NHS
South West London
Clinical Commissioning Group

Annual Report and Accounts
1 April to 30 June 2022

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1.1 About this report

The NHS South West London Clinical Commissioning Group (CCG) Annual Report for April, May and June 2022 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:

- **Performance Report** – including an overview, performance analysis and performance measures
- **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 financial statements

This report has been approved for submission by the Board of NHS South West London Integrated Care Board as the inheriting body of the functions of NHS South West London Clinical Commissioning Group.

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.

1.2 Performance Overview

1.2.1 Welcome and overview from the Clinical Chair and Accountable Officer

Welcome and overview

Welcome to the final annual report for South West London Clinical Commissioning Group (CCG). This report is a record of our work in the final three months of the CCG, April, May and June 2022, before the establishment of NHS South West London Integrated Care Board on 1 July 2002. The new Integrated Care Board now oversees the planning and funding of health services in South West London and has taken on many of the core functions previously delivered by the CCG.

Becoming an Integrated Care System (ICS)

Nationally, ICSs launch date was pushed back three months to 1 July 2022 to allow systems across the country to make the final arrangements to take on their statutory duties with a firm footing. In South West London we are proud to now be operating as a new Integrated Care System, with both our Integrated Care Board and Integrated Care Partnership working together to improve health and care across our boroughs.

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 build 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.

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 July 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 ICS partners.

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.

Primary care developments

Primary care networks (PCNs) continued to play an essential role in delivering the Covid-19 vaccination programme, running 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 establishing our Population Health Management programme, working with local communities to identify barriers to accessing health and care and to develop new services for those who need them most.

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 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.

Responding to the mental health crisis

We know people's emotional health and wellbeing was affected by the pandemic and demand for support 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 capacity to further support local people. Services such as crisis cafés and health and wellbeing spaces have helped patients without the need for them to go into hospital.

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 pandemic. In this report we have highlighted some of the many initiatives introduced in the past year to support priority work programmes.

Finally, we wanted to mark this final annual report by thanking our Governing Body, GP members and staff for how they adapted over the life of the CCG 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.

Sarah Blow

Accountable Officer

1.2.2 About us

NHS South West London Clinical Commissioning Group (CCG) was responsible for planning, commissioning and buying health services for people living and working in South West London up until 31 June 2022.

As a CCG, we were a membership organisation made up of over 180 GP practices within South West London. We served 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. South West London CCG was disestablished at the end of June 2022 and on 1 July 2022 NHS South West London Integrated Care Board was established, taking on many of the functions delivered formally by the CCG. This annual report covers the final three months of the CCG, from 1 April to 30 June 2022.

During this period we managed local healthcare budgets of over £575 million and commissioned a range of health services on behalf of our residents. The services that we were responsible for include primary care (the services you receive at your GP practice and pharmacy), hospital treatment, rehabilitation services, urgent and emergency care, community health services, mental health and learning disability services.

As a CCG our vision was to make South West London a great place to live and work.

We worked to these values:

- 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

The CCG constitution set out our responsibilities for commissioning care for patients. It also set out the rules and procedures we followed to ensure probity and accountability in the day to day running of the CCG. This was to ensure that decisions were taken in an open and transparent way and that the interests of patients and the public remained central.

You can read the constitution and standing orders on the CCG 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. These rights have been continued by the NHS South West London Integrated Care Board.

1.2.3 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 were 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 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 represented 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.

The borough Health and Care Plans for each borough are also available on our website.

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

- Croydon: Health and Wellbeing Board | Croydon council
- Merton: Merton Health and Wellbeing Board (mertonpartnership.org.uk)
- Kingston: Kingston Council – www.kingston.gov.uk
- Richmond: Health and Wellbeing Board - London Borough of Richmond upon Thames
- Sutton: Committee details - Health and Wellbeing Board - Sutton Council
- Wandsworth: Wandsworth Health and Wellbeing Board - Wandsworth Borough Council

1.2.4 Developing South West London Integrated Care System

South West London Health and Care Partnership was first established in 2018 and brought 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. During April, May and June 2022, South West London CCG continued to work with system partners to South West London Integrated Care System. This included new governance structures and collaborative ways of working. Our ICS took on statutory roles and responsibility on 1 July 2022 alongside the other 43 ICSs in the country.

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 ICS has been the strong engagement across all our partners. Therefore, as the Health and Care Bill progressed through Parliament and national guidance was published, we continued to engage and have 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.

In line with national guidance, South West London Integrated Care System was established on 1 July 2022, and now works 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.

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

Figure 1: The three parts of South West London ICS

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 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

On 1 July 2022, the South West London level of the South West London Integrated Care System established an Integrated Care Partnership (ICP) and an Integrated Care Board (ICB).

- **South West London Integrated Care Partnership** brings 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 brings together representatives from local authorities, the South West London Integrated Care Board, NHS providers, the voluntary sector, healthwatch and other partners. The Chair of NHS South West London ICB and Cllr Ruth Dombey are co-chairs of the ICP, which met for the first time on Wednesday 13 July 2022.

- **South West London Integrated Care Board** brings the local NHS together to improve population health and care. It leads 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: There are Chair and Chief Executive roles for the South West London Integrated Care Board, as well as four non-executive members, executive directors, members selected from nominations made by NHS trusts and foundation trusts, general practice and a local authority representative. The ICB met for the first time on Friday 1 July 2022.

NHS South West London Integrated Care Board is also a statutory organisation that took on many of the NHS planning functions previously held by South West London Clinical Commissioning Group. Following a staff consultation, staff previously employed by the CCG transferred to the ICB on 1 July 2022.

Partners across South West London worked together to design our ICS which was established on 1 July 2022. You can read more about the ICS and our work on the new South West London ICS website southwestlondonics.org.uk

1.2.6 Finance summary

This information serves as a summary of the CCG's accounts for 2022/23 Q1, 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

The CCG received £704.99m of funding to commission healthcare services for the local population for the first 3 months of the year. It spent an equal amount to the funding received and had a breakeven position as at 30 June 2022.

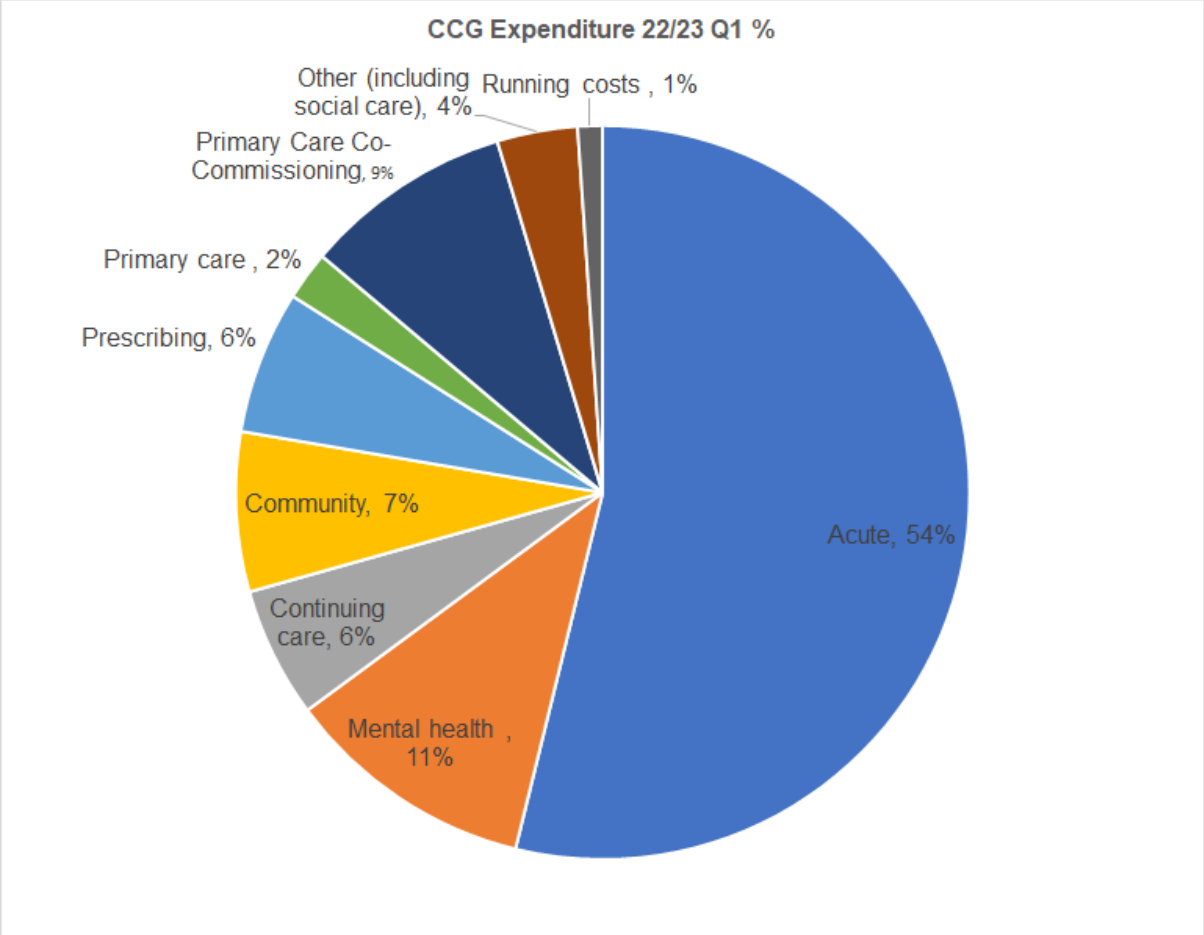
1.1.2.2 How we spent our budget

The CCG invested its funding as follows:

- Over half of this expenditure was acute services £379m.
- Mental health services £78m,
- Community health services £50m,
- Continuing healthcare placements £41m
- Primary care (including prescribing) £125m.
- The CCG spent £7.7m on running the organisation, which is in line with the agreed limit.

An analysis of the CCG's net expenditure in 2022/23 Q1 is set out below.

Commissioning areas	CCG Expenditure 22/23 Q1
	£m
Acute	379
Mental health	78
Continuing care	41
Community	50
Prescribing	45
Primary care	15
Primary Care Co-Commissioning	65
Other (including social care)	25
Running costs	8
TOTAL	**705**



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.

1.3 Performance analysis

In this section we describe our key achievements of April, May and June 2022, the final three months of South West London Clinical Commissioning Group. These include delivering the Covid-19 vaccination programme, the impact of the pandemic on services, our progress delivering key programmes of work, how we delivered our statutory duties – to involve local people and communities, to reduce health inequalities and to improve the quality of services – and our role in assuring delivery of performance and constitutional standards.

1.3.1 April, May and June 2022 highlights

Delivering the Covid-19 vaccination programme

Leading the South West London programme

118,720 Covid-19 vaccinations were delivered between 1 April and 30 June 2022. 36,048 of these were 1st and 2nd doses, 82,672 were 3rd, Booster or 2nd Booster doses, 61,031 were Spring Boosters. We continue to have the highest uptake rates for most groups compared with the rest of London. This includes the highest uptake for under 18s, the highest uptake for care homes and the highest uptake for booster vaccinations. 1,400 bank staff worked on the programme, and many have now been trained in administering the flu vaccine and other immunisations including monkey pox and polio. Beyond this, new people have been recruited into the NHS, over 270 staff recruited for the vaccination programme have gone to find roles within health and social care thanks to a retention programme. 5,468 people have volunteered to support the programme. During this period, we have begun to plan for the future of the vaccination programme – including readiness plans for winter 2022 and integrating with other immunisations programmes.

Spring Booster Programme

We delivered the Spring Booster Programme, which started on 20 March 2022 and continued in the lead up to 30 June 2022. Those aged 75 and over, and 12 and over who were immunosuppressed were offered another dose of the Covid-19 vaccination to ensure that they were protected for the summer months. As well as offering walk in clinics, and booked appointments, this was supported by a roving offer for Care Homes and patients that were housebound.

Vaccinations for 5 to 11-year-olds

The vaccination programme for children aged 5 to 11 was rolled out from 4 April 2022. We stepped up walk-in clinics and a bookable offer in our vaccination centres and hospital hubs. We have also run pop-up clinics in areas of low uptake. To support this programme, we talked to local people. Feedback received from over 800 parents and carers across South West London helped shape our communications messages as well as our operational approach in delivering vaccines for this group. Parents told us they wanted more information and data. We responded by communicating on websites and social media, and in face-to-face engagement to combat misinformation, share case studies from parents who had vaccinated their children and with a range of clinical voices.

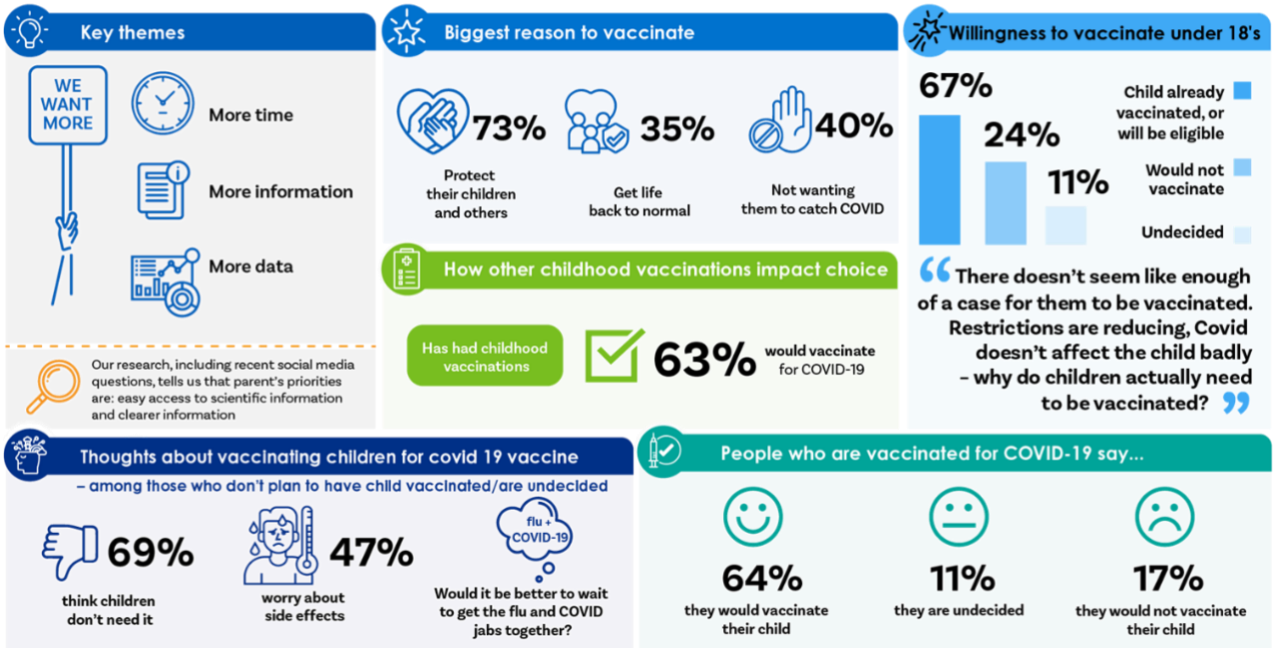


Figure 2: Key findings from the insight programme from talking to parents of 5 to 11-year olds: published 17 June 2022

Our continuing offer

It's never too late for people in South West London to get their 1st, 2nd or booster vaccinations. We run a roving model of pop-up vaccination clinics and also work hard to engage with local people in each of our boroughs and connected more deeply with the communities that we served. We continue to support local people to make informed choices about the vaccination through the information we provide, and we delivered 152 pop-up clinics between 1 April and 30 June. Our business intelligence team worked hard to analyse the data of those taking up the offer of the vaccine to help inform our approach, ensuring that we understand our areas of low uptake so that we can respond accordingly by offering outreach clinics and information sessions.

Throughout the programme we have worked closely with local authorities and the voluntary sector to support us in communicating and engaging with our diverse communities to help build trust and make sure that local people have the opportunity to make an informed choice about

their vaccinations. We have also worked hard together to offer the vaccine in a variety of locations including mosques, churches and shopping centres to make their choice as convenient as possible.

Other immunisation programmes

Building on the impact of the Covid-19 vaccination programme, our teams continued to support other immunisation programmes. This included childhood immunisations – particularly MMR and Polio. In response to the monkeypox cases in the UK, the NHS is offering smallpox (MVA) vaccination to people who are most likely to be exposed to monkeypox. Local NHS services are contacting patients and offering vaccine if they are at risk of exposure. They may also be offered the vaccine alongside other appointments, for example for HIV pre-exposure prophylaxis (PrEP).

Planning for the flu vaccination programme in Winter 2022 is also in motion.

Engaging with communities on vaccinations

Our overall vaccination engagement approach

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. Building on 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.

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.

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 continue to gather 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. In particular, for the new 5-11 programme, we gathered insights from parents through focus groups and surveys.

Insight from our communities informs the delivery of the vaccination programme and how we engage. The impact of this engagement work focused on parents of 5-11, for example, has influenced our messaging, how we reach people as well as operational planning for how and where to deliver vaccinations.

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, 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.

We continue to develop the way that we partner with the voluntary sector to expand our reach and strengthen our work through partnerships with community-based organisations. We also work to share the most up to date information with Local Authority colleagues. As a result, networks of community champions, regularly share information about the vaccine.

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. The learning from our engagement activity and regular feedback from communities gathered by our champions continues to inform our approach.

Delivering the vaccination programme in our six boroughs

Croydon

In Croydon we launched the vaccination van in partnership with Croydon Council. This was enhanced with engagement teams working alongside the clinics. To date, the van has vaccinated over 1,000 people from low uptake areas. Working alongside the council's 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. Pop up clinics have taken place in Thornton Heath, New Addington and North End.

Our engagement team continue to work 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. For example, recently we ran a focus group in partnership with the Croydon BME forum to inform our approach to vaccinating children aged 5 to 11. We also worked in partnership with Evolve Housing to plan and hold two health and wellbeing days at 2 youth hostels in Croydon. The event involved partners from local health and care services including Mind in Croydon, Off the Record, Change Grow Live, Aids Healthcare Foundation and the NHS Sexual Health service. Local clinicians attended the events to have conversations about the Covid-19 vaccination and general health concerns.

Merton

Our GPs, nurses and pharmacists worked with local communities to set up clinics in various community locations to bring vaccinations closer to local people. Pop ups were run in areas of low uptake including: the New Horizon Centre, Merton Civic Centre, and as part of community fun days in Pollards Hill 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.

Kingston

In Kingston, we have continued to work together with health and care partners as well as local voluntary and community organisations. We deliver virtual meetings and events for our diverse communities, including residents from ethnic minorities, those with learning disabilities and younger people. We worked with local community groups to set up clinics in various community locations such as Piper Hall Foodbank, the Hook Centre. We have also worked with the local library to hold regular pop ups, offering access to clinicians and opportunities for the community to come forward and ask questions about the vaccination.

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 at Age UK, LiveWell Kew and York House, Twickenham.

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

We continue our partnership work with Richmond Council including supporting the local community Covid champions programme and working with Public Health to deliver health-focused outreach work to targeted communities and areas in Richmond. The 'Come and have a chat about your health' community outreach bus has been visiting locations some of these are where uptake of the COVID-19 vaccine has been lower than the rest of the borough including Ham Youth Centre, Kew Community Trust and Heathfield Recreation Ground. Local people who haven't had any, or who are due a dose, can access a vaccine on the bus. The bus also hosts NHS professionals and pharmacists to answer general questions about health, as well as offering information about local council services and other support to help residents remain healthy and well. Local residents can have blood pressure checks, receive support to help stop smoking, information on preventing and reducing the risk of several diseases, including diabetes, cancer, and heart disease and information on immunisations. It is also an opportunity for us and partners such as Healthwatch Richmond to 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 high percentage of vaccine uptake for 1st and 2nd doses in South West London.

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.

We targeted vulnerable communities through setting up “pop up” clinics in various locations across the borough. Pop ups for specific groups took place at Cloverdale Court, Shanklin Village and Tennyson Grange Care Home.

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.

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 Katherine Low Settlement, Alton Estate and Tooting Leisure Centre. 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. Our community health vehicle visits locations in the borough chosen due to continue low vaccine uptake. This is an opportunity to promote local services, health and wellbeing information and have conversations and make connections with local people and communities. We have also been planning a programme of community champions in Roehampton to support vaccination uptake in partnership with Estate Arts.

Further key priorities in April, May and June 2022

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.

Primary Care

General Practices and Primary Care Networks (PCNs) continued to lead the transformational agenda in South West London in April, May and June 2022, and successfully delivered a range of work programmes. PCNs continued to support the Covid-19 vaccination programme, 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, most recently with the spring booster being delivered successfully to thousands of local residents including during April, May and June 2022.

With money from the NHS Digital First fund, the South West London Primary Care Provider Alliance provided additional primary care capacity over the Jubilee bank holiday in early June 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 over 2,500 calls over that weekend, with only 1% of calls being referred onwards to Emergency Departments or 999, meaning pressure on emergency and acute services was significantly reduced.

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

This was supported by the CCG's communication and engagement team to make sure local people were aware of the services available to them over the four day bank holiday weekend and to remind them to plan ahead and collect prescriptions in advance should they need to.

Primary Care Networks (PCNs)

PCNs continued to develop during April, May and June 2022, 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.

To support the recruitment and retention of the primary care workforce, the South West London training hubs continued to provide support during April, May and June 2022 with training, workforce development and education. Schemes implemented include:

- continuing professional development and training for our multi-professional workforce
- health and wellbeing coaches peer support
- multi professional faculty groups

We have also continued to make progress at Place level, with examples below:

Sutton Primary Care Network-led Community Virtual Ward

Sutton PCN continued to develop their community virtual ward during April, May and June 2022 which was established in the previous year and provides care and support to the most vulnerable unwell patients and families in their own homes.

Led by Sutton Primary Care Networks in partnership with Epsom and St Helier, and Sutton Health and Care, the aim of the virtual ward is to reduce unnecessary hospital admissions and length of stay.

Building on last year, we have increased capacity from 100 to 200 'virtual beds' and length of stay in hospital has dropped by an average of two to three days, which has helped ease the pressure on acute beds at Epsom and St Helier Hospitals during a very busy time.

Patients admitted to the virtual ward are supported by multi-disciplinary teams of specialists including GPs, hospital consultants, advanced nurse practitioners paramedics, social prescribers, pharmacists, social care professionals and co-ordinators.

A care plan has been put in place and patients' care is co-ordinated by "virtual ward rounds" which happen three-times a week. Patients' records are updated immediately after each ward round and are available to all the professionals involved in their care. On average, a patients' stay on the ward is between 5 and 7 days but can be longer if necessary.

In June 2022, Sutton's community virtual ward was shortlisted for a Patient Safety Award which recognises the hard-working teams and people who are striving to deliver improved patient care. The awards are organised by the Health Service Journal (HSJ) and the community virtual ward team is in the running to win the virtual or remote care initiative of the year. The award winners will be announced on 15 September 2022.

Clinical pharmacists in Wandsworth

Clinical pharmacists have continued to play a growing role in the care GP practices offers their patients.

As well as detailed reviews of medication, they have been talking to people about their overall health and welfare and advising 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.

A recent patient satisfaction survey found that 100% of the people surveyed were happy to be consulted again by the clinical pharmacist. During April, May and June 2022, the clinical pharmacy team continued to develop the scope of their work by taking part in the South West London lipid optimisation project to help improve the outcomes of patients with cardiovascular disease (CVD) and prescribing medications for ADHD.

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, and offered 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 Trust, Wandsworth GP Federation and out-of-hours provider SELDOC.

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. During April, May and June 2022, we worked with local people to plan two engagement sessions during July 2022. The engagement sessions aimed to find out local people's perception of how the Hub was working and to canvas possible names for the facility.

1.3.2 Service recovery and improving access following Covid-19

Reducing Long Waits in South West London

Normal health services continue to recover from the severe disruption caused during the Covid-19 pandemic as a result of 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 meant that in April 2022, there were still a large number of patients waiting to be seen and treated in our hospitals. But by June the vast majority had had their operations.

Locally, our four acute hospitals – St George's, Epsom and St Helier, Kingston and Croydon Health Services – continued to build on their partnership working to reduce the number of people waiting for procedures.

This work, which is led by our clinical networks of GPs, hospital doctors and nurses, includes giving people the option to choose another site further from their home for surgery if this would be mean they could be treated more quickly.

At Epsom Hospital, regional hubs provided eye care and orthopaedic treatments such as hip and knee surgery. This means that patients needing simple surgery such as cataract and knee replacement, can be seen quicker and discharged home, in most cases on the same day, resulting in a better patient experience.

South West London Elective Orthopaedic Centre – known as SWLEOC – continued to maintain expanded operating theatre capacity, 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 the end of June 2022, South West London had reduced the number of people waiting 78 and 104 weeks but recognize that there was more to do to reduce the number waiting 52 weeks.

All organisations in South West London continue to focus on the reduction of waiting lists and the treatment of people in a timely way.

Improving collaboration across South West London hospitals

South West London has six elective surgery hubs, which work together to reduce waiting times and share expertise. The success of this way of working is demonstrated in our data where only 20% of our waiting list for High Volume low complexity procedures, such as knee and cataract surgery has been waiting over 52 weeks.

These hubs offer mutual aid through all specialties to neighboring systems as well as those further afield, including Devon. We are now building on this success to deliver medium complexity day surgery and increase case mix the types of treatments we can deliver through these hubs.

South West London has an operating theatre productivity group, and with the system now achieving 110% of pre-covid activity we have been able to achieve an increase in the number of operations we can deliver by working in this way. In particular, Kingston Hospital has been praised as an exemplar by the national programme ‘Getting It Right First Time’ for the number of operations they are able to deliver in their operating theaters.

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’ increases our testing capacity to help manage the backlog created by the pandemic.

We have started a digital diagnostics programme aimed at modernising diagnostic capability across South West London. This has started with a shared Photo Archive and Radiology reporting system, which means that a patient’s images can travel with them and can be seen by their clinicians wherever they are in the system.

A second pilot project to create Clinical Decision Support capability in the Kingston system is underway using cloud based technology to enable clinicians to access support regardless of which service they are working in.

1.3.3 Improving access to cancer services

The number of people seen for an urgent referral for suspected cancer during 2022 so far has been higher than pre-pandemic levels. In May 2022, there were approximately 21% more

cancer referrals than May 2019. We continued to encourage people to come forward with possible cancer symptoms and to attend cancer screening to support earlier diagnosis and more effective treatment if cancer is found. However, there continued to be a backlog of people who were waiting for diagnostics and treatment and all providers have plans in place to ensure waiting times are minimised.

Throughout the pandemic, we have strived to maintain high quality and timely access to cancer services and to recover services back to their pre-pandemic levels. Despite the challenges during the pandemic, South Wwest London continues to provide good and resilient access to cancer services when compared with other regions.

This included ensuring that as many people as possible are treated within 62 days of GP referral. In May 2022, we delivered 78.4% against the 85% standard. Our focus continues to be returning to pre-pandemic rates of access to treatment, whilst also meeting the increased number of referrals.

During 2022/23 we will also focus on achieving the new 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. In May 2022, we delivered 72.2% against the 75% standard. The majority of Trusts are meeting this standard and there is further work to address variation between providers. We have also focused on making sure people waited no more than 31 days between the meeting with their doctor at which a treatment plan is agreed and the start of treatment. In May 2022, we delivered 94.4% against the 96% standard.

Read more about our performance in 1.4.5 – Assuring performance and delivery of constitutional standards.

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

All of our services worked hard to provide a high standard of care to people in south west London amidst sustained pressure across all urgent and emergency care services. We have continued to support improvements in services to benefit both patients and our workforce with a focus on getting people to the right care as quickly as possible. During April, May and June 2022, these have included:

- The expansion of the Urgent Care Response services which provided help to patients within 2 hours such as those who have fallen, end of life needs and reduced mobility, keeping them at home where possible.
- Implementation of the new 111 service at the end of May 2022 using the London Ambulance Service as a resilience partner to improve the response to patients.
- Increasing Same Day Emergency Care provision so more people can be treated quickly, avoiding an admission and avoiding the need to wait in A&E.
- Increased direct access so ambulance services and 111 can refer patients straight to services such as Same Day Emergency Care without going through A&E.

- Expansion of Virtual Wards enabling more people to stay at home and to be discharged from hospital sooner.
- Putting in place a range of measures to reduce the time patients wait in ambulances outside hospitals before going to A&E, and for those waiting for an ambulance in the community.
- Implementing a targeted communication campaign to raise awareness of what community pharmacies can do for residents encouraging people to use those services to access faster care closer to home.
- Working closely with our mental health partners to improve the experience of people in crisis coming to A&E and to support the development of alternative services such as the Mental Health Joint Response Car where a paramedic and mental health nurse respond to patients in crisis.

1.3.5 Making mental health services more responsive

We know people's mental health and emotional wellbeing continues to be impacted by the pandemic. Across all mental health services, demand continued to rise during April, May and June along with the complexity of people seeking support. This is a similar pattern as seen across the country.

During these three months we have worked hard to analyse key population and service data to develop our new all-age mental health strategy. We then used this data to produce an engagement survey and activities for over the summer. We have been seeking feedback from residents and service users on experiences of using mental health services. This feedback from local people will support us in developing our new strategy in the autumn.

We continued to deliver training to secondary schools aimed at preventing suicides in children and young people. Recognising the role our school pastoral staff have, we commissioned a training course to support pastoral staff's day-to-day interactions with young people at risk of self-harm or suicide. We continued to work closely with our Local Authority Public Health Leads to support local interventions and projects aimed at reducing suicides in middle-aged men, such as through 'Men's Sheds' in each borough where men can socialise and take part in activities while, at the same time, receive information and support for mental wellbeing.

We continued to support the South London Listens – a 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 we heard from our local communities. The plan sets out how we will deliver across four priority areas:

- Loneliness, social isolation and digital exclusion
- Work and wages
- Children, young people and parental mental health
- Access to services

More information about programme is available at www.southlondonlistens.org

Mobilising our new Maternal Mental Health Service

In 2021/22 we worked with our Mental Health Trusts and acute hospital maternity partners to develop new Maternal Mental Health Services which will sit alongside Perinatal Mental Health Services to support birthing for people who have complex mental health needs, such as due to a previous traumatic birth or a history of trauma. We began recruitment to staff roles for this service in April with new psychology roles at both mental health trusts, and the development of new joint midwifery roles, to be hosted by Kingston Hospital and Croydon Hospital. The teams are expected to begin service delivery later in 2022.

1.3.6 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.

Improving services for Children and Young People in Kingston and Richmond

Since the start of the Covid-19 pandemic health and care partners from across Kingston and Richmond have worked together to both maintain services during the pandemic and to respond to the increased mental health and emotional wellbeing needs of children and young people that had had not previously been forecast. We have worked with providers, families, and young people to make sure services provided are meeting the needs of those who use them. One of the early changes made was providers delivering services to families, children and young people online over video and phone to deliver training, assessments, and services as we came out of the pandemic. We are now providing a blended offer of online and face to face services, improving access.

In response to other health services being impacted by the pandemic, in Kingston and Richmond we invested additional funding to reduce the wait times for assessments for children and young people's services and encouraged providers to be flexible and creative in meeting the needs of service users.

A new Positive Behaviour Support Service for Children and Young People with Learning Disabilities was commissioned using mental health transformation funding after a gap in provision was identified.

We have also introduced a pilot Emotional Health and Wellbeing Hub, which offers children and young people early support to identify and manage emotional wellbeing to avoid escalating into acute need.

Feedback from and engagement with service users and their families have helped us to develop new ways of working and redesign systems to remove barriers to accessing services. We have introduced new protocols across health teams and have established regular meetings to better understand how to support children and young people and families. We have also developed

transitional pathways between children and young people's services and adult services to make sure that adult services are engaged in the process and care sooner.

The voice of the child is heard and evidenced routinely in a range of ways, including contributing to assessments, impartial advocacy advice, influencing service specifications and regular representation at board level.

1.3.7 Preventing the causes of ill health

Expert patients taking control of cardiovascular disease in Croydon

There is a critical need to improve the early identification and proactive management support of long term conditions amongst minority ethnic communities and people in deprived areas in Croydon. This is reflected in poor outcomes for people with cardiovascular disease and long term respiratory conditions in Croydon.

To address these health inequalities Asian Resource Centre for Croydon, working with Croydon BME Forum, have been commissioned by the CCG since September 2020 to deliver a long term conditions community outreach programme and to run an Expert Patient Programme to help people manage their condition better. The aims of this service include:

- Supporting raising grass roots awareness of risk factors that contribute to developing long term conditions and the importance of screening, early identification and self-management in key Croydon communities.
- Empowering patients to feel more confident in managing their own condition and keeping them active and engaged in their lives.
- Tackling health inequalities and increasing the uptake from hard-to-reach groups.

The Expert Patients Programme is promoted at Health Check events throughout the borough and specific long term conditions awareness events and campaigns targeted at communities identified as being at higher risk of developing illness.

The Expert Patients Programme is predominantly promoted to patients with hypertension, diabetes and respiratory chronic conditions, three of the six clinical priorities for reducing inequalities in South West London. An adapted Patient Activation Measures survey is taken before and after the course to show the difference in people's confidence to self-manage their health condition. Results from the surveys show that people who take part in the Expert Patients Programme report significantly increased confidence in self-managing their condition and looking after themselves. The outcome data also demonstrates that over 90% of people complete a practical action plan to address their underlying issues.

Using Population Health Management to boost social prescribing in Richmond

A new Social Prescribing Wellbeing Coordinator role has been established within the Hampton Primary Care Network (PCN) to reduce health inequalities and improve health and wellbeing in the most deprived communities in Richmond.

As part of the national Complee Care Community Programme, we used local Population Health Management tool HealthInsights to identify pockets of deprivation that are masked by PCN level data. By identifying those neighbourhoods where access to services and health outcomes are lowest, we have been able to develop a plan to improve support, outreach to and engagement with those communities and to improve referral to health and care services, and deployed outcomes tools to make sure we can continually assess whether our plan is working or not.

Working with the communities, our plan focusses on long term conditions and using social prescribing to support people and to address wider determinants of poor health and to help deal with the increasing number of mental health patients and consultations primary care are dealing with since the start of the Covid-19 pandemic.

A Social Prescribing Wellbeing Co-ordinator is focused on this population group, with dedicated time for community outreach work. They also link in with existing established community and voluntary sector organisations, making the most of existing trusted links into the community.

The clinically lead programme links in with existing health and care initiatives like Core20Plus5 to make the most of existing funding and support structures.

Plans are now in place for specialised personalised care roles to work with specific cohorts, and to explore funding and support opportunities and grants to further develop the service. Further Population Health Management insight work is also being carried out to identify areas that need more support and to make sure resources are being used effectively and efficiently to reduce health inequalities in Richmond and across South West London.

1.3.8 Improving care and outcomes for people with long term health conditions

The impact of the Covid-19 pandemic continues to be felt for people with long term health conditions. Access to and uptake of health checks, regular diagnostics and annual review appointments have been 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 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. We estimate that 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 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.

A South West London Virtual Pulmonary Rehabilitation Service

Pulmonary rehabilitation offers a structured exercise and education programme for people with lung disease, supporting improved exercise capacity and increased quality of life. The Covid-19 pandemic caused disruption to pulmonary rehabilitation services across South West London.

Funding provided by NHS England and Improvement is supporting a collaborative approach improving access and increasing flexibility for service users. Using a digital platform, the pulmonary rehabilitation team at St George's Hospital are delivering a remote virtual pulmonary rehabilitation service on behalf all providers across our six boroughs. This allows service users to benefit from a standardised approach to virtual pulmonary rehabilitation, the St George's Hospital team to develop expertise in virtual delivery, and the other providers space to focus on the traditional face to face delivery of the education programme. It also offers patients improved access through classes in evenings and weekends.

The service started in April 2022 and to date 73 patients have benefited from the service, which is being evaluated to assess the impact on people and staff involved in the project.

The work illustrates how technology and new ways of working is helping clinicians learn from the pandemic and how care is improved by working in partnership.

Blood pressure monitoring at home

For people with a diagnosis of hypertension, good blood pressure control is important to reduce the risk of complications heart attack and stroke. Following the Covid-19 pandemic, approximately 22%, or 37,400 fewer patients with hypertension in South West London have had a recorded blood pressure reading within their target range compared to before the pandemic. Patients have been able to benefit from a national NHS England and Improvement initiative, providing GP Practices with blood pressure devices, that can be allocated to patients who would benefit from greater monitoring of their blood pressure. To date, over 1,150 blood pressure monitors have been distributed to GP Practices, with nearly 1,600 patients submitting readings back to their Practice, enabling medication and lifestyle advice to be adjusted to enable improved control of their blood pressure.

This project illustrates to importance of self-management in living with long term conditions.

Access to a Cardiovascular Disease Decathlon Programme – a healthy lifestyle programme

The Decathlon programme was established in South West London in 2018 by the NHS, voluntary sector, and digital innovator partners working together as a prevention programme that uses peer support, community engagement, and behavioural change techniques (including incentivisation) to deliver better health and improved activation for people at risk from long term conditions in South West London.

The programme is a 10 week course (delivered in-person or online) that combines structured education with physical activity sessions. Participants work in teams throughout the programme facilitating peer support, and are incentivised to increase their activity via SweatCoin, which offers content and motivation between sessions. The programme was codesigned by local people with support from Wandsworth Community Empowerment Network.

To date, Decathlon has focussed on people at risk of type 2 diabetes and has delivered 92% completion rates, increased activity, and 2kg average weight loss for participants. Decathlon has shown it resonates with participants from a range of cultures and ethnicities and achieves equality of access and outcome across all population characteristics. This programme is now being extended to people at risk of developing cardiovascular disease.

National-first Personalised Digital Self-Management Support

Our ambition is to develop a national-first system-wide digital self-management solution that educates and empower patients to self-manage their conditions. This support is available across all care settings and is being personalised to support to people with multiple conditions and to improve their general health and wellness.

We have commissioned a single digital self-management solution and is building the digital infrastructure across care settings, enabling our clinical networks to co-produce and quickly implement additional, new clinical modules.

The South West London digital self-management service is an application that:

- Educates and empowers patients to self-manage.
- Is personalised and provides tailored content responsive to changes in patients' conditions.
- Provides evidence-based safety-netting and signposts of patients with red flag, urgent or deteriorating symptoms requiring clinical assessment.
- Is locally configured to integrate with existing pathways, services, and resources and to support patients along the entire patient pathway.
- Is available across all patient touch points and silos of care. For example. self-referral, community pharmacy, acute, A&E, and working with local authority to increase adoption.
- Supports general health & wellbeing; signposts to public health and NHS offerings like smoking cessation, social prescribing, IAPT and weight management.
- Embedded with behavioural science.

- Delivers a reduction in prescriptions and referrals to clinical services.
- Is a national digital exemplar project and a national digital exclusion pioneer project.

The South West London digital self-management app is now available to all GP practices in South West London to support patients with common musculoskeletal issues. More than 16,000 patients have received access and over 8,000 patients are active users.

Daniel, a user of the app said “I was very impressed with the efficiency and clarity of the system. My programme was clear and concise and the app was very user friendly. The fact that I didn’t have to travel to a face to face appointment gave me the flexibility to incorporate my rehab into my daily life.”

We are currently working with local authority, public health and pharmacy colleagues to expand access and adoption. Our clinical networks are currently coproducing clinical modules to support:

- Pelvic health issues.
- Hypertension and high cholesterol.
- Patients waiting for an acute appointment or for surgery and to support them post-surgery.
- Patients that feel tired.

We also have plans to develop modules to support patients with asthma, COPD, gastro and chronic pain.

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

The South West London Local Maternity and Neonatal System has made good progress during April, May and June 2022:

- We increased ‘Continuity of Carer’ models across South West London , with a focus on supporting those groups of people who have the poorest outcomes.
- We have continued the ongoing development and implementation of the ‘Maternal Medicine Network’ to provide support for women and birthing people with complex health conditions.
- We progressed on the development of an infant feeding strategy including formal development of a tongue-tie service/pathway, which we are expecting to finalise later in the year.
- We have had assurance on the national Ockenden recommendations for maternity services with all but one of our trust’s completing their regional site visits at the time of writing.
- We have supported our South West London trusts to ensure that staff are able to access apprenticeship opportunities to increase midwifery workforce, with a focus on Maternity Support Workers who will qualify as midwives following completion of their 3-year degree.

- We have recruited a ‘midwifery student expansion lead’ to support increasing the South West London maternity workforce using funds from a Health Education England.
- We have also recruited an engagement lead for maternity services at ICS level to increase engagement with seldom heard communities. It is so important that we understand how best to engage these groups so we can empower them and help them make informed choices.

1.3.10 Care for vulnerable people and at the end of life

Working with care homes continues 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. Progress during April, May and June 2022 has included:

Ageing Well and End of Life Care programmes

The Ageing Well and Palliative and End of Life Care activities across South West London supported caring for people at the end of life, including programmes across Care Homes, community services and Anticipatory Care. During April, May and June 2022, work progressed in the following areas:

Palliative and End of Life Care

Palliative and End of Life Care is a priority within the ICS, and a collaborative network was set up for providers across south west London so that they could come together to share best practice and enable shared learning. We worked through innovations across South West London and at Place, which aimed to create a integrated working across services to support people, and those close to them, at the end of life.

In May 2022, we finalised the bereavement services engagement project, where we, together with Kingston Voluntary Action and Healthwatch Kingston, developed and piloted a model to enable engagement across the community for bereavement services. This project was funded by NHS England through their ‘Getting to Outstanding’ programme and the model is due to be rolled out across the system this year.

The care planning system that used to be in place was replaced with a new system, the Urgent Care Plan, this digital application will go live at the end of July 2022 and will mean an opportunity for Advance Care Planning to be even more integrated across health and care providers.

To improve identification of those people at the end of their life, we have rolled out the ‘Early Identification Toolkit’. This tool can be run by GPs to identify who within their patient population may be considered appropriate for advance care planning conversations and decisions.

Enhanced Health in Care Homes

We continued to work with a range of organisations, including the care homes on the provision of services provided in 2021/22, reviewing the performance of these services and ensuring that they continued to be fit for purpose.

Our multidisciplinary meetings continued to focus on the wellbeing of care home residents, with the provision of a proactive and preventative approach to support partnership emphasis to clinical governance and decision making. Emphasis was based on building internal and external sustainable relationships, with varying expertise and resources to provide the varying needs of the care home population.

We continued to expand the provision of community services for care homes especially in the area of End-of-Life care. This service supported care home staff in becoming more confident and competent in in having difficult conversations with residents and their families and in the completion and maintenance of Advanced Care Plans. Additionally, care homes were supported to adopt the new London Urgent Care plan, enabling read/write access for care homes.

SWL ICB continued to work with the Health Information Network to embed into practice, the deterioration tool – RESTORE2 in care homes to support the ambition of the NHS patient strategy.

We have also implemented the ‘Making a Difference’ alerts tool, which supported care homes in flagging concerns about care provided to residents from other providers and responding to concerns which have been raised around the care provided by the home. This was put in place to improve patient care and safety and avoid escalation of issues.

1.4 Engaging people and communities

We will only know if our services are meeting the real needs of our citizens and communities by speaking to the people who use them and their families. Most importantly, we know we need to work hard to hear from those with poor health, understanding the context of people's lives, their social histories and how we can work with them to improve their health and wellbeing.

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.

Examples of the role and impact of engagement in specific programmes and projects are given throughout this annual report.

1.4.1 Governance and assurance

We had several mechanisms to support good practice engagement across our work and provide assurance that we are meeting our legal duties.

At a SWL level:

We replaced our previous Community Engagement Steering Group, to provide continued assurance that we have met our duty to involve and are in the process of establishing a People and Communities Engagement Steering Group. This group will receive reports from Place and SWL – evidencing engagement work. It will be responsible for reviewing engagement plans and activities and upholding the 10 principles for working with people and communities, and will meet on a quarterly basis.

Patient and public voice in governance

To support patient and community voice at a strategic level we had both Healthwatch and voluntary sector representation on the Programme Board, Primary Care Commissioning Committee and Governing Body. These representatives were supported by pre-meets to go through papers and offered debrief meetings where needed. Moving forward we will be inviting Healthwatch and the VCSE sector to have full seats on our ICP and be observers on our ICB – in addition to other relevant sub-committees.

South West London PPE Network

We also supported 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 SWL 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 the pandemic have influenced how we work moving forwards. From April – June 2022 the group focused on developing companion documents to support the implementation of the People and Communities Engagement Strategy. These included:

- People and communities charter – what our engagement strategy means for local people
- Guide to having your say in the SWL ICS – web content explaining how people can get involved at SWL and place levels
- Evaluation framework – a consistent approach to how we evaluate engagement work
- Valuing voices - remuneration policy - to set a consistent approach to remunerating people for taking part in engagement activities
- Toolkit and resources to support staff to engage with local people and communities

From July we will be working with colleagues in Quality to establish and patient engagement and experience panel which will include patient experience colleagues from our provider and community trusts. Its focus will be on collectively improving patient experience and outcomes across the system.

1.4.2 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:

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

1.4.3 How we enable and support people to get involved

We know there are unjustifiable differences in outcomes for people who experience health inequalities. Our Core20plus5 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.

We have developed multiple ways to ensure that local people and communities have a voice and are heard. Our work has focused on 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 continued to be an essential and valued element of our engagement approach. Not only did they provide critical friend challenge and expert advice, guiding our engagement work, but they also championed the voice of local people and communities on key strategic groups such as our Governing Body and Programme Board. Their own insight work provided us with additional sources of data to help ensure that our work is informed by the needs and aspirations of local people. They have been uniquely placed to ensure that this insight is followed up with decision makers – holding us to account.

In recognition that moving to an ICS will require greater participation from our local Healthwatch organisations, and that their focus is rightly on place, we have agreed to fund 2 dedicated SWL Healthwatch posts – and executive officer and a non-executive director. These posts will be hosted by a local Healthwatch organisation and will support our local Healthwatch organisations to collaborate at a system level – including participation in ICS decision making groups and committees. Procurement has commenced and we anticipate that a host organisation will be in place from July – ready to recruit to these roles.

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.
- **Community champions, core20connectors 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 to build trust and confidence within our diverse communities. We have also received funding to establish a network of core20connectors who will work with local populations experiencing health inequalities to improve their health and wellbeing and act as a link between the community and our system.
- **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 several 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 concluded several 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.

1.4.4 South West London led work – examples of impact

During April, May and June 2022 we have supported SWL led engagement activities. Often these are centrally coordinated and locally delivered. Over this period, they fall into 4 main categories:

Insight to inform service redesign or pathway change

Neurological services: stroke rehabilitation services

A focus groups was held in May 2022 with 13 service users and carers attending. The aim was to explore experiences of rehabilitation services in the community following inpatient hospital treatment following stroke.

A full transcript was made of the session and shared with the clinical team. Key findings were:

- All participants recounted positive experiences in the services received and the contribution to their recovery.
- Services are tailored to individual need and not limited in terms of timespan or sessions available.
- Different services (eg physiotherapy and speech and language services tend to work well together to treat the patient holistically
- The way services were provided – primarily staff attitude - also supported the mental wellbeing of both patients and their carers
- Patients felt able to, and encouraged to, continue with exercises on their own due to regular prompting and checks ins from services.
- Some issues were raised re quality of care provided by agencies commissioned to deliver care/support following hospital discharge
- Communication issues were identified between disparate services involved in discharge and provision of rehabilitation.
- Limitations were identified in terms of services to support patients and carers where the prognosis was less positive – ie those needing long-term care who were unable to regain independence

The clinical network is continuing to review the service, with further conversations taking place via voluntary sector organisation Bridges Self Management and the Neuro Voices patient group. However, clinical leads have said:

“We noted that a primary issue raised within the session was the poor communication between different services, and that patients were often responsible for ensuring that information had been processed. We have begun to have conversations with different services to explore this problem further. Though this will not be a quick fix, we now recognise this as a major priority for patients.”

Gynaecological services: Pelvic health app

We held a focus group session in May 2022 to explore women’s experiences with pelvic health during and following pregnancy, with the aim of supporting the development of an app that would support women to maintain pelvic health.

Seven women joined the discussion, and one shared their views via a one-to-one phone interview. A full transcript of the conversations was shared with the clinical team. The summary findings were:

- All participants supported the idea of the app – expressed that it was a great idea and would support women before and after pregnancy journey
- The app should be promoted during and after pregnancy – everyone spoken to was unaware of pelvic floor exercises, eg. what to do, when to do them, correct way of doing them. The app could be promoted through GPs/Midwifes/Health Visitors
- The app should be personalised or cover different types of pregnancy and birth, eg. multiple, assisted birth, C-section and show different information for each area.
- Considerations for the app:
    - Reminders of when to do the exercises - push notifications - building in "squeezy app"
    - Community wall - a forum for mums to get together to share their experiences and build friendships
    - App to acknowledge Mental Health - signposting/text about where to find support.
    - App could share ideas of support groups e.g. face to face in your boroughs
    - App could include other areas of exercise e.g. tummy muscles

The clinical team fed back to the participants and will be taking the following action:

- Working with maternity to ask for the pelvic floor app to be recommended at the first midwife ‘booking appointment.’
- Developing the app to include daily push notification as a reminder for users.
- Tailoring the app to the service user so that it is responsive to the person using it.
- Exploring if there are any community forums that the app could signpost the user to.

Insight to inform behaviour change campaigns

Insight to inform the messaging in our summer pharmacy campaign

In May 2022, we ran a survey to help refresh and refine our pharmacy campaign aimed to encourage working aged adults and parents of under 5s to view their local pharmacy as a first port-of-call for minor health concerns.

The survey launched on Wednesday 18th May 2022 and closed on Monday 30 May 2022. The survey was shared with the South West London People's Panel, Community Networks and on organic social media e.g., Facebook, Next-door and Twitter. The survey was completed by 999 respondents; the majority met the target audience of working aged adults. As a result of the insight, our Pharmacy campaign was amended to include "summer" messaging, highlighting the services available at pharmacies such as travel vaccinations and the qualifications pharmacists have to help encourage people to visit a pharmacy as the first port-of-call.

Health checks for people with Serious Mental Illness

People with chronic mental illness are invited to attend regular health checks of their physical health yet take up had been low. A survey was developed to ask people about their experiences of health checks to understand whether people felt they benefited from attending, and to explore why people had not attended.

The survey went live in March 2022 and remains open until August 2022. Regular reports are provided to the Mental Health clinical team.

As of 13 July 2022, 175 people had completed the survey. Key findings include:

- Over 80% were aware of health checks for people with serious mental illness, and over 90% had attended a health check within the previous two years.
- Around 50% learned about health checks via a mental health charity or peer support group, with 30% finding out via their GP or Care Coordinator.
- Respondents' experiences of health checks have mostly been positive. However notable numbers of respondents expressed that had felt uncomfortable during the health check, and that they didn't feel the purpose of the health check was explained clearly.
- There were variations in what was checked/discussed during the health check. Some practices appear to focus on the required elements, while some take a broader approach to discussing wellbeing.
- Over 60% of respondents said the health check had helped them think about/improve their physical wellbeing, 40% said it had helped their mental wellbeing and 6% said it made no difference.
- Over 90% of respondents said the health check had prompted them to make changes to their lifestyle. The most common changes made were taking more gentle exercise, joining a gym or class and reducing smoking.
- Of the small number of respondents that haven't had a health check, the most common reasons were: didn't know they existed, it was too difficult to get an appointment, and didn't know how to book an appointment.

The clinical team is continuing to review findings and target promotion of health checks accordingly.

Insight to inform strategy development

Mental Health Strategy

The engagement team worked with mental health strategic and clinical leads to devise a survey to gather the views of people with lived experience of mental illness; ie to ensure the voices of patients were central to strategic planning of mental health services within the ICS. The survey focused on:

- Prevention and early intervention (including self-care)
- Access to support
- Maintaining mental wellbeing following a crisis.

Sections of the survey also explored the views of people that had not received mental health services.

The survey went live in June 2022 and remains open until August 2022. Regular reports are provided to mental health strategic leads to help inform the strategy.

As of 8 August 2022, 715 people had completed the survey. Key findings:

- In terms of prevention, over 80% of respondents said time with family or friends supported their mental wellbeing. The next two most common responses (both over 60%) were taking exercise, and time spent in nature.
- Similarly, when asked what helped people stay well following a crisis, over 70% said support from friends and family with the next top answers being “activities I enjoy” and “spending time in nature”
- About 66% of respondents said that if they felt they needed support with their mental health, they would first go to family/friends. 63% said they would contact an NHS service.
- When asked about difficulties people had faced trying to access help, almost 60% said waiting times to see someone were too long. Other common answers were “feelings of shame/stigma” and “I didn’t know how to explain how I was feeling”

Responses to the survey continue to be collected and discussed with clinical and strategic leads.

Health inequalities

To support the work of the Health Inequalities Board, a survey has been developed to understand the lived experiences of people within the Core20+5 areas, and other people impacted by health inequality. The main purpose of the survey was to develop metrics that could be applied to evidence whether health inequalities were reducing. It was agreed that such metrics should be built on an understand of real issues affecting people’s lives.

The survey explores wide determinants of health:

- Physical, mental and emotional wellbeing
- Access to health, care and other support services
- Financial concerns
- Housing
- Safety
- Environment and access to green spaces

To ensure the survey questions are easy to understand and likely to yield meaningful data, the survey was piloted, via community organisations, in Croydon in June 2022. The survey is due to be rolled out mid-August 2022 and to remain open until the end of November – with a mid-point review in September 2022. A conversation guide is also being prepared so that community connectors and/or community organisations can collect data with individuals or small groups who may not be able to, or prefer not to, take the survey themselves.

1.5 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.

During April, May and June 2022, we have built on our work in the following ways, , with additional activities planned for future years.

1.5.1 Governance

In preparation for the establishment of NHS South West London Integrated Care Board and Integrated Care Partnership taking on statutory duties and responsibilities on 1 July 2022, Since the 2021/22 report, the SWL CCGs have become an Integrated Care System, with an Integrated Care Board and Integrated Care Partnership Board set up since July 2022. Both boards have received updates from the SRO of Health Inequalities on progress of the HI programme. The internal governance for this programme currently is as follows:

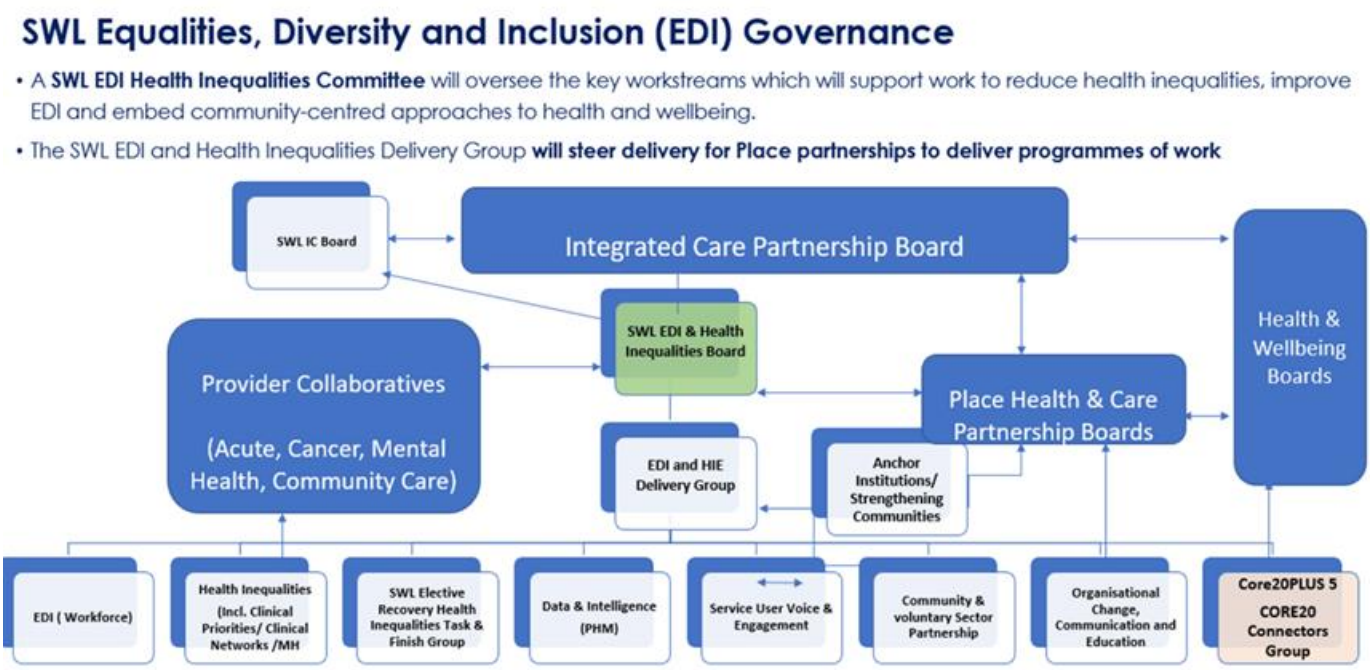


Figure 3: South West London Equalities, diversity and inclusion (EDI) governance

We have continued with the SWL Health Inequalities (HI) and Equality, Diversity & Inclusion (EDI) Delivery Group (chaired by the SRO), which reports into the SWL HI and EDI Board (Chaired by the ICB Chair). This Board reports into the ICP, which will lead on the financial governance of the HI funding and will be responsible for oversight of spend and outcomes. In addition to this, they will oversee the priorities and strategic work of the HI programme. As we have recently transitioned to an ICS, this structure may be subject to review or change.

1.5.2 Health Inequalities (HI) Programme priorities

Below is a timetable of priorities and health inequalities activities that are planned and underway (to date).

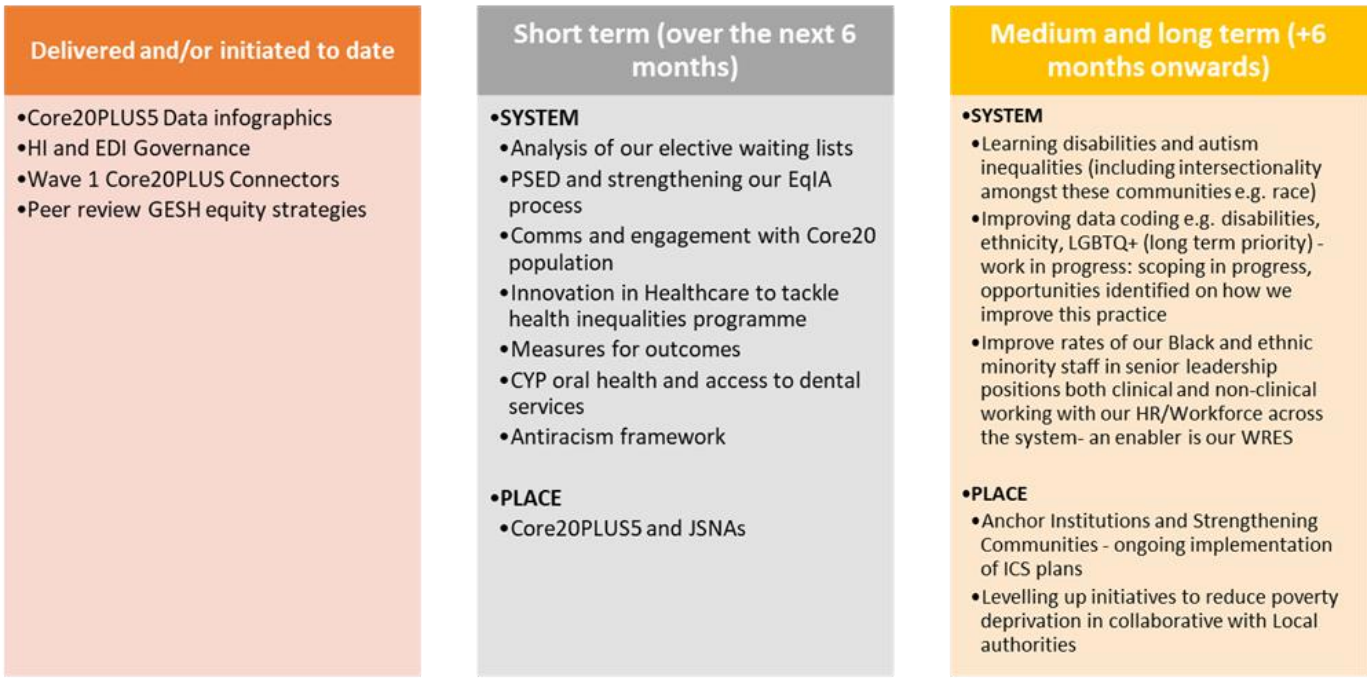


Figure 4: Timetable of priorities and health inequalities activities

Achievements to date

To date, we have developed with Core 20 Plus 5 data infographics for South West London with the BI Team. The data provides the deprivation demographics and prevalence of our population including the five clinical priorities. The data has been disaggregated at place level to provide hyper local insights into the needs of our six boroughs. The South West London infographics were presented to the ICB and ICP Boards in July, and borough level infographics have been shared and presented to place leaders including local authority public health colleagues.

South West London is part of the national Wave 1 cohort of the Core 20 Plus 5 Connectors programme, a support framework for progressing the goals of Core 20 Plus 5. The programme builds on many other community-based initiatives and experiences from other volunteer roles which support health improvement and reducing inequalities. So far, we have a voluntary and community sector delivery partner in each borough identified to implement the model, and five out of six boroughs have recruited or started recruiting connectors within the Core 20 communities. Currently, we have 25 connectors across South West London, with health events and activities taking place.

We have recently conducted a peer review on improving equity in clinical strategies for the St George's and Epsom and St Helier Group (GESH) with the aim to address any inequalities in elective activity. The peer review was completed by 12 colleagues within the ICS who are specialists in their programmes of work. The outcome of the review will feed into GESH's overall strategy. The offer has been offered to other trusts in South West London.

1.5.3 Public Sector Equality Duty

The Public Sector Equalities Duty consists of general and specific duties for public authorities to meet under the Equality Act 2010. We are committed to his duty and we continue to work hard to ensure we comply with our duties during April, May and June 2022, ensuring that all projects commissioned by NHS South West London CCG completed 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.

We have begun work to prepare for the 2022/23 report and in addition we are looking back at our compliance for 2021/22. We are also developing our Public Sector Equality Duty policy for NHS South West London ICB using relevant resources provided to us by the national team.

1.5.4 Population Health Management

Health Insights is the SWL Platform which provides Population Health Management (PHM) functionality and is also used for Quality, Performance and contracting purposes. For PHM have focused on increasing access, particularly self-service functionality to Health Insights as well as the data feeds to enable more linked data to be easily available and we have an established Working Group with this focus, as well as additional data feeds, to ensure linked data is available to enable cohort identification.

Place level activity

Sutton

Sutton place partners have developed a focus and methodology in addressing health inequalities with a strategic focus set out in their Local Health and Care Plan. They have a place governance which includes an inequalities and PHM subgroup overseeing delivery of Core20PLUS5 work plan. Sutton's approach is driven by understanding the data, engaging with our communities, aiming high, and moving fast within the context of limited resources.

Sutton Healthwatch focused on supporting the Core20PLUS areas (Roundshaw, St Helier, Central Sutton), particularly housing estates and the homeless. Working in collaboration with community Connectors on ways to maximise existing assets. Shanklin Village in Central Sutton hold a monthly coffee afternoon with residents in the community hall; and have agreed to use this resource to offer chair exercises and healthy eating advice.

Kingston

In Spring and Summer 2022, Kingston KVA supported a health event with place partners in New Malden for the Korean community. There were approx. 200 attendees, with health coaches and medica with a Korean background. The local PCN assisted with conversations around nutrition.

Wandsworth

Wandsworth Care Alliance have recruited a Core20PLUS Connector to work with grassroots group to build capacity in the local community, focusing on those with high rates of respiratory and heart diseases and more marginalised communities. They plan to have a bids process to recruit community health champions.

Croydon

Croydon Voluntary Action with Croydon BME Forum and Asian Resource Centre Croydon (ARCC) are delivery partners of the Core2PLUS Connectors programme.

Croydon Voluntary Action hosts the London Asset Based Community Development (ABCD) Training Centre and will be commissioned to deliver for the SWL Core20PLUS Connectors. With CVA, 25 refugee women from Croydon North are accessing healthcare support weekly and are engaged in peer support and preventative activity (nutrition, self-care, light exercise). ARCC have organised groups in Thornton Health, and in-Reach to Patients with Diabetes at Brigstock Practice.

Richmond

We are working with Richmond Health watch to develop a proposal for the Core20PLUS Connectors programme to see how a connector can work with other community initiatives to support the most deprived parts of Richmond, especially in areas like Ham, Heathfield and Hampton.

Merton

MertonConnected as delivery partners for the Core20PLUS Connectors programme worked with Somali Community CIC to raise awareness on vaccinations, mass testing and how to take preventative measures. Awareness was given in the Somali language by translating and handing out leaflets to hundreds of families across the borough of Merton, to show people the advantage of vaccination and other safety measures to stop the spread and reduce false propaganda and panic in the community and calibrated with Good Goal Relief our male Somali Organisation in Merton.

1.5.5 Addressing equality for CCG staff through the NHS Workforce Race Equality Standard

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 will be the start of the third year that the CCG's performance against the WRES indicators have been collected and we look here at the latest data available for this three month report. This data allows us to take action to improve against these indicators.

We have seen improvements across:

- **Recruitment**: the latest data shows that white staff are 1.2 times more likely to be appointed compared to the figure from 2019/20 of 1.8. This is a significant improvement from previous years. 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 8b and above have an inclusion champion , the use of a 'di-biasing toolkit' and our Program Director for Equality, Diversity and Inclusion sits on panels over 8d and above
- **Disciplinary Processes**: staff from ethnic minorities are now 0.1 times more likely to undergo a disciplinary process than white staff. Any figure under 1 is considered as no difference. This has seen is a significant improvement over the last two years from the previous year's date of 1.59 for 2019/20, 0.4 during 2020/21 and 0.1 for 2021/22 In the last year, we focused on resolution and working differently.
- **Percentage of staff experiencing harassment and bullying/abuse from other staff**: The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months has improved significantly from 35.5% of staff experiencing discrimination to 24.5% for ethnic minority staff and 23.4% to 17.8% for white staff.
- **Percentage of staff believing the organisation provides equal opportunities for career progression and promotion**: The 2021 staff survey shows that there has been an increase 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 from 18.4%.
- **Percentage of staff experiencing discrimination at work from managers/team leader**: This indicator has reduced from 26.1% to 17.5% of staff from ethnic minority backgrounds reporting experience 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

We have seen significant improvements on the WRES indicators there is always 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

1.5.6 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.

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 June 2022 our performance against the standard was 75.0%. This is a slight decrease on previous month's performance (of 76.6%) but reflects both seasonality and the impact of the Covid-19 Omicron variant on bed availability in hospitals and staffing levels. Our performance at the end of the financial year 2021/22 was 75.7%.

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

During this reporting period our focus has been on restoring services impacted by Covid 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 1,377 in June 2022. South West London CCG has the lowest number of patients waiting over 52 weeks and 104 weeks for treatment in London.

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.

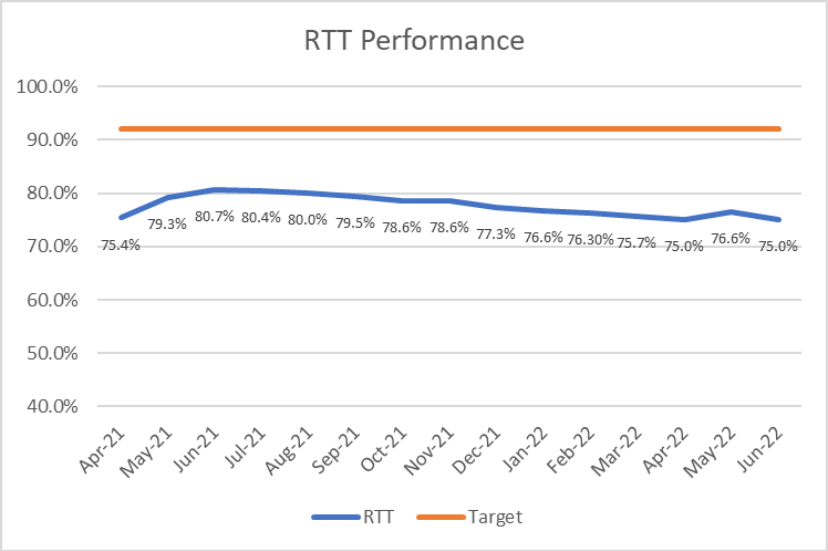


Figure 5: Referral to treatment performance

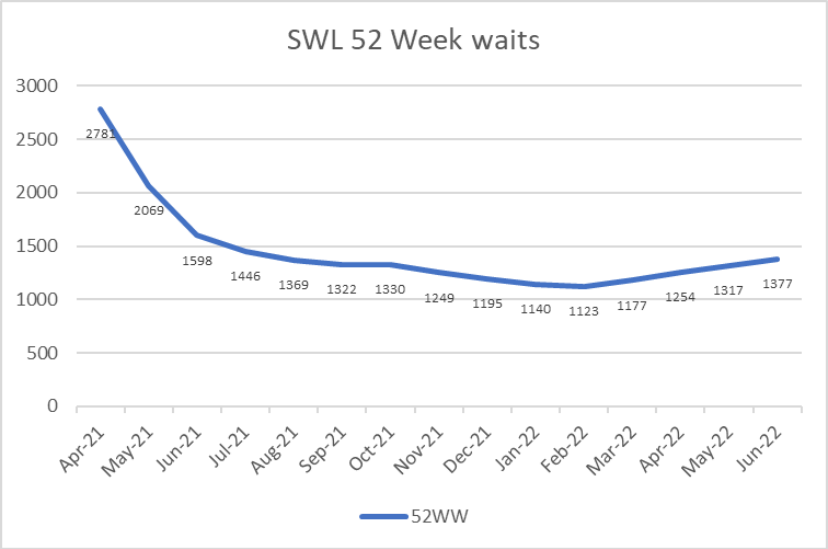


Figure 6: South west London 52 week waits

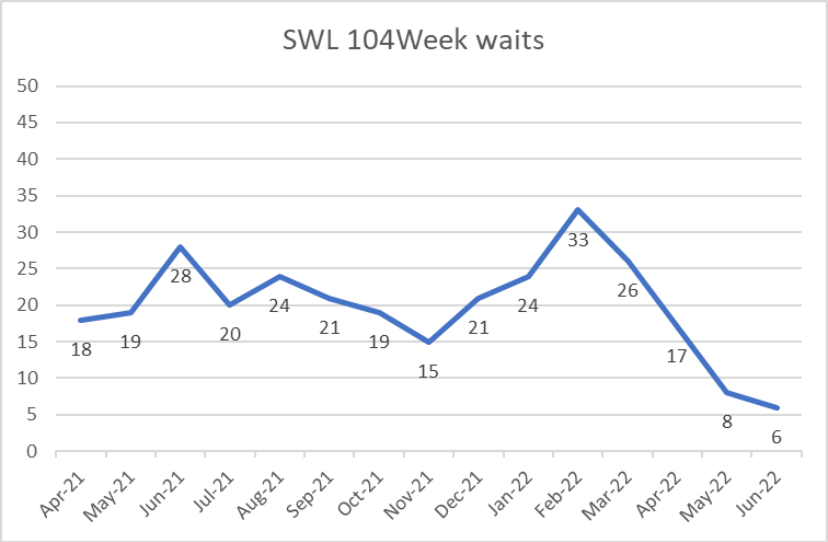


Figure 7: South west London 104 week waits

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 83.3% in June 2022. No CCG within England has achieved the 99% standard this year. Our performance was below the non-compliant London position of 85.7% but above the national performance outcome of 72.5%, and we are the fourth highest performing CCG within London for June.

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.

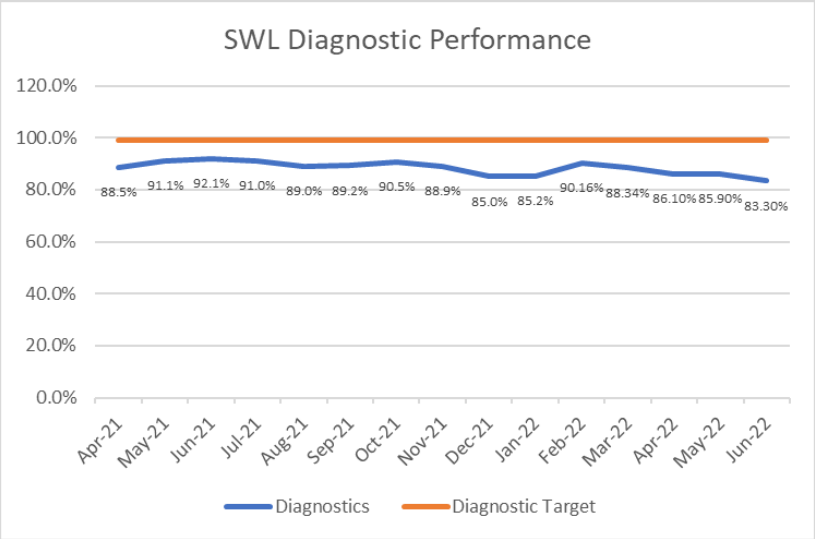


Figure 8: South west London diagnostic performance

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%. We have maintained this position into June 2022 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.

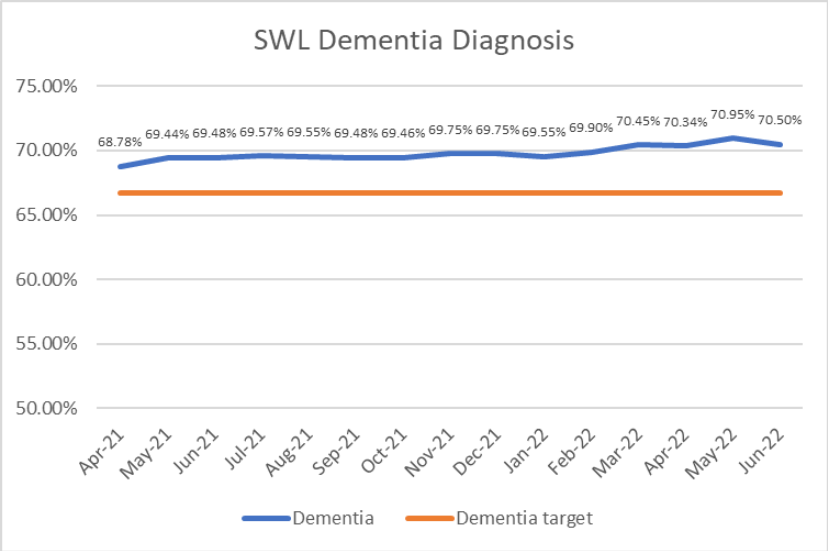


Figure 9: South west London dementia diagnosis

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:

- 95.7% of people start treatment within 6 weeks (75% standard)
- 99.8% 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. Provisional data for June 2022 shows 3,015 clients entered treatment, representing a decrease of 640 clients (18%) in comparison with the previous month and below the target trajectory of 3,300 clients per month.

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.

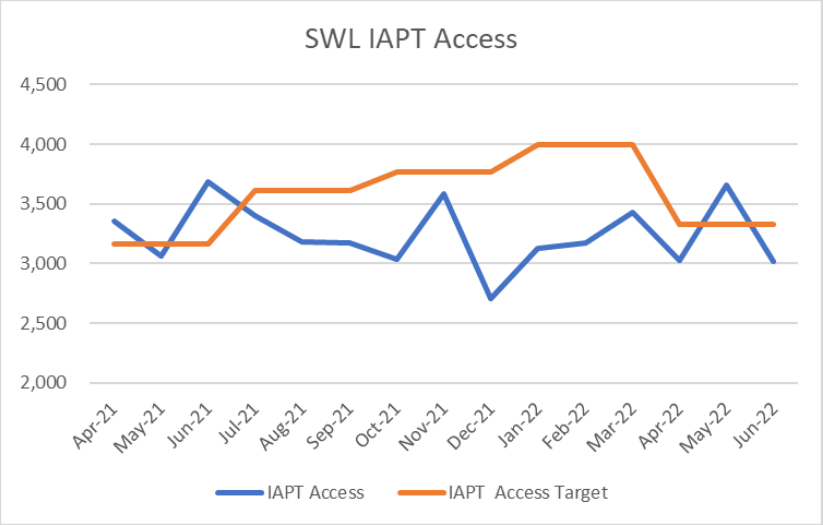


Figure 10: South west London IAPT access

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 55,937attendances in June 2022, peaking at 59,853 in June 2021.

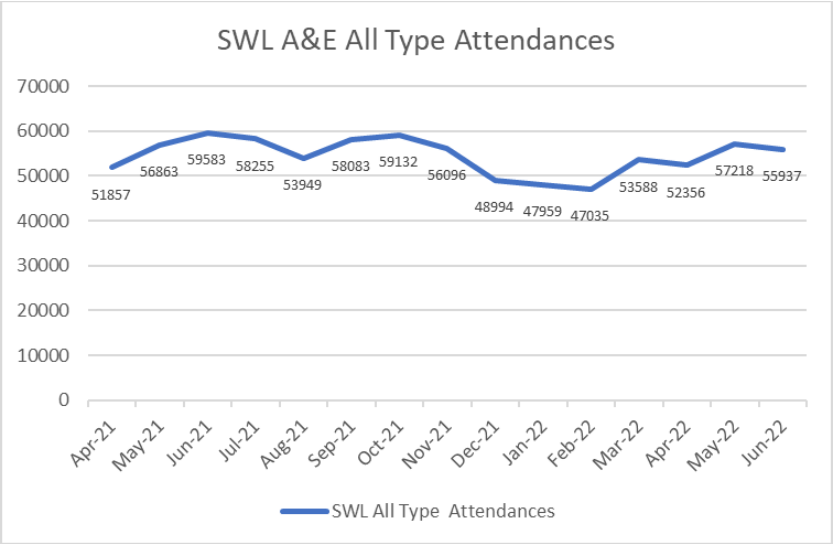


Figure 11: South west A&E all type attendees

Our performance against the 4-hour target has also decreased since April 2021, reducing from 90% in April 2021 to 74.0% in June 2022.

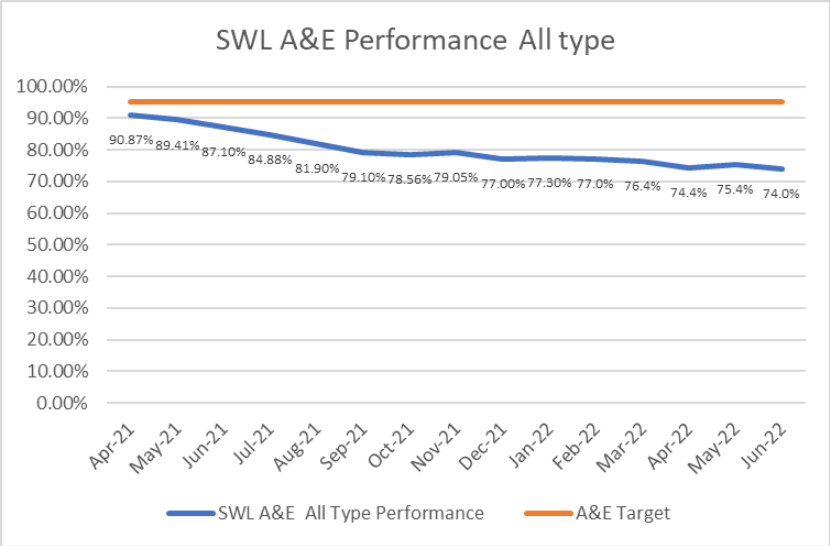


Figure 11: South west A&E performance all type

This means that 26.0% 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, with 977 patients waiting over 12 hours for admission in June 2022, up from 665 in March. This was highest number of 12-hour breaches in London and sixth highest nationally. 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.

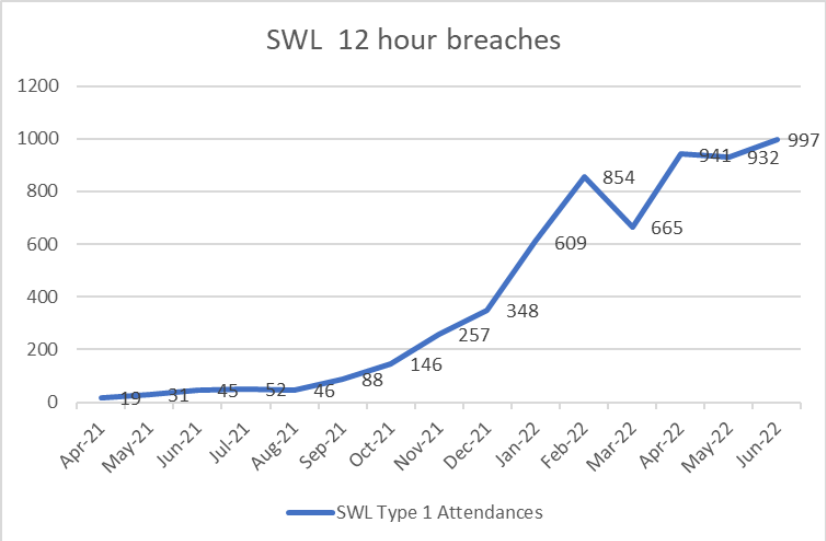


Figure 12: South west London 12 hour breaches

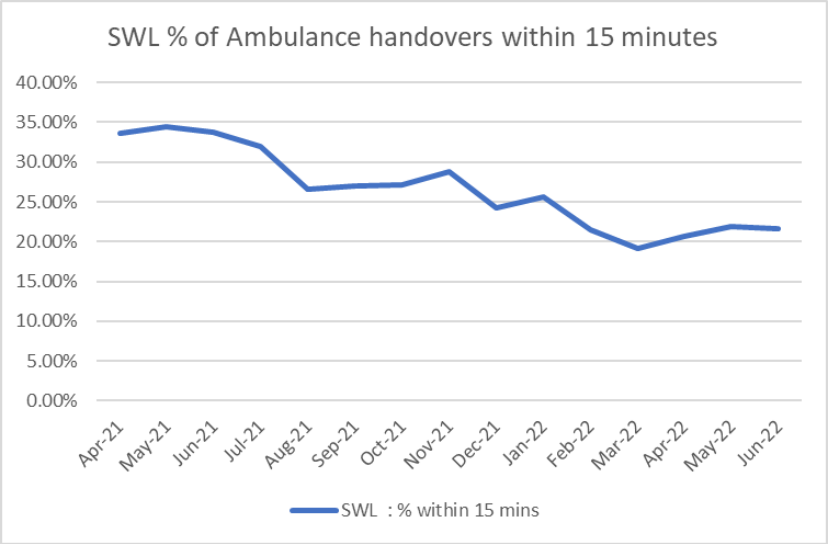


Figure 13: South west London percentage of ambulance handovers within 15 minutes

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.

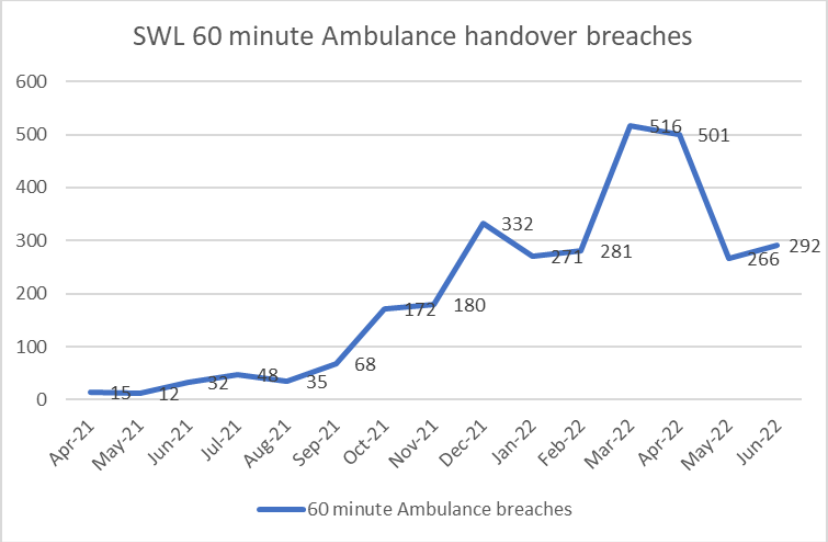


Figure 14: South west London 60 minute ambulance handover breaches

Trusts reported that complexities in multiple pathways for Covid and non-Covid patients lead to further inefficiencies, with patients grouped by covid 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.

Transforming care for people with learning disabilities

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

Based on the final NHS England data, we achieved the target of 75% for 2021/22. At the end of June 2022, the number of Annual Health Checks are ahead of previous years' activity. Clinical leads in our boroughs continue to work with individual practices to maximise the number of people with an LD who have their Annual Health Check and ensure that our rolling 12 month run rate returns to pre-Omicron levels.

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.

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.

Final data for Quarter 4 2021/22 showed that 39.0% of SMI patients (6,295 people) in South West London received all six annual health check elements. The national standard is 60% by Quarter 4. Latest data available for Quarter 1 2022/23, shows that performance improved to 40.5% in South West London, with 6,706 SMI patients having received all six annual health check elements. We established a new dedicated SMI health checks programme for 2022/23 to build on the good work in 2021/22 and continuing improvement towards the 60% national standard.

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.

Cancer waiting times

There are four cancer waiting time standards:

- 2 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

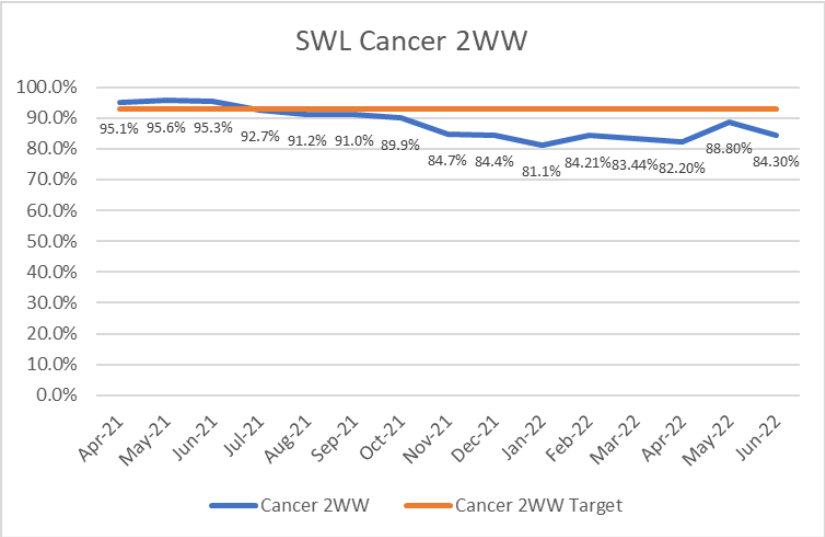


Figure 15: South west London cancer 2 week waits

We were the fourth highest performing CCG in London for 2 week waits in June 2022, with a performance outcome of 84.4%. This was slightly below the London position of 85.0% but above the National outcome of 77.7% for the month but did not meet the standard of 93%. The overall numbers of patients referred into the 2 week wait pathway in June 2022 increased by

13% compared to June 2019. This is above the London outcome, which saw a 5% increase across the same period.

Our providers have seen an 17% increase in 2 week waits referral activity in June 2022 in comparison to June 2019, the highest in London and above the London position of 7%. 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

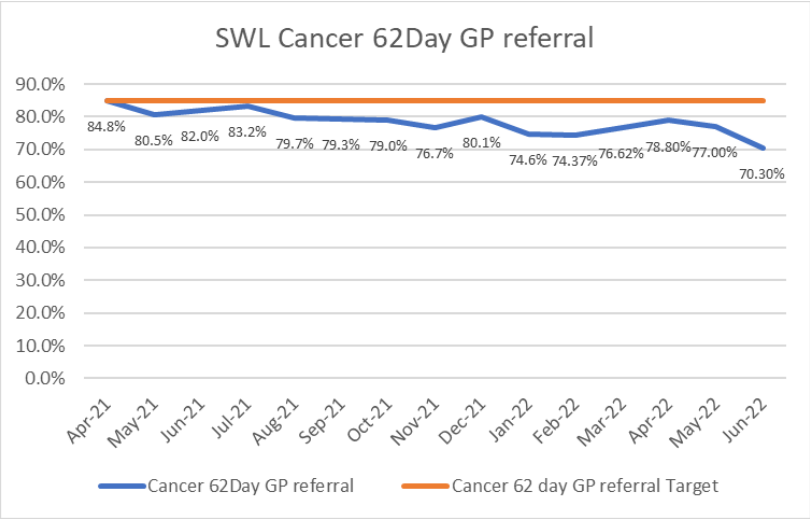


Figure 16: South west London cancer 62 day GP referral

We were the highest performing CCG in London against the 62 Day performance standard for June 2022, with an outcome of 70.3%, This was above the London (63.7%) and National CCG level performance (67.1%), 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. Performance in South West London 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 behind our trajectory for the number of patients waiting over 62 days for cancer treatment at the end of June 2022, which was 443 for the week ending 03/07/22, against the 2022/2023 Operating Plan trajectory of 427.

Faster diagnostics standard (FDS)

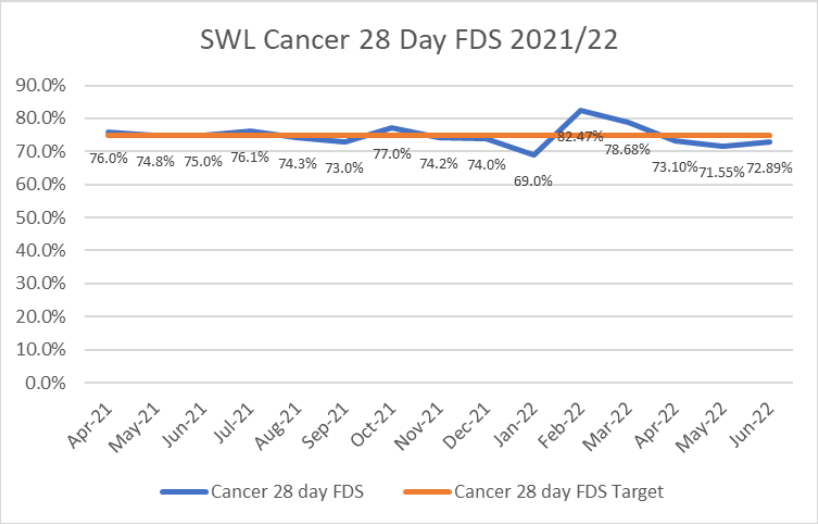


Figure 17: South west London cancer 28 day faster diagnostics standard 2021/22

This is a new standard introduced in April 2021 aims for 75% of patients to receive their result within 28 days. All CCGs were 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 June 2022 was 72.9%, which is below the target of 75%. We were the second highest performing CCG in London and exceeded both the London and national CCG level performance. Performance outcomes were above the expected target at four of the five South West London 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. Four South West London trusts were within the top 10 performing trusts in London, with one trust in the top three performing London trusts in June 2022.

Screening Services

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 achieved backlog clearance in April 2022. The South West London Breast Screening Service is utilising national funding for initiatives which include Health Promotion uptake and coverage, education and training (National Breast Education Centre), as well as administration recruitment to support backlog and return to round length recovery.

Bowel screening

The South West London Bowel Cancer Screening Service continues to meet 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. RM Partners funded extended access cervical screening continues to be available and focuses on out-of-hours extended provision to women across South West London. South West London ICS is now working with the London Regional Screening Team to support Provider Colposcopy performance sustainability.

1.5.7 Improving quality and safety

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.

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.

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, SWL 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 SWL 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 ICB during April, May and June 2022, the first quarter of the financial year 2022/23.

In this same period there were 86 serious incidents (SIs) and one never-event declared by SWL providers. The top three SI themes include: self-harm, falls and diagnostic delays. The never event related to a retained foreign object.

Priorities for 2022/23 include:

- Preparatory work and embedding of the new Patient Safety Incident Response Framework (PSIRF) across SWL.
- Strengthening system-wide shared learning as part of our Quality Management System and Quality Improvement approach.
- Themed deep dives and reviews of top recurring incident categories, supporting the production of targeted plans to address root causes.

Reducing Mortality

We continue to work with system partners to support the rollout of the Medical Examiner function to non-acute settings ahead of the statutory implementation in April 2023. We are raising awareness of the new service amongst community settings and supporting local pilot schemes via task and finish groups.

The ICS continues to support the development of a comprehensive, system-wide approach for monitoring and learning from mortality.

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.

During April, May and June 2022, a total of 350 alerts were raised across South West London ICS. The top three themes include: referral processes, discharge concerns and communication. 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 and 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:

- 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.
- Strategic use of MkAD alerts to identify and address quality concerns/issues across the ICB through quality initiatives to facilitate change and improve across the system.
- 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).

During April, May and June 2022, 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.

Progress made in Q1 included the improvement in thresholds of Klebsiella infections across all providers.

A summary of priorities for 2022/23 include:

- ongoing weekly surveillance of community and provider prevalence, and reporting of IPC events

- care home support arrangements
- support and review of action plans across SWL to establish common root causes of Healthcare Associated Infections (HCAIs), focusing on Gram Negative Blood Stream Infections (GNBSIs).

The Learning Disability Mortality Review

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 NHS England Learning Disability Mortality Review policy and NHSE recommendations, we continued to embed a small in-house team of reviewers and local area contacts, who coordinated and undertook reviews and support our partners across South West London to identify and implement learning from all reviews. An annual report is currently in development to be published by October 2022.

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 established an oversight panel to undertake the reviews and 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 findings of the review which was completed in March 2022 revealed that all 35 patients were deemed to have received safe care, however, there were key areas for improvement identified:

- Patient wellbeing related to weight management, exercise, diet and access to quality food.
- Monitoring of physical health.
- Lack of regular access to dental and optician checks.
- Access to sensory, communication and functional assessment to further inform patient plans.
- Impact of medicines management relating to impact on physical health, for example, weight gain.

- 9 of the 35 patients were prescribed psychotropic medicines without a mental health diagnosis that was immediately obvious to the panel, often prioritised over psychosocial modalities of treatment.
- The extent to which the patients were involved in their treatment plan was unclear

Our priorities in this area for 2022/23 include:

- Training to be provided to South West London commissioners and South London Partnership case managers relating to psychotropic medicines. With greater pharmacist involvement in complex medication regimes and greater scrutiny when reviewing indications and monitoring for psychotropic medications.
- 6 to 8 week visit template to be revised to address health and wellbeing, as well as medicines management. With more ‘healthy lifestyle’ and ‘physical health’ monitoring interventions in care treatment reviews.
- Ongoing development of medicines optimisation service to promote a healthy lifestyle, encourage meaningful patient involvement and build their agency in making informed decisions about their care.
- Greater involvement of people with lived experience in ongoing work with user led groups.
- Renewed focus on progressing discharge planning.
- Development of the autism strategy and action plan, including workforce development.

Improving positive experiences

One of our core objectives is to continue to improve the quality of people’s experiences of care. The Quality Complaints Review Panel was established in April 2022 and will continue to take place every quarter to provide oversight and governance of experiences of patients. The inaugural panel is planned at the end of September and bring all patient experience and engagement leads together to collaborate on improving our population and residents experiences of care across 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, the ICB is interviewing candidates in September 2022 for two patient partner vacancies to support the ICB to implement better experiences of care for patients.

Continuing Health Care and Children’s Continuing Care

In May 2022, the number of outstanding reviews for Continuing Healthcare across South West London was 304, and additional, 70 reviews have been completed for this reporting period.

Our priorities in this area for 2022/23 include:

- focus on bringing together continuing care services to meet the new national All Age Continuing Care model of care
- further reviews into quality-of-service provision

- establishment of a dedicated escalation team to clear the backlog of Continuing Healthcare cases

Reducing health inequalities and delivering 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 1.4 Reducing Health Inequalities.

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, SWL 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.

Adult Safeguarding

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.

Safeguarding Adults Reviews (SARs) are a statutory requirement for Safeguarding Adults Boards (SABs). Safeguarding adult practice can be improved by identifying what is helping and what is hindering safeguarding work, to tackle barriers to good practice and protect adults from harm. Over the last five years there have been 44 commissioned in SWL.

Analysis of Safeguarding Adults Reviews showed that self-neglect was the most common type of abuse, followed by neglect/omission, physical abuse and then organisational abuse. Certain forms of abuse were more common amongst people of certain age groups; for example, sexual abuse was more common amongst young people than older people.

The Safeguarding Adults Board ensures that the lessons learnt are shared with all the services involved through reports, briefings, summaries and discussions. There are action plans for each review setting out how its recommendations will be met, with regular updates on progress.

Child Safeguarding

Across NHS Southwest London ICB, there are five Safeguarding Children Partnership Boards, Croydon Safeguarding Children Partnership (CSCP), Kingston and Richmond Safeguarding Children Partnership (KRSCP), Merton Safeguarding Children Partnership (MSCP), Sutton Local Safeguarding Children Partnership (Sutton LSCP) and Wandsworth Safeguarding Children Partnership (WSCP).

Designated Professionals Safeguarding Children and Named Professionals from provider organisations all contribute to the functions of the partnerships.

A look back at SCR/LCSPR cases shows there has been 54 SCR/LCSPR across SWL commissioned in the last five years till Q1 this year. Annual numbers have fluctuated over the years with an increase in 2019-2020.

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.

1.5.8 Sustainable development

Since publishing the South West London Green Plan we have made progress on a number of commitments during this reporting period. All acute trusts have switched to recycled paper and conversations have started with Chief Information Officers across the system to implement a managed print system to reduce reliance on printing across South West London CCG.

A feasibility study for joint patient transport services at St George's and Epsom and St Helier hospitals was completed and our we had actively engaged at exploring electrifying the fleet and investigating electric charging points at St George's, in addition to the a new car park design at the hospital. St George's Hospital Pathology have also signed a contract with City Sprint to replace 31 vans using petrol with a complete fleet of elective vans, which will result in pathology courier services to be fully electric by 1 August 2022.

Our commitment to reducing MDI inhalers had also progressed during this period. We distributed communications materials to primary care, advising clinicians about how to shift to more environmentally-friendly inhalers while improving asthma care, and produced a parent advice sheet, which was co-ordinated by the Children and Young People's Asthma Network. We have supported this work with ongoing educational sessions.

In April, no desflurane was issued to SWL trusts. This was a significant milestone; usage has gone from 10% in 2019 to 0% for the first time. Our next step is to look at what to do to with supply of desflurane through the system should the trend to use them continue to decline and ensure we have arrangements in place so that destruction of supplies does not have a negative carbon footprint impact.

1.5.9 Complaints and PALS

Between 1 April 2022 and 30 June 2022, we received 81 formal complaints

Of these, 39 related to issues for which the CCG was responsible for investigating and responding to. We also received 42 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 April – June 2022, 1 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) 19 complaints.
- Mental health commissioning (access to services, availability and funding) - 7 complaints
- General Commissioning – 3 complaints
- Assisted conception (eligibility criteria) 3 complaints.
- Medicines Management - 2 complaints
- Primary Care - 2 complaints

- Individual Funding Requests - 2 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 continue to work on improving how we can learn from complaints and use this to improve the experiences of our patients. These efforts include a new data system that will help identify learning and emerging themes in complaints.

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.

Between 1 April 2022 and 30 June 2022 there were 115 such contacts.

The areas giving rise to most contacts were:

- Covid-19 vaccine - 42 contacts
- Primary care (GPs, NHS dentists, community pharmacies) - 14 contacts
- Continuing healthcare (assessment for eligibility process, payment) - 18 contacts
- Other NHS organisations - 9 contacts
- General commissioning - 6 contacts
- Mental health commissioning (access to services, availability and funding) - 8 contacts
- Individual funding requests (requests for funding for treatment/medication not routinely provided on the NHS) - 5 contacts
- Assisted conception (eligibility criteria, can funding be transferred, freezing of eggs) - 2 contacts
- Compliments to the CCG - 2 contacts

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 the period 1 April 2022 to 30 June 2022, 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

29 June 2023

2.1 Corporate Governance Report

2.1.1 Members Report

NHS South West London CCG was a clinically led member organisation and covered the London boroughs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth. This meant that GPs made decisions about local health services by using their local knowledge to improve services and focus resources where there is greatest need. The CCG was made up of 180 GP practices, which were organised into Primary Care Networks. The CCG's work was overseen by an elected Governing Body which was chaired by Dr Nicola Jones, a GP at the Brocklebank Practice, in Wandsworth throughout April, May and June 2022. Sarah Blow was the Accountable Officer for NHS South West London CCG. All Governing Body members had specific areas of responsibility and sat on committees of the Governing Body. The members exercised their constitutional rights in respect of the CCG through a membership group. Each member practice had a representative on the membership group.

2.1.2 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 were all represented on the Governing Body.

Our Governing Body met once in public between April and June, and we encouraged our community to join us to find out about the work we've been 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 the period, 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 had continued to be kept informed of the CCG's response to the Covid-19 pandemic during April, May and June 2022.

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 was to:

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

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

2.1.3 Governing Body members

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

Nicola's portfolio included 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.

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 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 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 Annette Pautz, GP Borough Lead for Kingston

Dr Annette Pautz joined the CCG Governing Body in April 2022 and has worked as a GP Partner in Kingston for the last 17 years. In addition to holding numerous leadership roles including Clinical Chair of the Borough Committee and Chair of the Kingston Council of Members, she has also worked as a Clinical Lead in Respiratory Medicine, Transformation and Community, leading on some of the largest transformation and other service design and development in Kingston and across Kingston and Richmond.

A large part of Annette's work has centred on the integration of services, with a strong collaborative approach, across health and care to not only improve outcomes, but also achieve efficiencies, reduce delays and provide a better experience for patients and staff.

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.

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.

Composition of Governing Body

Members of the Governing Body were as follows:

Position / Title	Name

Clinical Chair and GP Borough Lead, Wandsworth	Dr Nicola Jones
GP Borough Lead, Croydon	Dr Agnelo Fernandes
GP Borough Lead, Richmond	Dr Patrick Gibson
GP Borough Lead, Kingston	Dr Annette Paultz
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	Dr Asiya Yunus
Chief Executive, Surrey, and Sussex LMC	Dr Julius Parker
Local Authority Representatives	
Director, Merton Public Health	Dr 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

Committees of the Governing Body

Several sub-committees supported our Governing Body to carry out its statutory duties. The extent of authority to act of these committees depended 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 remained accountable for all of its functions including those that it had delegated. In discharging their delegated responsibilities, the Governing Body and its committees were 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, ensured 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 operated in accordance with their approved terms of reference.

Audit Committee

The Audit Committee was 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 supported the achievement of the CCG's objectives. A key purpose of the committee was to monitor the integrity of the financial statements of the CCG and assured itself that relevant risks, particularly financial, are appropriately

identified and managed within a robust system of internal control. The Committee was also responsible for seeking appropriate assurance functions on relating to ensuring arrangements for counter-fraud and audit work programmes.

Remuneration Committee

The Remuneration Committee was 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 had the power to make recommendations on fees and other allowances for all individuals directly appointed by the CCG as workers or employees.

Primary Care Commissioning Committee

The Primary Care Commissioning Committee met in public, and its purpose was 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 aimed to ensure that appropriate primary care services were 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 were invited to attend the Committee.

Quality, Performance and Oversight Committee

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

Finance Committee

The Committee was established to ensure that a robust financial strategy was 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 aimed to understand the drivers behind any variances against the plans, ensure any risks have been identified, and mitigating actions had been taken to address these whilst providing assurance to the Governing Body about delivery and sustained performance.

NHS South West London CCG 'Committees in Common'

The CCG's constitution provided for a mechanism that allowed 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 Nicola Jones	SWL CCG Clinical Chair	1/1
Dr Agnelo Fernandes	Croydon, elected GP Borough Lead	1/1
Dr Annette Paultz	Kingston, elected GP Borough Lead	1/1
Dr Vasa Gnanapragasam	Merton, elected GP Borough Lead	1/1
Dr Patrick Gibson	Richmond, elected GP Borough Lead	1/1
Dr Dino Pardhanani	Sutton, elected GP Borough Lead	1/1
David Smith	SWL CCG, Deputy Chair & Lay member Finance	1/1
Paul Gallagher	Lay Member, Audit Chair	1/1
Susan Gibbin	Lay Member, Public & Patient Engagement	1/1
Pippa Barber	Independent Registered Nurse	1/1
Sarah Blow	SWL CCG Accountable Officer	0/1*
James Murray	SWL Chief Finance Officer	0/1*
*Deputy Accountable Officer and Deputy Chief Finance Officer represented respectively		
Audit Committee		
Paul Gallagher	Lay Member, Audit Chair	2/2
David Smith	SWL CCG, Deputy Chair & Lay member Finance	2/2
Pippa Barber	Independent Registered Nurse	2/2
Dr Agnelo Fernandes	Croydon, elected GP Borough Lead	2/2

Dr Dino Pardhanani	Sutton, elected GP Borough Lead	0/2
Remuneration Committee		
David Smith	SWL CCG, Deputy Chair & Lay member Finance	1/1
Paul Gallagher	Lay Member, Audit Chair	1/1
Susan Gibbin	Lay Member, Public & Patient Engagement	1/1
Primary Care Commissioning Committee		
Susan Gibbin	Lay Member, Public & Patient Engagement	1/1
David Smith	SWL CCG, Deputy Chair & Lay member Finance	1/1
Mark Creelman	Locality Executive Director Merton and Wandsworth	1/1
Quality, Performance and Oversight Committee		
Pippa Barber	Independent Registered Nurse	1/1
Susan Gibbin	Lay Member, Public & Patient Engagement	1/1
Dr Nicola Jones	CCG Clinical Chair and elected GP Borough Lead for Wandsworth	1/1
Dr Patrick Gibson	Richmond, elected GP Borough Lead	1/1
Gloria Rowland	Chief Nurse/Executive Director of Quality	1/1
Jonathan Bates	Executive Director Systems Planning Performance and Delivery	1/1
Finance Committee		
David Smith	SWL CCG, Deputy Chair & Lay member Finance, Finance Committee Chair	2/2
Dr Vasa Gnanapragasam	Merton, elected GP Borough Lead	2/2
Paul Gallagher	Lay Member, Audit Chair	2/2
Pippa Barber	Independent Registered Nurse	2/2
James Murray	SWL Chief Finance Officer	1/2*
*Deputy Chief Finance Officer represented		

Register of Interests

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

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

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

The register of interests is available on our website www.swlondonccg.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.

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.

2.1.4 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

29 June 2023

2.2 Governance Statement

2.2.1 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 NHS South West London 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.

Between 1 April 2022 and 30 June 2022, the clinical commissioning group was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

2.2.2 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.

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.

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.

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.

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.

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.

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 2021/22. 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.

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.

Committees of the Governing Body periodically review those risks specific to their area and are made aware of significant changes to the risk register.

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 eleven 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 well-being 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 age)
- RRSWLCCG060 - Failure to fully utilize Queen Mary’s Hospital
- RRSWLCCG124 - Ambulance handover times

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 30 June 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 2021/22. 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 NHS London Shared Service (LSS) formerly NHS 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 relied on a number of third party providers (such as NHS SBS, NHS BSA, LSS (formerly NELCSU) 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.

Control Issues

NHS South West London CCG received services from a number of external providers and at the end of the year received a service auditor report from each of these:

1. NHS Business Services Authority (BSA) - Electronic Staff Record (ESR) -Type II ISAE 3000 Controls Report
2. Transformation Directorate within NHS England (previously NHS Digital) - Extraction and Processing of General Practitioner Data Services in England -Type II ISAE 3000
3. NHS Business Services Authority (BSA) - Prescription Payments Process -Type II ISAE 3402
4. Capita Business Services Limited - Primary Care Support England - Type II ISAE 3402

5. NHS England South, Central and West Commissioning Support Unit - Calculating Quality Reporting Service (CQRS) National - Type II ISAE 3402
6. NHS North of England Commissioning Support Unit – Payroll Services - Type II ISAE 3402
7. NHS Shared Business Services Limited (SBS) – Finance and Accounting Services - Type II ISAE 3402
8. NHS London Shared Service – Finance and Payroll Services – Bridge Letter

Where exceptions had been raised in these, we considered the impact on the CCG and if appropriate added local controls to mitigate the impact of any weaknesses identified. We shared these Service Auditor Reports with Internal Audit who do not consider there were any issues sufficiently significant to alter their view of the controls as designed and operated at the CCG.

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

The Governing Body, through its meetings, retained 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 retained 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, Performance and 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).

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.

2.3 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 an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

For the three months ended 30 June 2022, the head of internal audit opinion for SW London CCG is as follows:

The organisation has an adequate and effective framework for risk management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

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 opinion is limited to the internal audit work for the three-month period of 1 April 2022 to 30 June 2022; it also takes into consideration our cumulative knowledge of the South West London CCG.

Factors and findings which have informed our opinion

Safeguarding adults and children

Our review confirmed that an appropriate Safeguarding environment is in place during the period 1st April to 30th June at the CCG that encourages the reporting of emerging and operational safeguarding matters for both adults and children. There is sufficient training available in all areas and lessons learnt provide invaluable knowledge to the staff members to help improve safeguarding, however in some areas further training was required to be undertaken to ensure staff are all up to date with required levels of safeguarding training.

In addition, safeguarding protocols are regularly monitored and scrutinised by appropriate personnel and actions are taken in areas which do not meet the criteria. Our review confirmed that there are appropriate policies in place around safeguarding adults and children that were all up- to-date and regularly reviewed

Based on the findings from the review we provided **reasonable assurance** overall.

Adult continuing healthcare and personal health budgets

Whilst the review found many areas of a well- designed and compliant control framework, we identified there is absent or delayed completion of checklists, Decision Support Tools, Individual Service User Placement Agreements and three month and annual reviews that need to be addressed to ensure the organisation is maintaining control and working in the best interests of the service users. The CCG needs to ensure that contracts are in place with providers operating outside of the Approved Qualified Provider framework and that Local CHC meetings as well as SWL Continuing Health Care Leads meetings are held monthly between the six Boroughs to enable the Boroughs to have opportunities to work more collaboratively and to ensure issues are discussed/ resolved in a timely manner and best practice recorded and shared between the Teams. The monthly CHC Performance Dashboards should include the top ten Providers by Cost to enable monitoring of payments made to these providers, identifying any unusual trends and avoiding any financial loss.

We identified an absence of action plans and found the CHC Projects Risk Register was not fully populated. Performance across the six boroughs varied but in general the controls were found to be operating strongest and with fewest exceptions through our testing in Croydon with the rates of non-compliance with expected deadlines and milestones being higher in the remaining boroughs.

Based on the findings from the review we provided **reasonable assurance** overall.

CCG closedown – Stage 2

Overall, good progress was made with the CCG closedown and completion of the Due Diligence Checklist. Where tasks are currently outstanding, there are good reasons for this, and suitable updates have been provided to provide confidence they will be delivered. The further actions planned should enable the CCG (and ICB) to ensure progress continues to be monitored until the end of July.

There were clear reporting mechanisms in place to the SWL ICB Governance Oversight Group to which completion rates within each area are reported in order to monitor progress made with the plan and checklist. Furthermore, there was regular

communication within the CCG informing Executive Leads on key dates and information. We are satisfied that with the further steps planned there are adequate measures in place to give confidence that a successful transition is likely.

Based on the findings from the review we provided **reasonable assurance** overall.

Medicines management

We found that there was adequate representation from stakeholders in decision making through the Integrated Medicines Optimisation Committee and a lay member has recently been appointed to ensure a patient voice is involved in decision making. In addition, we confirmed there was a robust framework in place for the harmonisation of policies and ensuring consistency of practice across SWL CCG. We also found evidence of regular sharing of information and lessons learned through various communication channels and working groups. Recommendations raised were in regard to future governance arrangements upon establishment of the Integrated Care Board.

Based on the findings from the review we provided **reasonable assurance** overall.

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, that the CCG should consider whether the issues flagged within the Continuing Healthcare review should be flagged as significant control issues within the Annual Governance Statement (AGS). 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

Acceptance of internal audit management actions

Management have agreed actions to address all of the findings reported by the internal audit service during the period 1 April 2022 to 30 June 2022.

Implementation of internal audit management actions

Where actions have been agreed by management, these have been monitored by management through the action tracking process in place. The actions agreed in respect of the reports finalised during the period have not yet become due and these will be followed up when they become due.

Actions transferring to the ICB

As reported in our latest progress report to the CCG, there was one high priority action relating to IT Asset Management that has become due and is categorised as in the process of being implemented and this will transfer over to the ICB. We will continue to follow up on progress around this action and report on progress back to the ICB Audit Committee.

Our performance

Wider value adding delivery in Quarter 1 2022/23

Area of work	How has this added value?
SW London ICB Migration Project Board	We are continuing to attend the meetings of the SW London ICB Migration Project Board and supporting from an assurance perspective and attending South West London Governance Oversight Group.
Client Briefings	As part of our client service commitment, we continue to issue 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.
Employment Matters and Employment Law Bulletins	We have invited the CCG to the Employment and HR update webinar, which focusses on employment tax update, HR update and employment law update.

Working with other assurance providers

In forming our opinion we have not placed any direct reliance on other assurance providers

Conflicts of interest

RSM has not undertaken any work or activity during the period 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 between 1 April 2022 and 30 June 2022, 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

Factors influencing our opinion

The factors which are considered when influencing our opinion are:

- inherent risk in the area being audited;
- limitations in the individual audit assignments;
- the adequacy and effectiveness of the risk management and / or governance control framework;
- the impact of weakness identified;
- the level of risk exposure; and
- the response to management actions raised and timeliness of actions taken.

Summary of internal audit work completed

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
Safeguarding Adults and Children	Dr Gloria Rowland, Chief Nurse NHS in South West London	Reasonable Assurance [●]	0	1	1
Adults Continuing Healthcare and Personal Health Budgets	Jonathan Bates, Executive Director of System Planning, Performance & Delivery	Partial Assurance [●]	3	9	3
CCG Closedown Stage 2	Ben Luscombe – Chief of Staff	No opinion / Advisory [●]	0	0	0
Medicines Management (DRAFT)	Dr Gloria Rowland, Chief Nurse NHS in South West London	Reasonable Assurance [●]	0	4	1

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 cannot take 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.

2.3.1 Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Governing Body
- The Audit Committee
- The Quality and Performance Oversight Committee
- Internal Audit

The role and conclusions of each were captured within the reports of the assurance committees to the Governing Body.

No significant control issues have been identified at NHS South West London Integrated Care Board during during the reporting period (1 April 2022 to 30 June 2022).

Sarah Blow

Accountable Officer

NHS South West London Clinical Commissioning Group

2.4 Remuneration and Staff Report

2.4.1 Remuneration Report

Remuneration Committee

A summary of the duties and the membership of the remuneration committee is included within the Corporate Governance Report in section 2.1.3.

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.

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.

Senior manager remuneration (including salary and pension entitlements) - Audited

The table below discloses salaries and allowances paid by the CCG to Directors of significant influence.

Name and Title	1 April to 30 June 2022 [CCG reports]					
	(a)	(b)	(c)	(d)	(e)	(f)
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
	(bands of £5,000)	to nearest £100**	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
	£000'	£	£000'	£000'	£000'	£000'
Dr Agnelo Fernandes - GP Borough Lead, Croydon	20 to 25	N/A	N/A	N/A	N/A	20 to 25
Dr Annette Pautz - Place Member, Kingston (Kingston GP)	20 to 25	N/A	N/A	N/A	N/A	20 to 25
Charlotte Gawne - Director of Communications and Engagement	35 to 40	N/A	N/A	N/A	37.5 to 40	70 to 75
David Smith - Non-Clinical Vice Chair & Lay Member, Finance	1 to 5	N/A	N/A	N/A	N/A	1 to 5
Dr Dino Pardhanani - GP Borough Lead, Sutton	20 to 25	N/A	N/A	N/A	N/A	20 to 25
Gloria Rowland - Chief Nurse and Director of Quality	35 to 40	N/A	N/A	N/A	35 to 37.5	70 to 75
James Murray - Chief Finance Officer	35 to 40	N/A	N/A	N/A	N/A	35 to 40
Jonathan Bates - Executive Director Systems Planning Performance and Delivery	35 to 40	N/A	N/A	N/A	40 to 42.5	75 to 80
Karen Broughton - Executive Director Strategy and Transformation	35 to 40	N/A	N/A	N/A	35 to 37.5	70 to 75
Mark Creelman - Locality Executive Director Merton and Wandsworth	35 to 40	N/A	N/A	N/A	N/A	40 to 45
Matthew Kershaw - Place Base Leader for Health Croydon	25 to 30	N/A	0 to 5	N/A	N/A	30 to 35
Naz Jivani - Elected GP Lead Kingston Borough	20 to 25	N/A	N/A	N/A	N/A	20 to 25
Nicola Jones - Elected Governing Body Member Wandsworth Borough	30 to 35	N/A	N/A	N/A	N/A	30 to 35
Patrick Gibson - Elected Governing Body Member	20 to 25	N/A	N/A	N/A	N/A	20 to 25
Paul Gallagher - Lay Member for Audit and Conflicts of Interest Guardian	1 to 5	N/A	N/A	N/A	N/A	1 to 5
Pippa Barber - Independent Nurse	1 to 5	N/A	N/A	N/A	N/A	1 to 5
Sarah Blow - Accountable Officer	50 to 55	N/A	N/A	N/A	N/A	50 to 55
Susan Gibbin - Lay Member Patient Public and Engagement	1 to 5	N/A	N/A	N/A	N/A	1 to 5
Tonia Michaelides - Locality Executive Director Richmond and Kingston	30 to 35	N/A	N/A	N/A	7.5 to 10	35 to 40
Vasa Gnanapragasam - Elected GP Lead Merton Borough	15 to 20	N/A	N/A	N/A	N/A	15 to 20

Notes

*Taxable expenses and benefits in kind are expressed to the nearest £100.

*Matthew Kershaw is the Place Base Leader for Health Croydon and is on the payroll of Croydon Health Services NHS Trust, his total annual salary is in the range of £230k-£235k. South West London CCG is responsible for 50% of his costs.

Senior manager remuneration (including salary and pension entitlements) 2021/22 for comparison

Name and title	Salary	Expense payments (taxable)	Performance pay and bonuses	Long-term performance related bonuses	All pension related benefits	TOTAL
	(bands of £5,000)	(rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
	£000	£000	£000	£000	£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 - Place 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
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 Place 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 30 June 2023

Where the CCG contributed to pension schemes for senior managers, the benefits are shown in the table below:

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 30 June 2022 CCGs (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 30 June 2022 CCGs (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2022 CCGs	(f) Cash Equivalent Transfer Value at 31 March 2023	(g) Real Increase in Cash Equivalent Transfer Value	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Charlotte Gawne - Executive Director of Stakeholder and Partnership Engagement and Communications, SWL ICB	0 to 2.5	2.5 to 5	40 to 45	75 to 80	697	741	33	5
Gloria Rowland - Chief Nursing and Allied Health Professional / Director for Patient Outcomes, SWL ICB	0 to 2.5	2.5 to 5	30 to 35	55 to 60	487	523	28	5
Jonathan Bates - Chief Operating Officer, SWL ICB	2 to 2.5	2.5 to 5	50 to 55	95 to 100	836	885	37	5

Karen Broughton - Deputy CEO / Director of People & Transformation, SWL ICB	0 to 2.5	2.5 to 5	50 to 55	90 to 95	867	913	33	6
Mark Creelman - Locality Executive Director Merton and Wandsworth	0 to 2.5	0	20 to 25	0	301	314	11	4
Tonia Michaelides - Locality Executive Director Richmond and Kingston	0 to 2.5	0	40 to 45	80 to 85	770	789	8	5

Pension benefits 2021/22 (for comparison)

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	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2022	Lump sum at pension age related to accrued pension at 31 March 2022	Cash Equivalent Transfer Value at 1 April 2021	Cash Equivalent Transfer Value at 31 March 2022	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to partnership pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
	£000	£000	£000	£000	£000	£000	£000	£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

Notes

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.

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).

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).

Compensation on early retirement of for loss of office

There were no payments for early retirement or loss of office.

Payments to past directors - Audited

There were no payments to past directors.

Fair Pay Disclosure - Audited

As at 30 June 2022, annualised remuneration ranged from £1k to £220k (comparing the remuneration of the highest paid director, the top of the range increased by 26% against the 21/22 figure of £175k). 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 in 2022/23 is shown in the table below (the Q1 figures have been pro-rated to full year values)

	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff	£43,997	£58,186	£80,841
salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff	£43,997	£58,186	£80,841

The figures for 2021/22 were:

	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 2022/23 was £215k to £220k (an increase of 26% against the 2021/22 band, which was £170k to £175k), 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
2022/23	5.00	3.78	2.72
2021/22	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:

	2022/23 (bands of £5,000)	**2021/22 (bands of £5,000)**	**% change**
	£000s	**£000s**	
Salary of highest paid director (bands of £5k)	215 to 220	170 to 175	26%

In 2022/23, no employees received remuneration in excess of the highest-paid director (this was also the case in 2021/22)

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.

The following table shows the average percentage change from the previous financial year in respect of employees of the entity, taken as a whole:

	2022/23	**2021/22**	**% change**
	£000s	**£000s**	
Total salary and allowances for all employees on an annualised basis, excluding the highest paid director	38,934	37,399	4%
Average FTE number of employees (also excluding the highest paid director)	481	473	2%
Average salary per FTE	81	79	2%

2.4.2 Staff Report

Number of senior managers

Pay Band	Employee Headcount	FTE	Basic Pay for Quarter 1
Band 9	19	18.7	£490,911
VSM	10	9.8	£324,450
total	**29**	**28.5**	**£815,361**

Staff numbers and costs - Audited

	Permanently employed staff		Other staff (agency)		Total	
Category	**Cost, £000**	**Average WTE**	**Cost, £000**	**Average WTE**	**Cost, £000**	**Average WTE**
Add Prof Scientific and Technic	814	42.43	213	8.16	1,027	50.59
Administrative and Clerical	8,271	394.78	1,980	76.01	10,252	470.79
Allied Health Professionals	15	1.00	5	0.19	20	1.19
Medical and Dental	185	4.00	20	0.77	206	4.77
Nursing and Midwifery Registered	667	39.49	197	7.50	864	46.98
Total	**9,953**	**481.70**	**2,415**	**92.63**	**12,369**	**574.33**

Staff composition

Disability

Disability Flag	Headcount	%	FTE
No	430	85.1	409.26
Not Declared	40	7.9	37.56
Prefer Not To Answer	13	2.6	11.92
Unspecified	2	0.4	2.00
Yes	20	4.0	18.84
Grand Total	**505**	**100.0**	**479.58**

Ethnicity

Ethnic Group	Headcount	%	FTE
A White - British	219	43.37%	205.83
B White - Irish	11	2.18%	11.00
C White - Any other White background	38	7.52%	36.29
CA White English	3	0.59%	2.90
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	10	1.98%	9.50
GF Mixed - Other/Unspecified	1	0.20%	0.60
H Asian or Asian British - Indian	50	9.90%	46.19
J Asian or Asian British - Pakistani	12	2.38%	11.04
K Asian or Asian British - Bangladeshi	6	1.19%	5.60
L Asian or Asian British - Any other Asian background	11	2.18%	10.30
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	24	4.75%	23.70
N Black or Black British - African	45	8.91%	44.20
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	3	0.59%	3.00
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	9	1.78%	9.00
SA Vietnamese	1	0.20%	1.00
Z Not Stated	30	5.94%	28.12
Grand Total	**505**	**100.00%**	**479.58**

Sexual orientation

Sexual Orientation	Headcount	%	FTE
Bisexual	4	0.79	4.00
Gay or Lesbian	13	2.57	13.00
Heterosexual or Straight	413	81.78	392.93
Not Disclosed	70	13.86	64.65
Other sexual orientation not listed	2	0.40	2.00
Undecided	1	0.20	1.00
Unspecified	2	0.40	2.00
Grand Total	**505**	**100.00**	**479.58**

Religion

Religious Belief	Headcount	%	FTE
Atheism	68	13.47	66.83
Buddhism	2	0.40	2.00
Christianity	218	43.17	209.09
Hinduism	24	4.75	21.53
Islam	27	5.35	25.67
Not Disclosed	120	23.76	111.14
Other	29	5.74	27.50
Sikhism	15	2.97	13.83
Unspecified	2	0.40	2.00
Grand Total	**505**	**100.00**	**479.58**

Gender

Gender	Headcount	%	FTE
Female	384	76.0	358.28
Male	121	24.0	121.30
Grand Total	**505**	**100.0**	**479.58**

Age band

Age Band	Headcount	%	FTE
21-25	7	1.39	6.80
26-30	32	6.34	31.80
31-35	56	11.09	52.71
36-40	62	12.28	58.81
41-45	92	18.22	86.07
46-50	70	13.86	67.53
51-55	80	15.84	77.23
56-60	77	15.25	73.40
61-65	28	5.54	24.24
66-70	1	0.20	1.00
Grand Total	**505**	**100.00**	**479.58**

Marital Status

Marital Status	Headcount	%	FTE
Civil Partnership	7	1.39	6.80
Divorced	25	4.95	23.60
Legally Separated	4	0.79	3.80
Married	247	48.91	232.10
Single	171	33.86	164.40
Unknown	45	8.91	43.07
Unspecified	3	0.59	2.80
Widowed	3	0.59	3.00
Grand Total	**505**	**100.00**	**479.58**

Sickness absence data

The CCG sickness absence percentage rate was presented regularly to the CCG in the form of workforce reports. Individual sickness absence cases were managed by the line manager with advice and support from HR.

An occupational health (OH) service was available to provide professional clinical advice to line managers within the CCG.

The CCG also had access to an employee assistance programme which offered confidential access to emotional and practical support, including legal and financial advice.

Number of days lost in the quarter	1,127.54
Total staff number	478.05
Average working days lost in the quarter	2.36

Staff turnover percentages

The staff turnover figure, based on a 3-month average, at 30 June was 5.6% (It was 12.63% in 2021/22)

Staff engagement percentages

NHS Staff Survey

The CCG commissioned Picker Institute Europe to run an online 2021 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 and these are now in place. Following this all directorates have developed individual action plans which they are delivering in order to address areas within their team.

You can read more about the NHS staff survey on the NHS staff survey website.

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. As of June 2022 there is a reviewed policy covering sickness absence called “Managing Health and Attendance at Work”. This policy gives greater focus to maintaining health and wellbeing, strengthening more pro-active support for staff with a disability or long-term condition who require time off work, and paid time off for hospital appointments has been extended to include those related to IVF and gender re-assignment.

Our newly reviewed Disciplinary policy, as of June 2022, reflects a “Fair and Just” culture approach where there is now a commissioning manager to make impartial decisions throughout the procedure, and more support is offered for all parties involved throughout the process.

The final policy to be reviewed in this quarter was the Annual and Special Leave Policy which now lays out carer’s leave provisions.

Any new policies or review of current policies provide further support to staff and contribute to further inclusivity in the workplace.

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	£783.31
Total pay bill	£9,733,922
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.80%

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	100%

Other employee matters

People and Organisational Development Strategy

Our People and Organisational Development Strategy set out our approach to shaping our organisational culture and supporting our staff. The strategy was developed with insight gathered from staff and the aim was to make NHS South West London CCG a great place to work. To achieve this, we worked in partnership with our trade union colleagues and focused 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
- Worked to make sure our staff were representative and inclusive of the populations we served
- Involving our staff to help us transform and improve the way we work
- Developing compassionate and inclusive leaders

Caring for our staff

Our staff health and wellbeing network continued to organise bespoke activities to support staff to maintain their mental and physical health and wellbeing. e.g., group walking, dance sessions, mindfulness, and book club. In addition, we continued to promote free health and wellbeing resources for NHS staff through our staff newsletters and intranet.

Our SWL Mental Health & Wellbeing Hubs provided quick access to psychological support as well as rapid access to more specialist treatment, as required for all staff across the system. The SWL hubs were set up to treat distress and anxiety in a non-pathologising way, staff do not have to reach a threshold of a diagnosable mental health disorder to access psychotherapeutic support.

Staff were able to access an Employee Assistance Programme (EAP) which provided 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 were available to provide support to staff, signposting them to professional help and challenging mental health stigma in the workplace.

Supporting staff to develop

Based on the feedback and input of staff and managers across the CCG we co-designed a new appraisal approach which focused 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 came into effect in April 2022. A range of resources was also developed to support managers and staff ahead of, during and after their appraisal discussions.

We worked working with a range of teams and directorates to determine the collective development needs of staff to commission relevant development packages, and themes that have emerged relate to project and programme management training and digital development.

Recruitment

Our staff are our most important asset and we wanted to ensure that we attracted and kept 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. This remained in place throughout this reporting period.

Compassionate leaders

We commissioned a learning partner to support our compassionate and inclusive leadership programme, the aim of which was to explore and build an inclusive and compassionate culture through our most senior leaders. The programme was 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.

We celebrated 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 went 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.

Expenditure on consultancy

The reported expenditure on consultancy was £278k in 2022/23 Q1. The annualised amount would be £1,112k, which compares to £ 799k in 2021/22).

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 30 June 2022 for more than £245* per day and that lasted longer than six months:

	Number
Number of existing engagements as of 30 June 2022	24
Of which, the number that have existed:	

for less than one year at the time of reporting	7
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	0

*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 reporting period

For all off-payroll engagements between 1 July 2022 and 31 March 2023, for more than £245[(1)] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2002	113
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)]	93
No. subject to off-payroll legislation and determined as out of scope of IR35[(2)]	20
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 1 April 2022 and 30 June 2022

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	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.	22

Exit packages, including special (non-contractual) payments - Audited

Table 4: Exit Packages

There were no exit packages or other special payments between 01/04/2022 to 30/06/2022

2.4.3 Parliamentary Accountability and Audit Report

South West London CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report at page 122

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS SOUTH WEST LONDON CLINICAL COMMISSIONING GROUP

Independent auditor's report to the Members of the Board of NHS South West London Integrated Care Board in respect 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 CCG (the 'CCG') for the period ended 30 June 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 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its expenditure and income for the period 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 2022-23; 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 the "Events after the end of the reporting period note to the financial statements, which indicates that the Health and Care Bill allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS South West London CCG transferred to NHS South West London ICB on 1 July 2022. When NHS South West London CCG ceased to exist on 1 July 2022, its services continued to be provided by NHS South West London ICB.

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.

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 2022-23 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 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 2022) 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.

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.

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.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. 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.

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 themselves. 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:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial period 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

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.

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.

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.

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. Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 2022-23).
- We enquired of management and the Audit and Risk 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 ICB Audit and Risk 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 and any other fraud risks identified for the audit. We determined that the principal risks were in relation to:
  - Testing of journal entries based on a consideration of a range of risk factors.
- 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 unusual journal entries using criteria based on our knowledge of the entity and the risk factors identified.
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of prescribing accruals;
  - 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 estimates related to prescribing accruals and continuing healthcare provision.
- 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 other 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**.**

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.

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 made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer was 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 were operating effectively during the three month period ended 30 June 2022..

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. 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 planned and managed its resources to ensure it could continue to deliver its services;
- Governance: how the CCG ensured that it made informed decisions and properly managed its risks; and
- Improving economy, efficiency and effectiveness: how the CCG used information about its costs and performance to improve the way it managed and delivered its services.

We have documented our understanding of the arrangements the CCG had 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 have considered whether there is evidence to suggest that there were significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of NHS South West London Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Integrated Care Board of NHS South West London ICB, as a body, in respect of the ICB, 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 Integrated Care Board of NHS South West London ICB those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS South West London ICB and the CCG and the members of the Integrated Care Board of both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

Signature: Joanne Brown

Joanne E Brown, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

London

Date: 29 June 2023

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Statement of Comprehensive Net Expenditure for period ended 30 June 2022

	Note	3 Months 30 June 2022 £'000	31 March 2022 £'000
Income from sale of goods and services	2	(5,074)	(19,776)
Other operating income	2	(2,639)	(13,095)
Total operating income		**(7,713)**	**(32,871)**
Staff costs	4	12,264	47,408
Purchase of goods and services	5	699,904	3,074,317
Depreciation and impairment charges	5	343	363
Other Operating Expenditure	5	190	1,347
Total operating expenditure		**712,701**	**3,123,435**
Net Operating Expenditure		**704,988**	**3,090,564**
Finance expense	7	6	-
Net expenditure for the Year		**704,994**	**3,090,564**
Comprehensive Expenditure for the year		**704,994**	**3,090,564**

Statement of Financial Position as at 30 June 2022

	Note	30 June 2022 £'000	31 March 2022 £'000
Non-current assets:			
Property, plant and equipment	8	-	-
Right-of-use assets	9	2,530	-
Intangible assets	10	-	-
Total non-current assets		2,530	-
Current assets:			
Trade and other receivables	11	22,498	20,770
Cash and cash equivalents	12	-	1,951
Total current assets		**22,498**	22,722
Total current assets		**22,498**	22,722
Total assets		**25,028**	22,722
Current liabilities			
Trade and other payables	13	(196,829)	(247,790)
Lease liabilities	9	(1,367)	-
Borrowings	14	(9,223)	-
Total current liabilities		**(207,419)**	(247,790)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(182,391)**	(225,068)
Non-current liabilities			
Lease liabilities	9	(1,166)	-
Total non-current liabilities		(1,166)	-
Assets less Liabilities		**(183,557)**	(225,068)
Financed by Taxpayers' Equity			
General fund		(183,557)	(225,068)
Total taxpayers' equity:		**(183,557)**	(225,068)

The notes on pages 6 to 31 form part of this statement

The financial statements on pages 1 to 31 were approved by the ICB Board on the 28 June 2023 and signed on its behalf by:

Sarah Blow
Accountable Officer
28 June 2023

Statement of Changes In Taxpayers Equity for the period ended 30 June 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23		
Balance at 01 April 2022	**(225,068)**	**(225,068)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23		
Net operating expenditure for the financial year	(704,994)	(704,994)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(704,994)**	**(704,994)**
Net funding	746,505	746,505
Balance at 30 June 2022	**(183,557)**	**(183,557)**

	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 costs 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)

The notes on pages 6 to 31 form part of this statement

Statement of Cash Flows for the period ended 30 June 2022	Note	**3 Months 30 June 2022 £'000**	31 March 2022 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(704,994)	(3,090,564)
Depreciation and amortisation	5	343	363
Interest paid		6	0
(Increase)/decrease in trade & other receivables	11	(1,727)	(1,006)
Increase/(decrease) in trade & other payables	13	(50,962)	27,836
Net Cash Inflow (Outflow) from Operating Activities		**(757,333)**	(3,063,371)
Net Cash Inflow (Outflow) before Financing		**(757,333)**	(3,063,371)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		746,505	3,064,850
Repayment of lease liabilities	9	(346)	0
Net Cash Inflow (Outflow) from Financing Activities		**746,159**	3,064,850
Net Increase (Decrease) in Cash & Cash Equivalents	12	**(11,174)**	1,479
Cash & Cash Equivalents at the Beginning of the Financial Year		**1,951**	473
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(9,223)**	1,951

The notes on pages 6 to 31 form part of this statement

Note

The £9,223k overdrawn figure must be viewed together with items that had not cleared from the CCG's bank account by 30th June 2022.
These items include a £10,280k BACS run and uncleared cheques of £4k.
Once these items are factored in, the CCG bank account was in credit by £1,061k.
More details can be viewed on note 14.

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 on 6 July 2021. The Bill will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs. Should the Bill be passed the CCG functions, assets and liabilities will therefore transfer to an ICB.

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 30 June 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.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the clinical commissioning group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

Notes to the financial statements

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:

- £29.8m for two months prescribing expenditure based on budget information derived from NHS Business Services Authority data.
- £24.2m as an estimate of additional adult continuing care expenditure based on CCG client databases and trends.
- £22.7m Primary Care Delegated Commissioning accruals based on underlying data and assumptions of Practice payments not yet made or received by the CCG.

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.

Notes to the financial statements

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.

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

Notes to the financial statements

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.

Notes to the financial statements

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

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The clinical commissioning group assesses whether a contract is or contains a lease, at inception of the contract.

1.15.1 The Clinical Commissioning Group as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Notes to the financial statements

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 30th June 2022.

1.18 Continuing Healthcare Risk Pooling

In 2014-15 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 15.

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.

Notes to the financial statements

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.

1.22.3 **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.

Notes to the financial statements

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 Foreign Currencies

The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.26 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).

1.27 Adoption of new standards

On 1 April 2022, the clinical commissioning group adopted IFRS 16 'Leases'. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.

Under IFRS 16 the group will recognise a right-of-use asset representing the group's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

The clinical commissioning group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The group has utilised three further practical expedients under the transition approach adopted:

a) The election to not make an adjustment for leases for which the underlying asset is below £5,000.

b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.

c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

Notes to the financial statements

As of 1 April 2022, the group recognised £5.6m or right-of-use assets and lease liabilities of £5.4m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an £0.3m impact to tax payers' equity.

The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

The following table reconciles the group's operating lease obligations at 31 March 2022, disclosed in the group's 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

	Total £000
Operating lease commitments at 31 March 2022	(2,900)
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	27
Operating lease commitments discounted used weighted average IBR	(2,873)
Less: Low value leases	0
Less: Variable payments not included in the valuation of the lease liabilities	0
Lease liability at 1 April 2022	**(2,873)**

1.36 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2 Other Operating Revenue

	3 Months 30 June 2022 Total £'000	31 March 2022 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**4,554**	18,121
Other Contract income	**520**	1,655
Total Income from sale of goods and services	**5,074**	**19,776**
Other operating income		
Rental revenue from operating leases	**-**	336
Charitable and other contributions to revenue expenditure: non-NHS	**-**	25
Other non contract revenue	**2,639**	12,734
Total Other operating income	**2,639**	**13,095**
Total Operating Income	**7,713**	**32,871**

3 Disaggregation of Income - Income from sale of good and services (contracts)

	30 June 2022			31 March 2022		
	Non-patient care services to other bodies	Other Contract income	Total	Non-patient care services to other bodies	Other Contract income	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue						
NHS	1,035	-	1,035	2,508	148	2,656
Non NHS	3,519	520	4,039	15,613	1,507	17,120
Total	**4,554**	**520**	**5,074**	**18,121**	**1,655**	**19,776**

	Non-patient care services to other bodies	Other Contract income	Total	Non-patient care services to other bodies	Other Contract income	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue						
Point in time	4,554	520	5,074	18,121	1,655	19,776
Total	**4,554**	**520**	**5,074**	**18,121**	**1,655**	**19,776**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	30 June 2022		
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**7,626**	**2,311**	**9,937**
Social security costs	**949**	**-**	**949**
Employer Contributions to NHS Pension scheme	**1,341**	**-**	**1,341**
Apprenticeship Levy	**37**	**-**	**37**
Gross employee benefits expenditure	**9,953**	**2,311**	**12,264**

4.1.1 Employee benefits

	31 March 2022		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	29,551	9,083	38,634
Social security costs	3,416	-	3,416
Employer Contributions to NHS Pension scheme	5,178	-	5,178
Apprenticeship Levy	146	-	146
Termination benefits	34	-	34
Gross employee benefits expenditure	38,325	9,083	47,408

4.2 Average number of people employed

	30 June 2022			31 March 2022		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**482**	**93**	**574**	**474**	**80**	**554**

4.3 Exit packages agreed in the financial year

	30 June 2022					
	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Nil	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	31 March 2022					
	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
£25,001 to £50,000	1	33,793	-	-	1	33,793
Total	**1**	**33,793**	**-**	**-**	**1**	**33,793**

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.

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 NHS body of 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

	3 Months 30 June 2022 Total £'000	31 March 2022 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	3,215	13,287
Services from foundation trusts	244,738	1,137,678
Services from other NHS trusts	249,103	1,039,231
Purchase of healthcare from non-NHS bodies	76,799	355,574
Purchase of social care	997	3,751
Prescribing costs	45,899	181,796
General Ophthalmic services	8	37
GPMS/APMS and PCTMS	68,193	283,728
Supplies and services – clinical	675	2,329
Supplies and services – general	4,921	32,916
Consultancy services	278	799
Establishment	2,682	9,514
Transport	115	457
Premises	1,679	6,482
Audit fees	216	252
Other non statutory audit expenditure		
· Internal audit services	35	141
Other professional fees	154	5,896
Legal fees	83	298
Education, training and conferences	114	151
Total Purchase of goods and services	**699,904**	**3,074,317**
Depreciation and impairment charges		
Depreciation	343	347
Amortisation	-	16
Total Depreciation and impairment charges	**343**	**363**
Other Operating Expenditure		
Chair and Non Executive Members	208	848
Grants to Other bodies	-	846
Research and development (excluding staff costs)	-	20
Expected credit loss on receivables	(18)	(391)
Other expenditure	-	23
Total Other Operating Expenditure	**190**	**1,347**
Total operating expenditure	**700,437**	**3,076,027**

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 £180k exclusive of VAT

6 Better Payment Practice Code

Measure of compliance	30 June 2022		31 March 2022	
	Number	**£'000**	Number	£'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	17,411	195,746	69,996	681,397
Total Non-NHS Trade Invoices paid within target	17,117	190,663	69,275	665,693
Percentage of Non-NHS Trade invoices paid within target	**98.31%**	**97.40%**	**98.97%**	**97.70%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	344	506,164	1,926	2,217,386
Total NHS Trade Invoices Paid within target	341	506,110	1,891	2,213,030
Percentage of NHS Trade Invoices paid within target	**99.13%**	**99.99%**	**98.18%**	**99.80%**

7 Finance costs

	3 Months 30 June 2022 £'000	31 March 2022 £'000
Interest		
Interest on lease liabilities	6	-
Total finance costs	**6**	**-**

8 Property, plant and equipment

	30 June 2022					31 March 2022			
	Buildings excluding dwellings £'000	Information technology £'000	Furniture & fittings £'000	Total £'000		Buildings excluding dwellings £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	-	1,561	-	1,561	**Cost or valuation at 01 April 2021**	38	5,309	52	5,399
Reclassifications	-	-	-	-	Reclassifications	(38)	(420)	(38)	(495)
Disposals other than by sale	-	(1,561)	-	(1,561)	Disposals other than by sale	-	(3,329)	(14)	(3,343)
Cost/Valuation at 30 June 2022	**-**	**-**	**-**	**-**	**Cost/Valuation at 31 March 2022**	**-**	**1,561**	**-**	**1,561**
Depreciation 01 April 2022	-	1,561	-	1,561	**Depreciation 01 April 2021**	38	4,963	52	5,052
Reclassifications	-	-	-	-	Reclassifications	(38)	(420)	(38)	(495)
Disposals other than by sale	-	(1,561)	-	(1,561)	Disposals other than by sale	-	(3,329)	(14)	(3,343)
Charged during the year	-	-	-	-	Charged during the year	-	347	-	347
Depreciation at 30 June 2022	**-**	**-**	**-**	**-**	**Depreciation at 31 March 2022**	**-**	**1,561**	**-**	**1,561**
Net Book Value at 30 June 2022	**-**	**-**	**-**	**-**	**Net Book Value at 31 March 2022**	**-**	**-**	**-**	**-**
Purchased	-	-	-	-	Purchased	-	-	-	-
Total at 30 June 2022	**-**	**-**	**-**	**-**	**Total at 31 March 2022**	**-**	**-**	**-**	**-**
Asset financing:					**Asset financing:**				
Owned	-	-	-	-	Owned	-	-	-	-
Total at 30 June 2022	**-**	**-**	**-**	**-**	**Total at 31 March 2022**	**-**	**-**	**-**	**-**

9.1 Economic lives

		Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	3	3	3
Information technology	3	3	3
Furniture & fittings	3	3	3

9 Leases

9.1 Right-of-use assets

	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-
IFRS 16 Transition Adjustment	2,873	2,873
Cost/Valuation at 30 June 2022	**2,873**	**2,873**
Depreciation 01 April 2022	-	-
Charged during the year	343	343
Depreciation at 30 June 2022	**343**	**343**
Net Book Value at 30 June 2022	**2,530**	**2,530**

9.2 Lease liabilities

	30 June 2022 £'000	31 March 2022 £'000
Lease liabilities at 01 April 2022	-	-
IFRS 16 Transition Adjustment	-	-
Repayment of lease liabilities (including interest)	6	-
Lease remeasurement	(346)	-
Lease liabilities at 30 June 2022	**(340)**	**-**

9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	30 June 2022 £'000	31 March 2022 £'000
Within one year	(1,367)	-
Between one and five years	(1,166)	-
After five years	-	-
Balance at 30 June 2022	**(2,533)**	**-**
Effect of discounting	-	-
Included in:		
Current lease liabilities	(1,367)	-
Non-current lease liabilities	(1,166)	-
Balance at 30 June 2022	**(2,533)**	**-**

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	30 June 2022 £'000	31 March 2022 £'000
Depreciation expense on right-of-use assets	343	-
Interest expense on lease liabilities	6	-

9.5 Amounts recognised in Statement of Cash Flows

	30 June 2022-23 £'000	31 March 2021-22 £'000
Total cash outflow on leases under IFRS 16	(346)	-

10 Intangible non-current assets

	30 June 2022			31 March 2022	
	Computer Software: Purchased £'000	Total £'000		Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2022	192	**192**	**Cost or valuation at 01 April 2021**	1,919	**1,919**
Reclassifications	-	**-**	Reclassifications	495	**495**
Disposals other than by sale	(192)	**(192)**	Disposals other than by sale	(2,222)	**(2,222)**
Cost / Valuation At 30 June 2022	**-**	**-**	**Cost / Valuation At 31 March 2022**	**192**	**192**
Amortisation 01 April 2022	192	**192**	**Amortisation 01 April 2021**	1,903	**1,903**
Reclassifications	-	**-**	Reclassifications	495	**495**
Disposals other than by sale	(192)	**(192)**	Disposals other than by sale	(2,222)	**(2,222)**
Charged during the year	-	**-**	Charged during the year	16	**16**
Amortisation At 30 June 2022	**-**	**-**	**Amortisation At 31 March 2022**	**192**	**192**
Net Book Value at 30 June 2022	**-**	**-**	**Net Book Value at 31 March 2022**	**-**	**-**
Purchased	-	**-**	Purchased	-	**-**
Total at 30 June 2022	**-**	**-**	**Total at 31 March 2022**	**-**	**-**

10.1 Economic Lives	**Minimum Life (years)**	**Maximum Life (Years)**
Computer Software : Purchased	3	**3**

11.1 Trade and other receivables

	30 June 2022		31 March 2022	
	Current	**Non-current**	Current	Non-current
	£'000	**£'000**	£'000	£'000
NHS receivables: Revenue	5,386	-	10,717	-
NHS accrued income	6,942	-	69	-
Non-NHS and Other WGA receivables: Revenue	3,058	-	5,555	-
Non-NHS and Other WGA prepayments	3,506	-	3,325	-
Non-NHS and Other WGA accrued income	4,113	-	1,429	-
Expected credit loss allowance-receivables	(1,045)	-	(1,101)	-
VAT	533	-	770	-
Other receivables and accruals	6	-	8	-
Total Trade & other receivables	**22,498**	**-**	**20,770**	**-**
Total current and non current	**22,498**		**20,770**	

11.2 Receivables past their due date but not impaired

	30 June 2022		31 March 2022	
	DHSC Group Bodies	**Non DHSC Group Bodies**	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	**£'000**	£'000	£'000
By up to three months	197	184	2,393	2,506
By three to six months	972	3	3	43
By more than six months	4,100	1,065	2,579	1,123
Total	**5,269**	**1,251**	**4,976**	**3,673**

11.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	**Other financial assets**	**Total**
	£'000	**£'000**	**£'000**
Balance at 01 April 2022	(1,101)	-	**(1,101)**
Lifetime expected credit losses on trade and other receivables-Stage 2	56	-	**56**
Total	**(1,045)**	**-**	**(1,045)**

12 Cash and cash equivalents

	30 June 2022 £'000		31 March 2022 £'000
Balance at 01 April 2022	1,951	**Balance at 01 April 2021**	473
Net change in year	(11,174)	Net change in year	1,479
Balance at 30 June 2022	**(9,223)**	**Balance at 31 March 2022**	**1,951**
Made up of:		Made up of:	
Cash with the Government Banking Service	-	Cash with the Government Banking Service	1,951
Cash with Commercial banks	-	Cash with Commercial banks	-
Cash and cash equivalents as in statement of financial position	**-**	**Cash and cash equivalents as in statement of financial position**	**1,951**
Bank overdraft: Government Banking Service	(9,223)	Bank overdraft: Government Banking Service	-
Total bank overdrafts	**(9,223)**	**Total bank overdrafts**	**-**
Balance at 30 June 2022	**(9,223)**	**Balance at 31 March 2022**	**1,951**

13 Trade and other payables	30 June 2022 Current £'000	30 June 2022 Non-current £'000	31 March 2022 Current £'000	31 March 2022 Non-current £'000
NHS payables: Revenue	4,563	-	4,742	-
NHS accruals	18,650	-	21,188	-
Non-NHS and Other WGA payables: Revenue	23,482	-	48,563	-
Non-NHS and Other WGA accruals	82,637	-	86,451	-
Non-NHS and Other WGA deferred income	4	-	296	-
Social security costs	586	-	540	-
Tax	477	-	483	-
Other payables and accruals	66,430	-	85,527	-
Total Trade & Other Payables	**196,829**	**-**	**247,790**	**-**
Total current and non-current	**196,829**		**247,790**	

Other payables include £2,708,664 outstanding pension contributions at 30 June 2022

The Other Payables Figure of £66.4m at 30 June 2022 can be broken down into the following areas (2021/22 also detailed):

	30 June 2022 £m	31 March 2022 £m
Payroll and Pension Accruals	2.7	2.7
Approved & unapproved general invoices	0.8	2.0
Service Development Accruals	1.9	9.8
Covid-19 Accruals	0.8	2.1
Acute Accruals	0.8	1.8
Mental Health Accruals	12.4	6.6
Community Accruals Including Continuing Healthcare	31.4	30.3
Primary Care Accruals Including IT	6.5	16.8
Running Cost Accruals	0.2	1.1
Other Accruals	8.9	12.3
	66.4	**85.5**

14 Borrowings	30 June 2022 Current £'000	30 June 2022 Non-current £'000	31 March 2022 Current £'000	31 March 2022 Non-current £'000
Bank overdrafts:				
· Government banking service	9,223	-	-	-
Total overdrafts	**9,223**	**-**	**-**	**-**
Total Borrowings	**9,223**	**-**	**-**	**-**
Total current and non-current	**9,223**		**-**	

14.1 Repayment of principal falling due

	Department of Health £'000	Other £'000	Total 30 June 2022 £'000
Within one year	9,223	-	9,223
Between one and two years	-	-	-
Between two and five years	-	-	-
Between one and five years	**9,223**	**-**	**9,223**
After five years	-	-	-
Total	**9,223**	**-**	**9,223**

Note

The £9,223k overdrawn figure must be viewed together with items that had not cleared from the CCG's bank account by 30th June 2022

The Table below reconciles the general ledger balance to the CCG's bank account

Once uncleared items are factored in, it shows that the CCG bank account was in credit by £1,061k.

Description	£'000
General Ledger Balance	(9,223)
Uncleared BACS	10,280
Uncleared Cheques	4
Actual Bank Balance	**1,061**

15 Provisions

	30 June 2022		31 March 2022	
	Current	**Non-current**	Current	Non-current
	£'000	**£'000**	£'000	£'000
Continuing care	-	-	-	-
Total	**-**	**-**	**-**	**-**
Total current and non-current	**-**		**-**	

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 30 June 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 30 June 2022 in respect of employer liabilities of NHS South West London CCG (2021/22 £0).

16 Contingencies

The CCG had no outstanding claims at 30th June 2022 that are considered to have a likelihood that deems them reportable as a contingent liability in 2022/23.

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 30th June 2022 is £814k.

17 Commitments

NHS South West London CCG has no reportable commitments at 30th June 2022.

18 Operating segments

The CCG has just one operating segment which is the commissioning of healthcare.

19 Financial instruments

19.1 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.

19.1.1 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.

19.1.2 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.

19.1.3 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.

19.1.4 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.

19.1.5 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.

19 Financial instruments cont'd

19.2 Financial assets

	30 June 2022		31 March 2022
	Financial Assets measured at amortised cost £'000		Financial Assets measured at amortised cost £'000
Trade and other receivables with NHSE bodies	5,500	Trade and other receivables with NHSE bodies	9,604
Trade and other receivables with other DHSC group bodies	11,561	Trade and other receivables with other DHSC group bodies	1,904
Trade and other receivables with external bodies	1,398	Trade and other receivables with external bodies	5,167
Cash and cash equivalents	-	Cash and cash equivalents	1,951
Total at 30 June 2022	**18,459**	**Total at 31 March 2022**	**18,626**

The figure for Trade and other receivables excludes the following which are classed as non financial assets
Prepayments, £3,506k
VAT receivable £533k

The figure for Trade and other receivables excludes the following which are classed as non financial assets
Prepayments, £3,325k
VAT receivable £770k

19.3 Financial liabilities

	30 June 2022		31 March 2022
	Liabilities measured at amortised cost - carrying value £'000		Liabilities measured at amortised cost - carrying value £'000
Loans with external bodies	9,223	Loans with external bodies	-
Trade and other payables with NHSE bodies	622	Trade and other payables with NHSE bodies	851
Trade and other payables with other DHSC group bodies	23,422	Trade and other payables with other DHSC group bodies	25,739
Trade and other payables with external bodies	171,718	Trade and other payables with external bodies	219,880
Lease Obligations	2,533	Lease Obligations	-
Total at 30 June 2022	**207,518**	**Total at 31 March 2022**	**246,470**

The figure for Trade and other payables excludes the following which are classed as non financial liabilities.
Social security costs £586k
Tax £477k
Non NHS and Other WGA deferred income 4k

The figure for Trade and other payables excludes the following which are classed as non financial liabilities.
Social security costs £540k
Tax £484k
Non NHS and Other WGA deferred income 296k

20 Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

20.1 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 statutory functions

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 the BCF total fund.

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:

			30 June 2022 Amounts recognised in Entities books ONLY				31 March 2022 Amounts recognised in Entities books ONLY			
Name of arrangement	Parties to the arrangement	Description of principal activities	Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Better Care Fund	South West London CCG & London Borough of Croydon	Provision of Health & Social Care	-	-	-	3,106	-	-	-	12,307
Better Care Fund	South West London CCG & Royal Borough of Kingston	Provision of Health & Social Care	-	-	-	2,265	-	-	-	8,574
Better Care Fund	South West London CCG & London Borough of Merton	Community Health and Social Care services	-	-	(24)	3,764	-	-	(96)	14,347
Better Care Fund	South West London CCG & London Borough of Richmond upon Thames	Community Health and Social Care services	-	-	-	1,782	-	-	-	6,747
Better Care Fund	South West London CCG & London Borough of Sutton	Community Health and Social Care services	-	-	(1,765)	3,609	-	-	(6,090)	13,737
Better Care Fund	South West London CCG & London Borough of Wandsworth	Community Health and Social Care services	-	-	(77)	6,385	-	-	(363)	24,533

21 Related party transactions

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 Nelson Medical Practice
The Groves Medical Centre
Brocklebank Group Practice
Stonecot Surgery
Mulgrave Road Surgery
Parchmore 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 £10m.

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.

22 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 allowed for the establishment of Integrated Care Boards (ICBs) across England and abolished clinical commissioning groups (CCGs). South West London ICB took 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.

23 Losses and special payments

The CCG did not incur any losses in period to June 22.

Special payments

	30 June 2022		31 March 2022	
	Total Number of Cases Number	**Total Value of Cases £'000**	Total Number of Cases Number	Total Value of Cases £'000
Compensation payments	-	-	1	23
Total	**-**	**-**	**1**	**23**

24 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:

	30 June 2022			31 March 2022		
	Target £'000	**Performance £'000**	**Pass / Fail**	Target £'000	Performance £'000	**Pass / Fail**
Expenditure not to exceed income	712,709	712,707	Pass	3,123,579	3,123,435	Pass
Capital resource use does not exceed the amount specified in Directions	-	-	N/A	-	-	N/A
Revenue resource use does not exceed the amount specified in Directions	704,996	704,994	Pass	3,090,708	3,090,564	Pass
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	N/A	-	-	N/A
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	N/A	-	-	N/A
Revenue administration resource use does not exceed the amount specified in Directions	7,790	7,788	Pass	30,908	30,907	Pass