salaries and wages | 26,789 | 6,238 | 33,027 |
| Social security costs | 3,117 | 0 | 3,117 |
| Employer Contributions to NHS Pension scheme | 4,674 | 0 | 4,674 |
| Apprenticeship Levy | 60 | 0 | 60 |
| Termination benefits | 106 | 0 | 106 |
| **Gross employee benefits expenditure** | 34,746 | 6,238 | 40,984 |

### 4.2 Average number of people employed

| | 2021/22 | | | 2020/21 | | |
|---|---|---|---|---|---|---|
| | Permanently employed Number | Other Number | Total Number | Permanently employed Number | Other Number | Total Number |
| **Total** | **474** | **80** | **554** | 453 | 43 | 496 |

### 4.3 Exit packages agreed in the financial year

| | Compulsory redundancies | | Other agreed departures | | 2021/22 | |
|---|---|---|---|---|---|---|
| | Number | £ | Number | £ | Number | Total £ |
| £25,001 to £50,000 | 1 | 33,793 | - | - | 1 | 33,793 |
| **Total** | **1** | **33,793** | **-** | **-** | **1** | **33,793** |

| | Compulsory redundancies | | Other agreed departures | | 2020/21 | |
|---|---|---|---|---|---|---|
| | Number | £ | Number | £ | Number | Total £ |
| Less than £10,000 | 1 | 3,450 | - | - | 1 | 3,450 |
| £10,001 to £25,000 | 3 | 57,020 | - | - | 3 | 57,020 |
| £25,001 to £50,000 | 1 | 30,000 | - | - | 1 | 30,000 |
| **Total** | **5** | **90,470** | **-** | **-** | **5** | **90,470** |

As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the NHS National Terms and Conditions (Agenda for Change) guidelines.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

### 4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the CCG participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

#### 4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually.

Copies can also be obtained from The Stationery Office.

#### 4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

## 5 Operating expenses

| | 2021/22 Total £'000 | 2020/21 Total £'000 |
|---|---|---|
| **Purchase of goods and services** | | |
| Services from other CCGs and NHS England | 13,287 | 17,259 |
| Services from foundation trusts | 1,137,678 | 917,685 |
| Services from other NHS trusts | 1,039,231 | 828,864 |
| Services from Other WGA bodies | 0 | 15 |
| Purchase of healthcare from non-NHS bodies | 355,574 | 384,704 |
| Purchase of social care | 3,751 | 3,573 |
| Prescribing costs | 181,796 | 180,742 |
| General Ophthalmic services | 37 | 42 |
| GPMS/APMS and PCTMS | 283,728 | 257,260 |
| Supplies and services – clinical | 2,329 | 2,348 |
| Supplies and services – general | 32,916 | 36,924 |
| Consultancy services | 799 | 1,302 |
| Establishment | 9,514 | 19,462 |
| Transport | 457 | 1,292 |
| Premises | 6,482 | 9,356 |
| Audit fees | 252 | 252 |
| Other non statutory audit expenditure | | |
| • Internal audit services | 141 | 141 |
| • Other services | 0 | 72 |
| Other professional fees | 5,896 | 2,169 |
| Legal fees | 298 | 250 |
| Education, training and conferences | 151 | 1,044 |
| **Total Purchase of goods and services** | **3,074,317** | **2,664,755** |
| **Depreciation and impairment charges** | | |
| Depreciation | 347 | 885 |
| Amortisation | 16 | 125 |
| **Total Depreciation and impairment charges** | **363** | **1,010** |
| **Provision expense** | | |
| Provisions | 0 | (1,715) |
| **Total Provision expense** | **0** | **(1,715)** |
| **Other Operating Expenditure** | | |
| Chair and Non Executive Members | 848 | 721 |
| Grants to Other bodies | 846 | 160 |
| Research and development (excluding staff costs) | 20 | 155 |
| Expected credit loss on receivables | (391) | (34) |
| Other expenditure | 23 | 13 |
| **Total Other Operating Expenditure** | **1,347** | **1,015** |
| **Total operating expenditure** | **3,076,027** | **2,665,066** |

Limitation on auditor's liability - In accordance with the terms of engagement with the trust's external auditors, Grant Thornton UK LLP, its members, partners and staff (whether contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £2million in the aggregate in respect of all such services.

To note that Grant Thornton UK LLP do not provide Internal audit services for the CCG.

Audit Fees are £210k exclusive of VAT'.

## 6 Better Payment Practice Code

| | **2021/22** | | 2020/21 | |
|---|---|---|---|---|
| | **Number** | **£'000** | Number | £'000 |
| **Measure of compliance** | | | | |
| **Non-NHS Payables** | | | | |
| Total Non-NHS Trade invoices paid in the Year | 69,996 | £681,397 | 64,304 | £651,334 |
| Total Non-NHS Trade Invoices paid within target | 69,275 | £665,693 | 63,430 | £636,417 |
| **Percentage of Non-NHS Trade invoices paid within target** | **98.97%** | **97.70%** | 98.64% | 97.71% |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | 1,926 | £2,217,386 | 6,809 | £1,776,085 |
| Total NHS Trade Invoices Paid within target | 1,891 | £2,213,030 | 6,551 | £1,770,243 |
| **Percentage of NHS Trade Invoices paid within target** | **98.18%** | **99.80%** | 96.21% | 99.67% |

## 7 Operating Leases

### 7.1 As lessee

#### 7.1.1 Payments recognised as an Expense

| | Buildings £'000 | 2021/22 Total £'000 | Buildings £'000 | 2020/21 Total £'000 |
|---|---|---|---|---|
| **Payments recognised as an expense** | | | | |
| Minimum lease payments | 1,163 | **1,163** | 2,140 | **2,140** |
| **Total** | **1,163** | **1,163** | **2,140** | **2,140** |

#### 7.1.2 Future minimum lease payments

| | Buildings £'000 | 2021/22 Total £'000 | Buildings £'000 | 2020/21 Total £'000 |
|---|---|---|---|---|
| **Payable:** | | | | |
| No later than one year | 1,364 | **1,364** | 75 | 75 |
| Between one and five years | 5,458 | **5,458** | 211 | 211 |
| After five years | - | **-** | 500 | 500 |
| **Total** | **6,822** | **6,822** | **786** | **786** |

### 7.2 As lessor

#### 7.2.1 Rental revenue

| | 2021/22 £'000 | 2020/21 £'000 |
|---|---|---|
| **Recognised as income** | | |
| Rent | - | - |
| Contingent rents | 336 | 262 |
| **Total** | **336** | **262** |

## 8 Net gain/(loss) on transfer by absorption

NHS Croydon CCG, NHS Kingston CCG, NHS Merton CCG, NHS Richmond CCG, NHS Sutton CCG and NHS Wandsworth CCG merged from 1st April 2020 to form NHS South West London CCG.

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector.

Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

The table below identifies the Statement of Financial Position at 1st April 2020 for the six former CCGs. The corresponding net debit reflecting the loss is recognised within the income and expenses as disclosed within the Statement of comprehensive Net expenditure, but outside operating activities.

| | **2021/22 £'000** | 2020/21 £'000 |
|---|---|---|
| Transfer of property plant and equipment | - | 1,232 |
| Transfer of intangibles | - | 141 |
| Transfer of cash and cash equivalents | - | 687 |
| Transfer of receivables | - | 31,788 |
| Transfer of payables | - | (174,997) |
| Transfer of provisions | - | (1,774) |
| **Net loss on transfers by absorption** | **-** | **(142,923)** |

## 9 Property, plant and equipment

| | 2021/22 | | | |
|---|---|---|---|---|
| | Buildings excluding dwellings | Information technology | Furniture & fittings | Total |
| | £'000 | £'000 | £'000 | £'000 |
| **Cost or valuation at 01 April 2021** | 38 | 5,309 | 52 | 5,399 |
| Reclassifications | (38) | (420) | (38) | (495) |
| Disposals other than by sale | 0 | (3,329) | (14) | (3,343) |
| **Cost/Valuation at 31 March 2022** | **0** | **1,561** | **0** | **1,561** |
| **Depreciation 01 April 2021** | 38 | 4,963 | 52 | 5,052 |
| Reclassifications | (38) | (420) | (38) | (495) |
| Disposals other than by sale | 0 | (3,329) | (14) | (3,343) |
| Charged during the year | 0 | 347 | 0 | 347 |
| **Depreciation at 31 March 2022** | **0** | **1,561** | **(0)** | **1,561** |
| **Net Book Value at 31 March 2022** | **0** | **0** | **0** | **0** |
| Purchased | 0 | 0 | 0 | 0 |
| **Total at 31 March 2022** | **0** | **0** | **0** | **0** |
| **Asset financing:** | | | | |
| Owned | 0 | 0 | 0 | 0 |
| **Total at 31 March 2022** | **0** | **0** | **0** | **0** |

### 9.1 Economic lives

| | Minimum Life (years) | Maximum Life (years) |
|---|---|---|
| Buildings excluding dwellings | 3 | 3 |
| Information technology | 3 | 3 |
| Furniture & fittings | 3 | 3 |

| | | | | 2020/21 |
|---|---|---|---|---|
| | Buildings excluding dwellings | Information technology | Furniture & fittings | Total |
| | £'000 | £'000 | £'000 | £'000 |
| **Cost or valuation at 01 April 2020** | 38 | 5,309 | 52 | 5,399 |
| Reclassifications | 0 | 0 | 0 | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 |
| **Cost/Valuation at 31 March 2021** | **38** | **5,309** | **52** | **5,399** |
| **Depreciation 01 April 2020** | 38 | 4,077 | 52 | 4,167 |
| Reclassifications | 0 | 0 | 0 | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 |
| Charged during the year | 0 | 885 | (0) | 885 |
| **Depreciation at 31 March 2021** | **38** | **4,963** | **52** | **5,052** |
| **Net Book Value at 31 March 2021** | **0** | **347** | **0** | **347** |
| Purchased | 0 | 347 | 0 | 347 |
| **Total at 31 March 2021** | **0** | **347** | **0** | **347** |
| **Asset financing:** | | | | |
| Owned | 0 | 347 | 0 | 347 |
| **Total at 31 March 2021** | **0** | **347** | **0** | **347** |

The balances as at 1st April 2020 relate to those transferred by absorption (note 8)

## 10 Intangible non-current assets

| | Computer Software: Purchased £'000 | 2021/22 Total £'000 |
|---|---|---|
| **Cost or valuation at 01 April 2021** | 1,919 | **1,919** |
| Reclassifications | 495 | **495** |
| Disposals other than by sale | (2,222) | **(2,222)** |
| **Cost / Valuation At 31 March 2022** | **192** | **192** |
| **Amortisation 01 April 2021** | 1,903 | **1,903** |
| Charged during the year | 16 | **16** |
| **Amortisation At 31 March 2022** | **192** | **192** |
| **Net Book Value at 31 March 2022** | **0** | **0** |
| Purchased | 0 | **0** |
| **Total at 31 March 2022** | **0** | **0** |

### 10.1 Economic lives

| | Minimum Life (years) | Maximum Life (years) |
|---|---|---|
| Computer software: purchased | 3 | 3 |

| | Computer Software: Purchased £'000 | 2020/21 Total £'000 |
|---|---|---|
| **Cost or valuation at 01 April 2020** | 1,919 | **1,919** |
| Reclassifications | 0 | **0** |
| Disposals other than by sale | 0 | **0** |
| **Cost / Valuation At 31 March 2021** | **1,919** | **1,919** |
| **Amortisation 01 April 2020** | 1,778 | **1,778** |
| Charged during the year | 125 | **125** |
| **Amortisation At 31 March 2021** | **1,903** | **1903** |
| **Net Book Value at 31 March 2021** | **16** | **16** |
| Purchased | 16 | **16** |
| **Total at 31 March 2021** | **16** | **16** |

The balances as at 1st April 2020 relate to those transferred by absorption (note 8)

### 11.1 Trade and other receivables

| | 2021/22 Current £'000 | 2021/22 Non-current £'000 | 2020/21 Current £'000 | 2020/21 Non-current £'000 |
|---|---|---|---|---|
| NHS receivables: Revenue | 10,717 | 0 | 6,982 | 0 |
| NHS accrued income | 69 | 0 | 1,761 | 0 |
| Non-NHS and Other WGA receivables: Revenue | 5,555 | 0 | 5,439 | 0 |
| Non-NHS and Other WGA prepayments | 3,325 | 0 | 3,731 | 0 |
| Non-NHS and Other WGA accrued income | 1,429 | 0 | 2,580 | 0 |
| Expected credit loss allowance-receivables | (1,101) | 0 | (1,355) | 0 |
| VAT | 770 | 0 | 620 | 0 |
| Other receivables and accruals | 8 | 0 | 7 | 0 |
| **Total Trade & other receivables** | **20,770** | **0** | **19,765** | **0** |
| **Total current and non current** | **20,770** | | **19,765** | |

### 11.2 Receivables past their due date but not impaired

| | 2021/22 DHSC Group Bodies £'000 | 2021/22 Non DHSC Group Bodies £'000 | 2020/21 DHSC Group Bodies £'000 | 2020/21 Non DHSC Group Bodies £'000 |
|---|---|---|---|---|
| By up to three months | 2,393 | 2,506 | 511 | 3,769 |
| By three to six months | 3 | 43 | 195 | 145 |
| By more than six months | 2,579 | 1,123 | 2,755 | 1,180 |
| **Total** | **4,976** | **3,673** | **3,461** | **5,094** |

### 11.3 Loss allowance on asset classes

| | Trade and other receivables - Non DHSC Group Bodies £'000 | Other financial assets £'000 | Total £'000 |
|---|---|---|---|
| Balance at 01 April 2021 | (1,355) | 0 | **(1,355)** |
| Lifetime expected credit losses on trade and other receivables-Stage 2 | (304) | 0 | **(304)** |
| Lifetime expected credit losses on trade and other receivables-Stage 3 | 362 | 0 | **362** |
| Credit losses recognised on purchase originated credit impaired financial assets | 196 | 0 | **196** |
| **Allowance for credit losses at 31 March 2022** | **(1,101)** | **0** | **(1,101)** |

## 12 Cash and cash equivalents

| | 2021/22 £'000 | | 2020/21 £'000 |
|---|---|---|---|
| **Balance at 01 April 2021** | 473 | Balance at 01 April 2021 | 687 |
| Net change in year | 1,479 | Net change in year | (214) |
| **Balance at 31 March 2022** | **1,951** | Balance at 31 March 2021 | 473 |
| | | | |
| **Made up of:** | | Made up of: | |
| Cash with the Government Banking Service | 1,951 | Cash with the Government Banking Service | 473 |
| | | | |
| **Balance at 31 March 2022** | **1,951** | **Balance at 31 March 2021** | **473** |

The balances as at 1st April 2020 relate to those transferred by absorption (note 8)

## 13 Trade and other payables

| | 2021/22 Current £'000 | 2021/22 Non-current £'000 | 2020/21 Current £'000 | 2020/21 Non-current £'000 |
|---|---|---|---|---|
| NHS payables: Revenue | 4,742 | 0 | 3,104 | 0 |
| NHS accruals | 21,188 | 0 | 11,039 | 0 |
| Non-NHS and Other WGA payables: Revenue | 48,563 | 0 | 47,872 | 0 |
| Non-NHS and Other WGA accruals | 86,451 | 0 | 85,221 | 0 |
| Non-NHS and Other WGA deferred income | 296 | 0 | 607 | 0 |
| Social security costs | 540 | 0 | 478 | 0 |
| Tax | 484 | 0 | 452 | 0 |
| Other payables and accruals | 85,527 | 0 | 71,182 | 0 |
| **Total Trade & other Payables** | **247,790** | **0** | **219,954** | **0** |
| Total current and non-current | **247,790** | | **219,954** | |

Other payables include £2,707,000 of outstanding pension contributions at 31 March 2022

The 2021/22 Other Payable Figure of £85.5m Can be broken down into the following areas (2020/21 also detailed):

| | 2021/22 £m | 2020/21 £m |
|---|---|---|
| Payroll and Pension Accruals | 2.7 | 2.5 |
| Approved & unapproved general invoices | 2.0 | 1.0 |
| Service Development Accruals | 9.8 | 11.3 |
| Covid-19 Accruals | 2.1 | 14.6 |
| Acute Accruals | 1.8 | 0.3 |
| Mental Health Accruals | 6.6 | 7.6 |
| Community Accruals Including Continuing Healthcare | 30.3 | 17.5 |
| Primary Care Accruals Including IT | 16.8 | 10.5 |
| Running Cost Accruals | 1.1 | 1.4 |
| Other Accruals | 12.3 | 4.5 |
| | 85.5 | 71.2 |

## 14 Provisions

| | 2021/22 Current £'000 | 2021/22 Non-current £'000 | 2020/21 Current £'000 | 2020/21 Non-current £'000 |
|---|---|---|---|---|
| Continuing care | 0 | 0 | (0) | 0 |
| **Total** | **0** | **0** | **(0)** | **0** |
| **Total current and non-current** | **0** | | **(0)** | |

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS continuing healthcare claims relating to periods of care before the establishment of Clinical Commissioning Groups. However, the legal liability remains with the CCG. The total value of NHS Continuing Healthcare provisions accounted for by NHS England on behalf of the CCG at 31 March 2022 is £264k.

Legal claims are calculated from the number of claims currently lodged with NHS Resolution and probabilities provided by them. £0 is included in the provisions of NHS Resolution as at 31 March 2022 in respect of employer liabilities of NHS South West London CCG (2020/21 £7,500).

## 15 Contingencies

The CCG had no outstanding claims in 2021/22 that are considered to have a likelihood that deems them reportable as a contingent liability in 2021/22.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS continuing healthcare claims relating to periods of care before the establishment of Clinical Commissioning Groups. However, the legal liability remains with the CCG. The total value of NHS Continuing Healthcare contingent liabilities accounted for by NHS England on behalf of the CCG at 31 March 2022 is £814k.

## 16 Commitments

NHS South West London CCG has no reportable commitments at 31st March 2022.

## 17 Operating segments

The CCG has just one operating segment which is the commissioning of healthcare

## 18 Financial instruments

The fair value of assets and liabilities as detailed in notes 18.2 and 18.3 are the same as the carrying value

### 18.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

### 18.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

### 18.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

### 18.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

### 18.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

### 18.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

### 18.2 Financial assets

| | 2021/22 | | |
|---|---|---|---|
| | Financial Assets measured at amortised cost £'000 | Equity Instruments designated at FVOCI £'000 | Total £'000 |
| Trade and other receivables with NHSE bodies | 9,604 | | 9,604 |
| Trade and other receivables with other DHSC group bodies | 1,904 | | 1,904 |
| Trade and other receivables with external bodies | 5,167 | | 5,167 |
| Cash and cash equivalents | 1,951 | | 1,951 |
| **Total at 31 March 2022** | **18,626** | **-** | **18,626** |

| | 2020/21 | | |
|---|---|---|---|
| | Financial Assets measured at amortised cost £'000 | Equity Instruments designated at FVOCI £'000 | Total £'000 |
| Trade and other receivables with NHSE bodies | 7,853 | | 7,853 |
| Trade and other receivables with other DHSC group bodies | 4,166 | | 4,166 |
| Trade and other receivables with external bodies | 3,395 | | 3,395 |
| Cash and cash equivalents | 473 | | 473 |
| **Total at 31 March 2022** | **15,887** | **-** | **15,887** |

The 2021/22 figure for Trade and other receivables excludes the following which are classed as non financial assets - Prepayments, £3,325k, and VAT receivable, £770k.

### 18.3 Financial liabilities

| | 2021/22 | | |
|---|---|---|---|
| | Financial Liabilities measured at amortised cost £'000 | Other £'000 | Total £'000 |
| Trade and other payables with NHSE bodies | 851 | | **851** |
| Trade and other payables with other DHSC group bodies | 25,739 | | **25,739** |
| Trade and other payables with external bodies | 219,880 | | **219,880** |
| **Total at 31 March 2022** | **246,471** | **-** | **246,471** |

| | 2020/21 | | |
|---|---|---|---|
| | Financial Liabilities measured at amortised cost £'000 | Other £'000 | Total £'000 |
| Trade and other payables with NHSE bodies | 825 | | **825** |
| Trade and other payables with other DHSC group bodies | 45,492 | | **45,492** |
| Trade and other payables with external bodies | 172,101 | | **172,101** |
| **Total at 31 March 2022** | **218,418** | **-** | **218,418** |

The 2021/22 figure for Trade and other payables excludes liabilities for Social security costs £540k, Tax £484k and Non NHS and Other WGA deferred income 296k as these are defined as non financial liabilities.

## 19 Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

### 19.1 Interests in joint operations

South West London CCG hosts a Better Care Fund pooled budget with the London Borough of Croydon. Under these arrangements funds are pooled under section 75 of the NHS Act 2006. NHS South West London CCG contributes to the pool for the services delivered as a provider of healthcare. Members to the BCF pool account for transactions and balances directly with providers. Subject to the requirements of National Guidance and the Better Care Fund plan the agreed return of underspends is in the following proportions: CCG 70%; Council 30%

Royal Borough of Kingston hosts a Better Care Fund pooled budget for the Borough. Under these arrangements funds are pooled under section 75 of the NHS Act 2006. NHS South West London CCG contributes to the pool for the services delivered as a provider of healthcare. Members to the BCF pool account for transactions and balances directly with providers. Partners are solely liable for any overspends to services commissioned exercise of their

London Borough of Merton hosts a Better Care Fund (including community equipment) pooled budget for the Borough. Under these arrangements funds are pooled under section 75 of the NHS Act 2006. NHS South West London CCG contributes to the pool for the services delivered as a provider of healthcare. Members to the BCF pool account for transactions and balances directly with providers. Partners are solely liable for any overspends to services commissioned exercise of their statutory functions

London Borough of Richmond hosts a Better Care Fund pooled budget for the Borough. Under these arrangements funds are pooled under section 75 of the NHS Act 2006. NHS South West London CCG contributes to the pool for the services delivered as a provider of healthcare. Members to the BCF pool account for transactions and balances directly with providers. Partners are solely liable for any overspends to services commissioned exercise of their statutory functions

London Borough of Sutton hosts a Better Care Fund pooled budget for the Borough. Under these arrangements funds are pooled under section 75 of the NHS Act 2006. NHS South West London CCG contributes to the pool for the services delivered as a provider of healthcare. Members to the BCF pool account for transactions and balances directly with providers. Under the section 75 financial risk is shared on the basis of the financial contribution to

London Borough of Wandsworth hosts a Better Care Fund pooled budget for the Borough. Under these arrangements funds are pooled under section 75 of the NHS Act 2006. NHS South West London CCG contributes to the pool for the services delivered as a provider of healthcare. Members to the BCF pool account for transactions and balances directly with providers. Partners are solely liable for any overspends to services commissioned exercise of their statutory functions

NHS South West London CCG's shares of assets/liabilities and income and expenditure handled by the pooled budgets in the financial year were:

| | | | Amounts recognised in Entities books ONLY 2021/22 | | | |
|---|---|---|---|---|---|---|
| **Name of arrangement** | **Parties to the arrangement** | **Description of Principal activities** | **Assets £'000** | **Liabilities £'000** | **Income £'000** | **Expenditure £'000** |
| Better Care Fund | South West London CCG & London Borough of Croydon | Provision of Health & & Social Care | 0 | 0 | 0 | 12,307 |
| Better Care Fund | South West London CCG & Royal Borough of Kingston | Provision of Health & Social Care | 0 | 0 | 0 | 8,574 |
| Better Care Fund | South West London CCG & London Borough of Merton | Community Health and Social Care services | 0 | 0 | (96) | 14,347 |
| Better Care Fund | South West London CCG & London Borough of Richmond upon Thames | Community Health and Social Care services | 0 | 0 | 0 | 6,747 |
| Better Care Fund | South West London CCG & London Borough of Sutton | Community Health and Social Care services | 0 | 0 | (6,090) | 13,737 |
| Better Care Fund | South West London CCG & London Borough of Wandsworth | Community Health and Social Care services | 0 | 0 | (363) | 24,533 |

| | | | Amounts recognised in Entities books ONLY 2020/21 | | | |
|---|---|---|---|---|---|---|
| **Name of arrangement** | **Parties to the arrangement** | **Description of Principal activities** | **Assets £'000** | **Liabilities £'000** | **Income £'000** | **Expenditure £'000** |
| Better Care Fund | South West London CCG & London Borough of Croydon | Provision of Health & & Social Care | 0 | 0 | 0 | 10,094 |
| Better Care Fund | South West London CCG & Royal Borough of Kingston | Provision of Health & Social Care | 0 | 0 | 0 | 8,167 |
| Better Care Fund | South West London CCG & London Borough of Merton | Community Health and Social Care services | 0 | 0 | (96) | 13,644 |
| Better Care Fund | South West London CCG & London Borough of Richmond upon Thames | Community Health and Social Care services | 0 | 0 | 0 | 6,050 |
| Better Care Fund | South West London CCG & London Borough of Sutton | Community Health and Social Care services | 0 | 0 | (6,090) | 13,329 |
| Better Care Fund | South West London CCG & London Borough of Wandsworth | Community Health and Social Care services | 0 | 0 | (363) | 23,362 |

## 20 Related party listing

Details of related party transactions with individuals are as follows:

St George's University Hospitals NHS Foundation Trust
Epsom & St Helier University Hospitals NHS Trust
Croydon Health Services NHS Trust
Kingston Hospital NHS Foundation Trust
South West London & St George's Mental Health NHS Trust
Chelsea & Westminster NHS Hospitals Foundation Trust
The Royal Marsden NHS Foundation Trust
Houslow and Richmond Community Healthcare NHS Trust
London Ambulance Services NHS Trust
South London and Maudsley NHS Foundation Trust
Guys & St Thomas NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
London Borough of Croydon
London Borough of Wandsworth
London Borough Of Sutton
Royal Borough of Kingston upon Thames
London Borough of Richmond upon Thames
London Borough of Merton
Your Healthcare CIC
The Church Lane Practice
The Groves Medical Centre
Brocklebank Group Practice
Stonecot Surgery
Mulgrave Road Surgery
South Norwood Medical Practice
Haling Park Medical Practice

*The Department of Health and Social Care is regarded as a related party. During the year NHS South West London CCG has had a significant number of material transactions with NHS entities for which the Department is regarded as the parent Department*
*The materiality level set for these transactions is £30m which is 1% of the clinical commissioning group's total operating expenses*

*In addition, NHS South West London Clinical Commissioning Group has had a number of transactions with local government bodies.*

*The above practices have GPs or nurse practitioners on executive committees of the CCG and have received payments in respect of practice and clinical services commissioned by the CCG.*

## 21 Events after the end of the reporting period

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021 and was passed on the 28th April 2022. The Bill allows for the establishment of Integrated Care Boards (ICBs) across England and will abolish clinical commissioning groups (CCGs). South West London ICB will take on the commissioning functions of South West London CCG on the 1st July 2022 with the assets, liabilities and operations transferring across to the new organisation.

## 22 Losses and special payments

The CCG did not incur any losses in 2021/22 (2020/21 Nil)

Special payments

| | **Total Number of Cases 2021/22 Number** | **Total Value of Cases 2021/22 £'000** | Total Number of Cases 2020/21 Number | Total Value of Cases 2020/21 £'000 |
|---|---|---|---|---|
| Compensation payments | 1 | 23 | - | - |
| **Total** | **1** | **23** | **-** | **-** |

## 23 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS Clinical Commissioning Group performance against those duties was as follows:

| | **Target** | **Performance** | **2021/22 Pass / Fail** |
|---|---|---|---|
| Expenditure not to exceed income | 3,123,579 | 3,123,435 | Pass |
| Capital resource use does not exceed the amount specified in Directions | - | - | N/A |
| Revenue resource use does not exceed the amount specified in Directions | 3,090,708 | 3,090,564 | Pass |
| Capital resource use on specified matter(s) does not exceed the amount specified in Directions | - | - | N/A |
| Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | - | - | N/A |
| Revenue administration resource use does not exceed the amount specified in Directions | 30,908 | 30,907 | Pass |

| | Target | Performance | 2020/21 Pass / Fail |
|---|---|---|---|
| Expenditure not to exceed income | 2,706,109 | 2,706,050 | Pass |
| Capital resource use does not exceed the amount specified in Directions | - | - | N/A |
| Revenue resource use does not exceed the amount specified in Directions | 2,671,919 | 2,671,860 | Pass |
| Capital resource use on specified matter(s) does not exceed the amount specified in Directions | - | - | N/A |
| Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | - | - | N/A |
| Revenue administration resource use does not exceed the amount specified in Directions | 30,726 | 29,890 | Pass |

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