NHS
South East London
Clinical Commissioning Group

Annual Report and Annual Accounts 2022/23

(April 2022 to June 2022)

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1. Welcome and Introduction

Dear reader,

Welcome to the NHS South East London Clinical Commissioning Group (CCG) annual report and accounts, covering the first quarter of the 2022/23 financial year.

On 28 April 2022, HM Government passed the Health and Social Care Bill that confirmed the establishment of Integrated Care Boards from 1 July 2022, and the co-terminous dissolution of Clinical Commissioning Bodies. As a result, this annual report covers the last three months of the operation of NHS South East London Clinical Commissioning Group, for the period from 1 April 2022 to 30 June 2022.

During this period, NHS South East London CCG continued to work to deliver its priority to ensure that the 1.9 million people living in South East London experience the highest possible standard of care within the resources available. The CCG has focussed on ensuring that the preparations for transition to an Integrated Care Board have not detracted from the day-to-day business of meeting the health needs of our residents.

During the final three months of the CCG's operations, we have continued to work as a clinical led organisation that works collaboratively with our partners to improve outcomes and address health inequalities in our population. New initiatives such as the acute flow improvement group have been introduced and we have worked hard to address performance challenges, including achieving a significant reduction in the number of people waiting 104 weeks or more for treatment, within the context of the recovery phase of the Covid-19 pandemic and the continual operation of the vaccination programme.

We will continue to maximise the benefits of the enhanced levels of joint working that emerged during the Covid-19 response in south east London, working in partnership with local NHS services, local authorities and voluntary and community organisations to deliver a more seamless experience of care, tackling health inequalities and seeking to transform and shape services so that they work best for everyone.

As we transition from a CCG to an Integrated Care Board, I would like to thank everyone in the CCG, our partners and those who have directly and indirectly supported the NHS in south east London, for the commitment and resilience they have demonstrated in developing a health service that meets the needs of the population of south east London.

Jonty

Dr Jonty Heaversedge
GP and Chair, NHS South East London Clinical Commissioning Group

2. Who we are

This section sets out the key duties, purpose and activities of the CCG and provides a description of the organisation's structure and the environment within which we operate.

2.1. Introduction to NHS South East London CCG

NHS South East London Clinical Commissioning Group is a clinically led organisation responsible for planning, paying for and monitoring most of the health services in the six boroughs that we cover, with the priority of ensuring that the 1.9 million people living in south east London experience the highest possible standard of care within the resources made available.

NHS South East London Clinical Commissioning Group (CCG) was established on 1 April 2020, working across the London Boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

The CCG aims to work with partners to improve care and health outcomes for local people. CCG's are established as membership organisations, whose members, in the case of NHS South East London CCG, represent the GP practices that serve the six boroughs.

Led by a governing body made up of local GPs drawn from across our boroughs, other clinicians, executives and lay members, the CCG is responsible for planning and paying for most health care services local people use. CCGs ensure that residents can access the best possible care from the services commissioned on their behalf.

This involves assessing local needs and prioritising the use of funding with our partners, including local authorities, hospitals, community and primary care services. CCGs monitor the care provided, as well as respond and adapt to changing local circumstances in response their responsibility for commissioning to improve the health of their entire population.

The CCG's main purpose is to improve the health and wellbeing of south east London people. We will do this by:

- Ensuring that the services we commission for local people are high quality, safe and accessible.
- Working with our partners across health and social care, including those in the voluntary and independent sectors, to plan and improve services.
- Building effective relationships with organisations that deliver care to improve the way that services are joined up and are in the best interests of those using these services
- Making sure that the money we receive from the Government is used to provide the right services, to the right people and at the right time.

As our population continues to grow and age, we will see an increase in demand for health and social care services, as more people live for longer with pre-existing and often long-term conditions. Today, there is unacceptable variation in the care people experience across our six boroughs in terms of its quality, ease of access and the outcomes experienced.

We are trying to address these issues by delivering a concerted and targeted approach to how care is delivered, tackling variations in quality and outcomes to reduce current inequalities. We do this by making our services more joined up and easier to use, which in turn will make them more cost-effective to run.

We support work underway within south east London to improve the care and services people use in the community or when they need urgent medical help, sometimes in an emergency. We are equally focused on preventative intervention and use of population health data to proactively identify those in need of care. We want to ensure that people who have health conditions such as cancer, cardiovascular disease, respiratory illnesses and diabetes experience better services and outcomes. At the same time, we are working to see improvements in the quality and consistency of our maternity services, and the care provided for people of all ages with a mental health condition and/or learning disability and autism.

We are committed to promoting equality and diversity for the people of south east London. Our commissioning processes are underpinned by human rights principles. This means that commissioning decisions will be subject to fairness, respect, equality, dignity and autonomy. We also have leadership roles for equality and diversity, which sit on our governing body to ensure that it is championed at the highest levels.

Engagement with the public enables us to make better decisions underpinned by a clear understanding of public views, concerns and aspirations. Knowing what people think about existing health services is vital to help us improve the experience of care for all patients.

We base our engagement activities on evidence of what works well, as well as national best practice. We continue to involve local people at neighbourhood and borough level, and there will be occasions when we need to engage with people across borough boundaries, sometimes across south east London.

We continue to reach out proactively to people and communities so they can be involved in a consistent way. We remain committed to addressing the inequalities and barriers to participation and involvement of seldom heard groups in south east London – including young people, those yet to develop health conditions, people from our LGBTQI+ communities, those living in areas of deprivation within our boroughs and people from black and minority ethnic communities.

We aim to deliver all of this in a way that is sustainable and respects the environment we all live and work in, recognising the benefits to the health and wellbeing of our population that we can bring through our contribution to tackling the climate change challenge by

making changes to our own ways of working. Through working together with our ICS partners and local communities we can achieve the national target of a net zero carbon NHS by 2040.

2.2. Our duties

Under the National Health Service Act 2006, CCGs have several duties and powers. You can find full details of these here.

The statutory duties of the CCG require us to arrange for the provision of hospital and other accommodation and medical and other services to meet the reasonable needs of the people we are responsible for. This includes people who are provided with primary medical (GP) services by a member practice within the CCG or people who usually live in the local authority areas within south east London. Additionally, the CCG is charged with arranging for the provision of ambulance services and emergency services for every person present within south east London.

In this annual report, we describe how we have fulfilled these duties to improve the quality of local services, reduce health inequalities, promote involvement of each patient in their own care, offer patient choice, support the integration of services, work together with the public and patients and ensure that we have plans in place to deal with surges in demand for services and major incidents.

We certify that the NHS South East London CCG has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

2.3. Our population

South east London has a highly diverse population, and the health and care needs of its 1.9 million people are complex. The population is growing and is predicted to increase by 9.5%, exceeding 2 million, by 2029. The expected growth in the older population far outstrips the overall population growth rate (by three times in both 65-80 years and 80+ years); this is likely to lead to increasing demand for care across the system overall. There is significant health inequality, both within and across our six boroughs. Life expectancy at birth can vary within a borough by up to nine years between the most and least deprived areas. When it comes to people's health, the wider determinants of health – such as deprivation, the local environment, housing, crime, education, employment and social isolation – have a significant impact, as do individual lifestyle choices. One in five children in south east London live in low-income homes, with most of our boroughs, Greenwich, Lambeth, Lewisham and Southwark, ranking amongst the 15% most deprived local authority areas in the country. Whilst Bexley and Bromley are comparatively less deprived, they both still have pockets of significant deprivation. The proportion of people from black and minority ethnic backgrounds also differs across our boroughs, from 60% in Lambeth to 19% in Bromley. We also have a higher-than-average proportion of local people identifying as LGBTQI+. For example, Lambeth and

Southwark have the second and third largest lesbian, gay and bisexual communities in the country. There is a large prison population of over 3,500 adult men and young adults across four prisons situated in Greenwich and Lambeth.

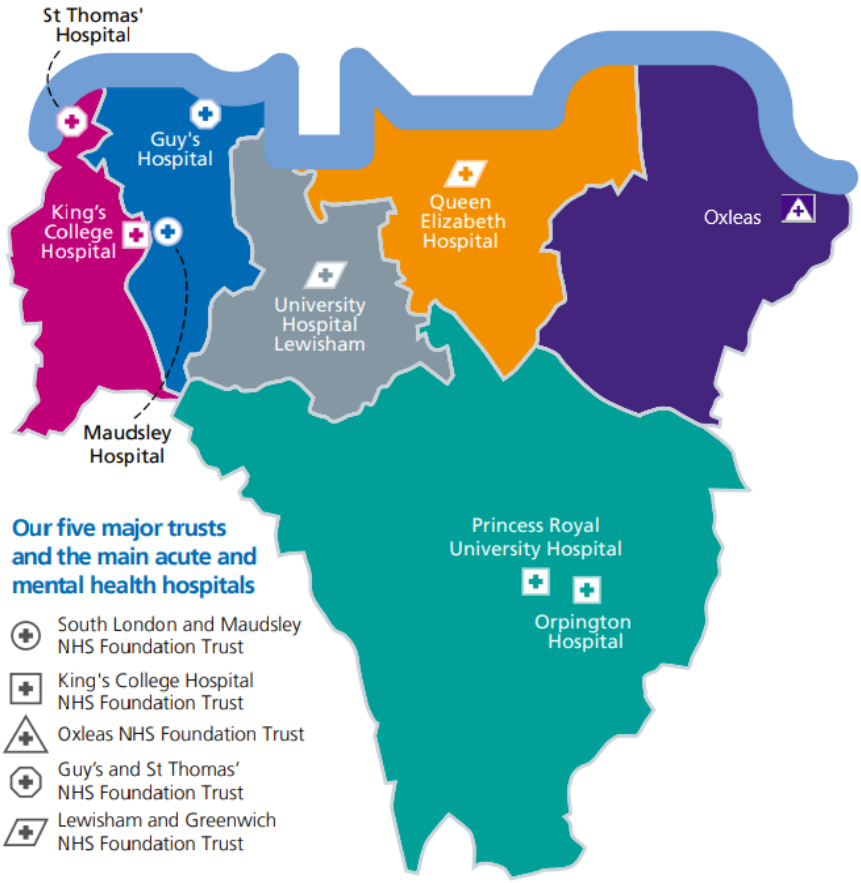
More information on each of our boroughs can be found on their local pages through the CCG's website: www.selondonccg.nhs.uk.

2.4. Partnership Working across South East London

People living in south east London access most of their health and social care very locally. When they do need more specialist care they have access to some of the country's finest specialist medical care through our teaching hospitals and wider acute provision and often access those services right across our six boroughs. However, people tell us that health and care services are often fragmented, resulting in duplication and confusion for those who use them. Not only is this unacceptable, it impacts on the quality of outcomes and increases the cost of delivering these services.

The key to making our services better is through improved partnership working. When it comes to health and social care, organisations working in isolation can rarely affect the types of change needed to bring about the greatest benefit for most people. Our map of south east London's boroughs and hospital locations, if overlaid by the wider range of organisations, providers and community support that make a difference to peoples' lives, is hugely complex. We need to do more to help local people navigate this system and access the right advice and care.

Our partnership working, driven through our integrated care system (ICS), named Our Healthier South East London, aims to bring about real improvement. Our ICS currently brings together six local authorities, five NHS trusts and NHS South East London CCG. You can find out more about its work at www.ourhealthiersel.nhs.uk .



In addition, the CCG continues to develop positive working relationships with Healthwatch and voluntary and community sector organisations.

The benefit of partnership working has been formally recognised through the Governments Health and Care Bill which aims to transform delivery of health and social care services. These proposals build on the NHS's recommendations in its Long Term Plan and will result in the NHS and local authorities being given a duty to collaborate with each other. This will be co-ordinated on an ICS level by a statutory organisation called the Integrated Care Board (ICB), with mechanisms to ensure formal input to ICS wide decisions by a variety of health and social care stakeholders. At the same time as the ICB becomes a statutory body, the CCG will be disestablished. The date for this change was 1 July 2022.

2.5. Working at borough and system levels

NHS South East London CCG operates with borough-based boards to deliver the CCG's plans at a local level, working closely with local authorities (who are represented on CCG borough based boards) and additionally with wider partners in Local Care Partnerships.

The overall aim is to bring together commissioning and provider organisations from across the health and care system in each borough to plan and provide a range of coordinated services that deliver more integrated care for local people, with a focus on the health and wellbeing of the local population. This means that our boroughs have health and wellbeing strategies that cover the development of health and care services locally.

In this way, the CCG can work at different population levels, within a neighbourhood or a whole borough through borough-based initiatives, or where most appropriate across more than one borough or even the whole of south east London.

All of this is overseen by the CCG's Governing Body, with membership drawn from all six boroughs. For information on our Council of Members and our Governing Body, and our governance structure please refer to our Annual Governance Statement on page 85. Individual borough-based information regarding the Boards and their local care partnerships can be found at www.selondonccg.nhs.uk

2.6. Key risks and influences on South East London

Delivery of the CCG's ambitions set out in the ICS's Long Term Plan and other system strategies, in a way that truly impacts and improves the health of our population, underpins all of the CCG's activities.

NHS South East London CCG therefore strives to deliver high quality services at best value, whilst working in a challenging environment which presents a number of key risks to the delivery of its objectives. These risks manifest themselves in several areas including:

- A financially challenging environment, driven by increased activity particularly in our acute providers
- Service performance, and the impact on the CCG in achieving constitutional and national targets against which we are measured, particularly following recovery from the pandemic
- Health inequalities within the borough, requiring a dynamic, patient-centred response

The CCG produces a monthly Board Assurance Framework (BAF) that details the key risks and mitigations to the delivery of the above-described duties and objectives. The BAF is available on the CCG's website under governing body papers. More information on how the CCG identifies and manages its risks is included in the Governance section of this annual report.

3. Performance Report

3.1. Performance Overview:

This section of the annual report provides information on the CCG's performance - measured in terms of compliance against national constitutional and performance and standards for our south east London population - for the quarter from April to June 2022.

The performance assessment needs to be seen in the context of the pandemic impact and the need to manage available capacity to meet on going Covid demand, pent up and increased urgent and emergency care and mental health demand plus the recovery of elective activity and work to reduce the waiting list backlogs that have built up as a result of the pandemic.

Our 2022/23 plans seek to continue the positive progress made over the last year, with targets again recognising the legacy of the pandemic and the need to recover before we can get back to the delivery of pre pandemic constitutional and performance targets.

As a consequence of the need to respond at pace to the Covid-19 pandemic, the CCG was able to accelerate the implementation of a number of innovations in healthcare delivery that were already underway but were delivered more quickly within the context of the pandemic and from which our residents are already benefiting. In addition to an enhanced level of system working, the ways in which primary care services, in particular have been delivered have been explored to ensure maximum outreach and access to our local communities.

The use of technology and digital solutions to maximise access have resulted in an expansion in online video consultations, use of tele-services to deliver clinical assessments and support quick referrals to secondary pathways (for example, for dermatology referrals), remote monitoring of patients, and general access to information via online means. The SEL Digital First programme has an aim to ensure that, by 2023, every patient in south east London has equitable access to general practice support enhanced by Digital First tools which are safe, inclusive and easy to use, as well as equitable access to remote monitoring services. Local activity to achieve digital maturity is monitored through a programme dashboard, and investment in digital accelerator schemes and the use of a patient champion model across the ICS are further ways in which the team are working towards fully equitable digital access for patients.

Primary care has also been supported by the Clinical Effectiveness South East London (CESEL) team, a quality improvement team formed of clinical leads from each SEL borough and a small central team, who deliver supportive interventions such as guides, education events and facilitation visits. Looking forward, CESEL has led one of four successful London pathfinder project bids, looking at a hypertension project and partnering in a childhood immunisation project. Both projects bring welcome funding for improving

outcomes and reducing inequalities. In addition, the team is working with SEL practices to support diabetes improvement and achieve both local and national diabetes targets.

The system has continued to focus on implementing agreed system wide urgent and emergency care pathway developments and improvements, including the on-going development of the SEL 111 service, the development and roll out of Same Day Emergency Care, sustaining and further enhancing the discharge improvement, developing our community services to support admission avoidance and supported discharge across both physical and mental health, and ensuring we can provide timely support for mental health patients in crisis.

Sustainability and the environment are matters that have featured highly on the agenda for the CCG. The SEL ICS 'Green plan' was published on 31 March 2022 - outlining how we will make progress towards the NHS's commitment to net zero by 2040, over the next three years. Partners across the ICS have been working collaboratively to develop system-wide plans, and the CCG specifically has published a plan to support Primary Care. We also believe that the focus on sustainability should support our 'anchor' approach – how as a large public sector organisation we can best support the communities we serve.

More detail on many of these initiatives, and how we have worked with our local communities to deliver them and ensure they meet their needs, is provided in the performance analysis section (3.2.1) below.

Summary position for South East London CCG

Acute performance summary

The following table provides the final South East London CCG position for the main performance and constitution standards. Also included is the trust-wide position, which provides the collective performance across the three acute trusts located in south east London. The final 2021/22 position (March 2022) is also shown to provide a comparison against current year performance.

- Elective care - Referral to Treatment (RTT) waiting times: The percentage of referral to treatment (RTT) incomplete pathways (patients yet to start treatment) within 18 weeks.

- Elective care - Referral to Treatment (RTT) 52 week waits: The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 52 weeks or more.

- Elective care - Referral to Treatment (RTT) 104 week waits: The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 104 weeks or more.

- Elective care - Referral to Treatment (RTT) 78 week waits: The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 78 weeks or more.

- Diagnostic waits: The percentage of patients waiting six weeks or more for a diagnostic.

- A&E 4-hour performance: Percentage of A&E attendances where the patient spent four hours or less in A&E from arrival to transfer, admission or discharge.

- Cancer two week waits: Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer.

- Cancer 62 day waits: Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.

- Cancer 28 day waits (faster diagnosis standard): Percentage of patients receiving communication of diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, within 28-days following an urgent referral for suspected cancer, a referral for breast symptoms where cancer was not initially suspected, or an urgent referral from an NHS Cancer Screening Service

Metric	Standard	SEL CCG		SEL Trusts	
		June 2022	March 2022	June 2022	March 2022
RTT 18 week wait performance	92%	**68.7%**	68.8%	**68.5%**	68.2%
RTT 52 week wait performance	0	**4,584**	3,818	**4,951**	4,240
RTT 78 week wait performance*	0	**404**		**440**	
RTT 104 week wait performance	0	**12**	100	**6**	112
Diagnostics 6 week waits	1%	**7.9%**	6.1%	**7.6%**	6.6%
A&E 4-hour performance**	95%			**70.5%**	69.3%
Cancer 2 week waits	93%	**88.0%**	82.1%	**88.3%**	81.3%
Cancer 62 day waits	85%	**68.3%**	71.0%	**67.5%**	68.7%
Cancer 28 day faster diagnosis standard	75%	**72.9%**	71.5%	**73.2%**	71.4%

*RTT 78 week wait performance was not reported in 21/22

**A&E 4-hour performance is not reported at a CCG level

Mental health performance summary:

The following table provides the final South East London CCG position (where available) for the following key mental health performance standards and targets. Where the final position has not yet been published, the latest position is provided. The final 2021/22 position (March 2022) is also shown to provide a comparison against current year performance.

- Improving Access to Psychological Therapies (IAPT) access rate: This is the number of people entering treatment as a percentage of the estimated prevalence of people with common mental health disorders.

- IAPT recovery rate: The percentage of people who have completed treatment and are moving to recovery.

- Dementia diagnosis: Diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence.

- SMI physical health checks: The proportion of people on the GP serious mental illness (SMI) registers who have received a comprehensive physical health assessment in the 12 months to the end of the reporting period.

- Children & Young People under the age of 18 who have had at least two contacts from NHS funded mental health services as a proportion of those estimated to have mental health needs.

- The proportion of Children and Young People (CYP) with eating disorders (routine cases) that wait four weeks or less from referral to start of NICE-approved treatment.

- The proportion of Children and Young People (CYP) with eating disorders (urgent cases) that wait one week or less from referral to start of NICE-approved treatment.

- Inappropriate adult acute mental health Out of Area Placement (OAP) bed days: The number of bed days for inappropriate Out of Area Placements (OAPs) in mental health services for adults in non-specialist acute inpatient care.

- Early Intervention in Psychosis (EIP) waiting times: First episode psychosis treatment with NICE recommended package of care within two weeks of referral.

Metric	2022/23 Target	Period	Latest position	March 2022
IAPT access rate	6.2%	Q4 2021/22	**5.0%**	5.0%
IAPT recovery rate	50%	May 2022	**49.1%**	51.6%
Dementia diagnosis	66.7%	June 2022	**68.7%**	69.1%
SMI physical health checks	60%	Q1 2022/23	**34.8%**	33.4%
CYP access	35%	May 2022	**37.8%**	38.0%
CYP eating disorder wait times – routine	95%	Q1 2022/23	**34.7%**	41.2%
CYP eating disorder wait times – urgent	95%	Q1 2022/23	**64.3%**	27.3%
OAP bed days	0	June 2022	**1,065**	1,145
EIP waiting times	60%	May 2022	**60.0%**	59.3%

For more detail on our work with partners to support performance delivery in these areas, please refer to the performance analysis section below.

3.2. Performance analysis

This section outlines the CCG's role in respect of the following:

- The performance of commissioned providers against national performance Standards
- Assurance and improvement of quality and safety of care
- Infection prevention and control and safeguarding activities
- Work with people and communities
- Promoting and addressing issues of equality
- Supporting and developing our staff
- Our financial performance
- Highlights from our borough teams
- Sustainable development
- A forward view into 2022/23

3.2.1. Provider performance

NHS Constitution standards and national performance indicators in 2022-23

Acute and urgent and emergency care services

Elective care

South east London trust-wide referral to treatment performance (percentage of incomplete pathways waiting less than 18 weeks) was 68.5% in June 2022, which is below the 92% standard. There was an increase in waiting list size during the quarter, with 233,984 patients on the waiting list in June 2022 compared to 227,085 at the end of March 2022.

The number of people waiting over 52 weeks was 4,951 in June 2022, compared to 4,240 at the end of March 2022. At the end of June 2022 there remained a cohort of 6 patients waiting more than 104 weeks across south east London providers, which was above the national target of 0. However, this was a decrease from the position at the beginning of the quarter. There were 112 at the end of March 2022. Over 104 week waits continue to be monitored closely.

All three south east London acute providers continue to work collectively under the governance of the Acute Provider Collaborative (APC). Work is being carried out with the APC to reduce over 78 week waits to 0 by March 2023 and to monitor over 104 week wait risks. SEL Trusts work together, providing mutual aid as appropriate, to prevent breaches.

SEL CCG continued to support the APC with the development of an SEL Patient Tracking List (PTL). This PTL is updated on a weekly basis and allows detailed review and monitoring of booking profiles, key procedures and will allow actionable reports to be provided to the various elective recovery workstreams.

A non-admitted transformation programme is underway. Work is ongoing with urology, gynaecology and general surgery to implement clinical triage of referrals. Follow-up audits have been undertaken in gynaecology and urology to identify opportunities to reduce non-value adding follow-ups and similar work is being undertaken in dermatology. A waiting times website has been developed which allows GPs to see waiting times for first appointments for different specialties across the three trusts. The website also contains information on the alternative services available in each borough.

Diagnostics

The June 2022 SE London Trust-wide diagnostic performance position was 7.6% which is above the target of 1%. In June 2022 there remained 2,665 people waiting over 6 weeks across south east London Trusts. Improvement plans and additional capacity and activity are planned across acute and community sites to address this backlog during 2022/23.

Urgent and emergency care

A&E attendances continued to be exceptionally high during Q1 2022/23. Covid infection rates continued to impact staffing levels, hospital admissions and affected flow due to enhanced infection control measures. At the end of June 2022 there were 71,453 A&E attendances compared to 72,074 at the end of March 2022.

The south east London trust-wide performance against the standard of 95% of attendances being admitted, transferred or discharged within four hours, was 70.5% in June 2022 which was an improvement compared to March 2022 (69.3%).

Staff Covid-related absences added to ongoing capacity challenges at acute, mental health and community providers and social care. This impacted the timely flow of patients out of emergency departments and the number of 12-hour trolley waits. In June 2022, there were 760 12-hour trolley waits across all south east London trusts.

SEL CCG continued to work with mental health providers to develop and improve mental health crisis services and to provide higher levels of care out of hospital. All south east London sites with an emergency department (ED) are now delivering some mental health assessment capacity so that presenting patients can be seen in an appropriate environment away from the main emergency departments.

The new Acute Flow Improvement Group has been established. This has representation from senior operational leads from all SEL acute providers and meets regularly to cover a wide range of urgent and emergency care flow issues. The London Ambulance Service (LAS) is also involved with this group and works with all SE London ED sites to improve handover times. The SEL Operations Centre has daily check-ins with sector ED departments and they work together to alleviate issues and mitigate risks.

Cancer

The primary focus during the first quarter of 2022/23 continued to be backlog reduction and maintaining or increasing activity levels (diagnostic, outpatients and treatments) and meeting the 28 day Faster Diagnosis Standard (FDS).

The trust-wide position for the percentage of patients seen within 2 weeks of an urgent GP referral was 88.3% at the end of June 2022. This is below the target of 93% but an improvement in performance from March 2022. The percentage of patients with first treatment within 62 days of urgent GP referral was 67.5% in June 2022, which is below the target of 85%.

The Faster Diagnosis Standard (FDS) was not achieved in June 2022 for SEL trusts with a performance of 73.2% against a target of 75%.

A South east London system-Level Performance Improvement Plan (PIP) has been in place during quarter 1 of 2022/23. The PIP plan has actions covering the 2 week wait and FDS standards, 31 day and 62 day standards, backlog reduction, Inter Trust Transfers and whole pathway reviews.

Rapid Diagnostic Clinic (RDC) provision has been expanded to the Princess Royal University Hospital and Queen Elizabeth Hospital sites as well as at the existing Guy's and St Thomas' Trust site. As this becomes fully operational over 2022-23 it should help to improve FDS performance.

Mental health care services

A trajectory was agreed to improve the overall south east London access rate to IAPT services in 2021/22. The trajectory was achieved in quarter one. However, performance deteriorated to 5.0%, below a trajectory of 6.2%, in quarter four. This is the latest available data at the time of publication.

In May 2022, south east London achieved a recovery rate of 49.1% which was below the national target of 50%. IAPT services delivered timely access to care with 89.7% of patients entering treatment in six weeks against a target of 75%, and 98.5% of patients entering treatment in 18 weeks against a target of 95%.

From August 2021, NHS South East London CCG has met the dementia diagnosis rate target of 66.7%. In June 2022, the SEL performance was 68.7%.

Throughout the pandemic, the proportion of people on the severe mental illness (SMI) register receiving an annual physical health check remained below the national standard of 60%. Performance was impacted by the subsequent drop in face-to-face GP appointments which are required to carry out some of the tests. Despite an increased number of checks carried out in the last twelve months (achieving 34.8% of people on GPs' SMI registers by Q1 2022/23) there is more to do to increase both service capacity and uptake.

To help drive improvement longer term, the CCG established a steering group which has representation from across the SEL health system. The group has captured good practice being implemented in parts of SEL and will be working with boroughs to implement good practice more consistently across SEL to drive improvement. The steering group will also oversee the implementation of a population health management approach to improving the uptake of SMI physical health checks with an initial focus on improving the capture and use of data.

The number of inappropriate out of area placements (OAPs) bed days in mental health services decreased between March 2022 to June 2022. At the end of June 2022 there were 1,065 bed days reported which was, however, above the local plan of eliminating OAPs by March 2022. Providers are focused on reducing length of stay and improving flow within their inpatient wards to free up capacity and reduce OAPs.

Performance against the Children and Young People (CYP) access standard was 37.8% in May 2022 and is compliant with target. There are challenges in meeting CYP eating disorder waiting times for both routine referrals and urgent referrals with performance in Q1 2022/23 of 34.7% and 64.3% respectively against a target of 95%. Investment has been agreed to support capacity expansion and pathway and access improvements.

In May 2022, 60.0% of patients in SEL were treated within two weeks of referral achieving the target of 60% for Early Intervention In Psychosis (EIP) waiting times.

Learning Disability and autism

The Learning Disability and Autism (LDA) programme during Q1 2022/23 continued to focus on Long Term Plan (LTP) commitments and priority actions, working to achieve mandatory priorities such as reducing reliance on inpatient care and annual health checks (AHCs).

The LDA priority actions focus on:

- Early intervention and admission prevention
- Delivering coordinated care for people with learning disability and autism
- Commissioning to improve community capacity

The LDA programme focused on activities to reduce admission to hospital and on Care, Education and Treatment Reviews (CETRs) to support discharge from hospital.

3.2.2. Quality Assurance of commissioned care

During Quarter 1 2022-23 the Quality team continued to work collaboratively with commissioned providers, to ensure a focus on quality assurance and improvement of services, supporting the Covid-19 Pandemic recovery programme and business as usual activities.

The team continued to attend provider led Quality Committees as well as having informal conversations to discuss areas of concern and risk. This process has supported the establishment of quality ways of working within the emerging Integrated Care Board and Integrated Care Partnerships.

The CCG has continued to review serious incidents and quality alerts (QAs) which are mechanisms used when the quality of services falls below acceptable standards and patients may suffer from harm or not have the expected quality of service. Serious Incident and Quality Alert reporting supports our local services to investigate and identify “lessons” – the things that we can do to prevent the incident reoccurring.

During quarter 1 2022/23, a total of 320 quality alerts were raised. This was a slight decrease on the previous two quarters, the fourth quarter saw 348 and the third saw 333. However, this is an increase compared to quarter 1 in 2020/21 when Datix was first rolled out. Quality alerts are rated using a Red, Amber, and Green grading system based upon the information provided at the time of the alert being submitted. This continues to be the most optimal method in identifying a follow up process on the high number of alerts received. Grading can change dependent on outcomes and when themes and patterns begin to emerge.

Two new elements to quality alert reporting and analysis were introduced during the latter part of the quarter: firstly, standardised wording to support providers responding to QAs according to grading supporting a reduction in email flow, and secondly an additional free text box on the Datix form to highlight ‘Impact to patient safety’. Providers are continually reminded to detail the impact to patient safety as thoroughly as possible to support the grading process. QAs during quarter 1 were rated as:

- Red - 21
- Amber - 195
- Green – 104.

In quarter 1 April to June 2022, a total of 163 Serious Incidents (SIs) were declared. This is an increase of 16% when compared to those reported in Q4 2021/22 (n=141) and 31% increase when compared to Q1 2021/22 (n=124). Reporting numbers demonstrate Providers commitment to reporting incidents. Of note, Q1 showed a significant increase in Pressure Ulcer and Treatment delay SIs. The converse is a significant reduction of 60% in Diagnostic incidents reported in Q1 2022/23 (n=8) compared to Q4 2021/22 (n=20) reflecting work being done by acute providers to streamline diagnostic pathways and the continued work with the ICS Performance Team. On average, 5 Never Events are reported each quarter to SEL ICS Quality Team. However, Q1 22/23 showed a reduction with only 1 Never Event being reported.

The quality team have implemented monthly SI reconciliation meetings with the 3 acute provider Trusts, which assist in identifying key themes, hotspots and trends leading to effective actions being developed to address the underlying causes. The Quality team works proactively with providers to support the identification of themes and sharing of learning.

The CCG's internal Serious Incident Panel reviews all complex and/or thematic SIs and provides feedback to providers to include and review via their Harm Free Action plans were applicable. Never Events - so called because they are defined as wholly preventable and as such commissioned providers have failed to implement national processes and guidance, are included within SI reporting. Never Event themes are consistently related to wrong site surgery, retained foreign objects and medication. It has been proposed that an early focus of the new SEL System Quality Group will be a focus on Never Events with a view to achieving a system wide reduction of incidents.

When the quality of healthcare within a service in south east London raises concerns, there is an escalation process in place to NHSE/I for support. The forum where this occurs is the Joint Strategic Oversight Group. This London-wide group triangulates known concerns in healthcare providers and members of the Group can co-ordinate support to drive forward improvements.

The Local Maternity and Neonatal System Surveillance Committee has been established and is meeting regularly to jointly review quality issues. All providers of maternity services are members of the committee and will support feedback on key themes and trends, and lessons learned over the south east London system. The Committee has jointly reviewed and supported Provider compliance with the 7 immediate and essential actions from the initial Ockenden Review. The final Ockenden report was published on 30 March 2022 and this committee will continue to provide system peer support and learning to achieve compliance with the 15 essential actions details in this final report.

3.2.3. Infection Prevention and Control

The South East London Integrated Care System Infection Prevention and Control (SEL ICS IPC) forum was established in September 2020, initially weekly to support the Covid-

19 pandemic but now continues monthly to provide a platform for organisations to share learning, identify risks and implement guidance in a consistent way across the sector and in all care settings.

Infection prevention and control (IPC) activities during the first quarter of 2022/23 have focused on supporting health and social care organisations to implement the changes to the IPC guidance to safely support the Covid-19 recovery plans, managing this is a way that provides consistency across south east London ensuring that staff and patients remain safe.

The first two chapters of the England IPC Manual were published in May 2022 and focussed on Standard IPC Precautions and Transmission Based Precautions. Providers have been supported to implement these via the SEL ICS IPC forum.

During Q1 22/23 the SEL ICS IPC forum continued to monitor and support the identification of learning from all outbreaks both Covid and non-Covid. The SEL ICS IPC group also reviewed compliance with minimising rates of *Clostridioides difficile* (*C.difficile*) and Gram-negative bloodstream infections to threshold levels set by NHS England and NHS Improvement. Monthly reporting provides an opportunity to benchmark with London data and identify and agree early mitigations outbreaks and share learning to support minimising rates.

As part of the South East London CCG/ICS strategy for antimicrobial stewardship and the reduction of Gram negative blood stream infections a MicroGuide app has been commissioned over a three year period. The app which is easily accessible to all frontline clinicians across all care settings, via mobile or laptop devices, will be used to distribute antimicrobial guidelines, provide a decision support tool to support prescribing/treatment choices and enable to capturing and monitoring of data to support compliance monitoring.

Key IPC work programmes continued alongside the Covid-19 response. Presentations and updates were provided at various meetings such as borough protected learning time and practice nurse forums throughout the year. GP audits are conducted to advise and support continued IPC improvements.

3.2.4. Safeguarding

The corporate responsibilities for safeguarding children and adults at risk are explicit and are informed by legislation and national directives. Essential to corporate business is the requirements defined in the statutory guidance on safeguarding and promoting the welfare of adults and children under The Care Act 2014 and Section 11 of the Children Act 2004.

SEL CCG is statutorily responsible for ensuring that the organisations from which we commission services provide a safe system that safeguards vulnerable adults and children at risk of abuse or neglect. This includes specific responsibilities for looked after children and the Child Death Overview process which includes sudden unexpected death in childhood. These duties include:

- A clear line of accountability for safeguarding properly reflected in our governance arrangements (i.e., having a named executive lead to take overall leadership responsibility for the organisation's safeguarding arrangements)
- Ensuring that all health providers from which services are commissioned (both public and independent sector) have comprehensive and effective single and multi-agency safeguarding arrangements in place
- Clear policies in place setting out our commitment, and approach, to safeguarding including domestic abuse, workforce policy, supervision policy, safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults as appropriate
- A clear statement of our commitment to safeguarding adults and children and modern slavery which is accessible to the public
- Ensuring staff are trained in recognising and reporting safeguarding issues in line with the intercollegiate document's 1,2,3, appropriate supervision and ensuring that their staff are competent to carry out their responsibilities for safeguarding

During Q1 2022/23, NHS South East London CCG's safeguarding team continued to ensure compliance with these responsibilities and are responsive to national and local developments and priorities. Key achievements and developments during Q1 2022/23 include:

- development of the future South East London Integrated Care Board Safeguarding Governance Framework
- continued delivery of the NHS South East London CCG Safeguarding sub-committee
- Regional and national priorities have been identified and safeguarding designates have taken lead responsibility for exploring learning and improvement within:

    - Domestic Abuse
    - Modern Slavery
    - Safeguarding Adult Reviews (SAR) / Serious Case Review (SCR) / Domestic Homicide Reviews (DHR) themes and learning
    - Do not attempt cardiopulmonary resuscitation (DNA/CPR)
    - Child Sexual Abuse
    - Serious Youth Violence and Multi-agency Child Exploitation (MACE) panels

Safeguarding Tracker activity

An analysis of historic SCRs, SARs, DHRs has identified themes and learning that can be shared across the 6 boroughs. The 2022/2023 priorities are informed by these reports specifically how to triangulate learning from all reviews which will be via use of the Portal and Designate meetings. Other priorities informed from the analysis include: Youth violence, Think family, Special Educational Needs/Disabilities (SEND) and Children Looked After (CLA) who are adult subjects of, or family of, SARs and DHR's.

The NHSE/I national safeguarding tracker that captures details on SCRs, SARs and DHRs is being implemented across south east London boroughs that is being rolled out across London CCGs/ICBs. It is anticipated that this will improve future reporting, identifying trends and themes as well as providing the opportunity to compare regional and national data.

Deep dives into both adult and children serious case reviews highlighted key priority areas for SEL CCG/ICB highlighted in the table below for the year 2022/23.

Adults	Overlapping themes	CYP
Mental capacity	Neglect	Familial violence
Self-neglect	Think Family	Serious Youth violence
Lack of SG policies and processes	Professional Curiosity	Sexual abuse
Care Leavers	Domestic Abuse	Child criminal exploitation
	Mental Health	SEND
	Information sharing	Self-harm

Children Looked After

The Covid-19 pandemic has affected the children looked after population in numerous ways: foster carer's resigning, mental and emotional impact of not being able to see birth family, significant delays in legal proceedings and therefore permanency planning. The stand down of certain procedures has also meant delays in assessments. In south east London, an audit is being undertaken to understand looked after children's populations health needs to support working towards greater compliance of our statutory duties. Two issues have been identified: children placed out of borough (a long-standing challenge but increasing numbers) and young people in unregulated placements (a significant increase emerging post pandemic). Unregulated placements

can impact the administration of prescribed medication amongst other challenges for best health outcomes.

Liberty Protection Safeguards (LPS)

A Designated Lead – Mental Capacity Act and Liberty Protection Safeguards is making good headway in ensuring readiness for LPS implementation. The pandemic has delayed the publication of guidance and implementation date – now October 2022. SEL have a working group including all stakeholders CHC, local authority social services, providers and agreed process and pathways for LPS implementation. This is ongoing work with training needs and IT systems being discussed.

Special Education Needs and Disabled people (0 – 25 years) SEND

The duties for SEL CCG fall under the Children and Families Act 2014, Equality Act 2010, NHS Act 2006, Health and Social Care Act 2012, Care Act 2014 are to:

- commission services jointly for children and young people (up to age 25) with SEND, including those with Education Health and Care (EHC) plans
- work with the Local Authorities to contribute to the local offer of services available
- ensure that health providers inform parents and the appropriate local authority where they think that a young child under compulsory school age has, or probably has, special educational needs and/or a disability
- have mechanisms in place to ensure practitioners and clinicians support the integrated EHC needs assessment process
- agree personal budgets, where they are provided for those with EHC plans.

The NHSEI maturity matrix is used to evaluate the SEL SEND landscape and identify areas for development. There is a mixed picture across the 6 boroughs with developing collaboration and sharing of best practice. Strong links have been established between the SEND Teams and to ensure the South East London Learning Disability and Autism programme. The team have been members on the ICS Oversight Panels for the Safe & Wellbeing reviews completed by the Learning Disability and Autism programme.

3.2.5. Working with people and communities

Developing our services through working with people and communities who use them is a core aspect of the CCGs engagement programme. To support this work the CCG has a dedicated engagement team and has appointed public members to form the majority membership of the CCGs Engagement Assurance Committee (EAC), that reports directly to the Governing Body and considers and advises on the CCGs approach to engagement activity. Our borough based boards are also important fora for developing relationships at a local level and seeking views and opinions on development of services.

A key area of work in engagement between April and June 2022 was finalising the Integrated Care System (ICS) Working with People and Communities Strategic Framework. A steering group was set up to oversee the development of the framework and was independently chaired and included people with lived experience, EAC members, Healthwatch, people working across the system including the voluntary, community and social enterprise sector, and experts including academics. The framework sets out the ICS ambition for how we want to work with local people and communities and what we need to put in place to do this. The framework was submitted to NHS England on 27 May 2022 and approved at the first ICB meeting in public on 1 July following substantial engagement with a range of stakeholders. As part of the development process we commissioned community engagement with seldom heard communities through trusted community organisations to understand how people's day to day life affects their health and wellness, what makes it difficult, what health and care services could do to make it easier and what do we need to do differently to support people to share their experiences and views and work with us to make a difference. The table below outlines the organisations we commissioned and the communities they work with.

Name of organisation	Communities they work with	Boroughs
Act for Change	Young people who have experienced trauma	Bexley / Greenwich
Creating Ground	Migrant women (primarily from Africa)	Greenwich / Lewisham
Lambeth Links	LGBTQ+ communities	Lambeth, Southwark and SEL
Panjshir Aid	Afghan community	Southwark
East Africa Association	Somali women	Lambeth, Southwark with links to Greenwich
South East Greenwich Islamic Centre	Bengali community	Greenwich

The insight gained from this work informed the development of our approach, our vision and mission for working with people and communities, and we have tried to address the issues that we heard including:

- We need to build relationships and trusts with communities
- We need to make engagement accessible and inviting
- We need to coordinate our engagement better across south east London
- We need to go out to communities and bring the conversation close to people
- We need to recognise the impact that engagement has on people
- We will continue to develop our ways of working in these areas over the next year

In April we launched Let's talk health and care in south east London, the new ICS online engagement platform, enabling local people to give us their views at their convenience in

a number of ways including chat forums, asking questions and filling in surveys. Each local care partnership in south east London has their own page on the platform for their engagement projects in addition to the south east London projects. One of the first projects on the platform was asking people to tell us about their health, what's important to them and what we would need to do differently to support them to tell us their views and experiences. This insight also informed the development of the strategic framework for working with people and communities.

The ICS Engagement Practitioners' Network met three times during this period (April – June). The network was set up the previous year and its role is to support the ICS to take a more aligned and coordinated approach to engagement. Discussions have centred on the development of the working with people and communities strategic framework with a particular focus on the vision, mission and operating principles, the development of the engagement toolkit and how to share insight across the system. A review of the network took place after six months in May which showed that members welcome the opportunity to network with other engagement leads and that we need to further develop our ways of working to coordinate engagement across south east London.

We continue to fund the Director of South East London Healthwatch post and have agreed funding for a further two years. We work closely with the Director who has a key role in bringing coordinated insight from local people and critical challenge to our decision-making processes through sitting on a number of boards and committees and she is a key member of the ICS Engagement Practitioners' Network, contributing to the development of the strategic framework.

The engagement team has worked with the ICS Musculoskeletal (MSK) Network to involve people with lived experience of MSK in transforming MSK services in south east London. A community MSK lived experience group was set up and had its first two meetings in May and June, following two engagement webinars at the end of March, and now meets bimonthly. The group currently has 15 members who bring their lived experience insights into the work around supporting patients and improving pathways. To ensure that the voice of people with lived experience of MSK is involved at all levels, including within decision-making structures, we have started a process of recruiting two people with lived experience to sit on the SEL MSK programme board. The programme is planning to continue engaging with people with lived experience as part of the review through using different methods to reach people and collect insights such as: online chat forum, face to face road show and surveys. More information about how people with lived experience of MSK are involved can be seen on the Let's talk health and care engagement platform - Improving the patients journey for people with musculoskeletal conditions (MSK)

Key priorities for the forthcoming year are to work with local people and communities as part of the ICS strategy development process so that what matters to local people

informs the strategy; and to further develop systems and processes to take forward the ambition for working with people and communities as set out in the strategic framework.

3.2.6 Patient experience, complaints, and Patient Advice and Liaison Services

As part of our commitment to continually improve the quality of local health services we value all feedback we receive, either as a compliment or a complaint. This information is used to help us manage our performance and highlight any areas where we could make improvements. All complaints received are responded to individually via our complaints process.

Our complaints policy and procedure has adopted the principles as outlined in the Parliamentary and Health Service Ombudsman's principles of good complaints handling, principles of good administration and principles of remedy.

We work closely with local health service providers, monitoring the standard of complaints handling, ensuring all complainants are informed of their statutory rights under the NHS Constitution. This includes being given the information about the NHS complaints service provided by a local advocacy team and the option to take their complaint to the Parliamentary and Health Ombudsman if they are not satisfied with the way the complaint has been dealt with.

The complaints we receive and manage are about the services we commission locally, whilst complaints about GP services are handled by NHS England.

Between 1 April 2022 to 30 June 2022, we received 42 formal complaints. Of these, 13 related to issues the CCG is responsible for investigating and responding to. We also received 29 complaints relating to issues which we are not directly responsible for, which were forwarded to the appropriate organisation for investigation and response. These included complaints for NHS provider Trusts, GPs, dentists and community pharmacies.

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

- Continuing healthcare (assessment for eligibility process, payment),
- Mental health commissioning (access to services, availability and funding)

The CCG recognises the importance of complaints and aspires to resolve all complaints at a local level. However, there are occasions when complainants remain unhappy with the outcome of their concern and approach the Health Service Ombudsman for a review of their concerns. Of the complaints we received in within the time period specified, nil have been referred to the Parliamentary and Health Service Ombudsman.

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. Our Patient Experience service (including complaints and PALS) provides valuable insight into the day-to-day experiences of patients accessing and using the services we commission.

This intelligence is used throughout the CCG in planning future services, quality monitoring and service improvement. Softer intelligence is discussed on a weekly basis at Senior Team meetings and escalated which helps identify issues early and minimise any adverse impact for patients and the public.

Patient Advice and Liaison Services (PALS)

Our Patient Experience team always listen carefully to the concerns raised by patients and provide advice 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 Patient Experience 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 members of the public and MPs.

Between 1 April 22 to 30 June 22, 39 MP enquiries were received. The areas giving rise to most contacts were:

- Primary care - access
- Continuing healthcare – funding decisions
- Adult mental health – access

Within the same reporting period a total of 356 PALS enquiries were recorded from members of the public. Key themes of enquiry were:

- Primary care access
- Audiological medicine – change in service provision
- Covid & Prescribing queries

3.2.7 Focus on equalities, diversity and managing health inequalities

SEL CCG has two separate duties covering equality and also health inequalities. The purpose of both duties, however, is to ensure that decision makers give informed and conscious consideration in respect of both statutory frameworks.

Public Sector Equality Duty

The public sector equality duty, set out in the Equality Act 2010, requires public authorities, (which includes CCGs), in the exercise of their functions:

- to eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between people who share a protected characteristic and those who do not and
- foster good relations between people who share a protected characteristic and those who do not.

The protected characteristics include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Actions on equality requires:

- removing or minimising disadvantages suffered by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people and
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Health Inequalities Duties

The Health and Social Care Act 2012 requires CCGs to:

- have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved
- exercise their functions in an integrated way and
- are integrated with health-related and social care services, where they consider that this would improve quality and reduce inequalities in access to those services or the outcomes achieved.

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society and arise from socio-economic status and deprivation, geography, protected characteristics or 'inclusion health' groups. Action on health inequalities requires prioritizing and improving the lives of those with the worst health outcomes.

The CCG publishes a Public Sector Equality Duty (PSED) Report annually. The report outlines how the CCG is considering equalities and health inequalities in all it functions. It also includes an update on actions to address our equality objectives. The 2021/22 report can be found here.

The section below explains and highlights how the CCG has ensured compliance with the specific duties of the Equality Act 2010 and the Health and Social Care Act 2012.

Equalities Governance

During April-June, as the CCG transitioned to ICB arrangements, the Equalities Committee continued to meet to ensure the organisation maintains momentum with this agenda.

The Equalities Committee oversees, progresses and monitors equalities and health inequalities activities in the CCG. The committee has a workforce and patient focus and is co-chaired by a Governing Body lay member (with responsibility for both equality and

diversity and patient and public involvement) and a clinical lead.

The committee met monthly bringing together a broad range of representatives from across the CCG including quality, human resources, organisational development, patient and public engagement, members from the Integrated Care System, Healthwatch and chair of our Black, Asian and Minority Ethnic (BAME) staff network. The committee provides leadership, oversight and accountability on matters related to equalities and health inequalities, with responsibility for approving, overseeing and assuring delivery of the CCGs Equalities Delivery Plan (EDP). Through the development and monitoring of the EDP, the CCG ensures all its statutory duties and reporting responsibilities are undertaken and that the CCG is embedding a culture of equalities and inclusion through all its functions. The committee also has responsibility for reporting to the Governing Body on progress.

As good practice, at the end of the financial year, a review of effectiveness is conducted by the committee chair, to seek assurance that the committee has been able to meet its obligations under its Terms of Reference. The conclusion from the review was that the committee has been effective in maintaining the CCGs focus and profile on EDI, meeting its core duties and establishing a model that could be replicated in the new Integrated Care Board.

Demonstrating equalities progress

Significant progress has been made in implementing the CCGs Equalities Delivery Plan (EDP) which sets out a series of commitments against specific objectives, based on actions from a variety of sources including the Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap. External ICS commitments are also included in this plan, with monthly reporting on progress to the Equalities Committee.

Equalities in Recruitment Group (ERWG)

A working group has been set up, with representation from all staff champion groups, focusing on identifying and implementing a range of improvements to the recruitment process, as well as employee career development throughout their time at SELICB. In the first instance, in order to understand the starting position of the CCG (now ICB) and to ensure the ERWG had a focus, an external audit of current recruitment practices was completed in 2021, and five main areas of attention were identified: job descriptions, upskilling staff, advertising and applications, shortlisting and interviewing. A Terms of Reference was agreed and approved in early 2022 and work is now ongoing.

Examples of the work being undertaken include:

- the review of job descriptions/person specifications and adverts to ensure absence of bias (building in checks at the commencement of the recruitment process)
- encouragement of applications by disabled people - job opportunities within the ICB will be advertised on a disability job board run by, and for, disabled people and

- review of language used throughout the recruitment and selection process which may inadvertently work as barriers for a range of potential applicants.

Equality Analysis (EA) process
Processes are in place to ensure Equality Analyses (EAs) are completed for all policies, procedures, strategies, organisational change, and services that are introduced or reviewed. A full EA was completed for the Elective Recovery Plan, highlighting a range of positive impacts from the SEL programme. Actions were also identified to ensure equity of access for waiting list management across a range of protected characteristics, including development of a health inequalities dashboard.

A comprehensive package of support is available to all staff including EA toolkit, author and reviewer training sessions, EA review and 1:1 sessions.

Menopause Policy
The CCG's Women and Parent staff champion group piloted an awareness training module for all staff, and an additional session for line managers, on menopause. Post this training, a representative task and finish group met to support the development and implementation of a CCG menopause policy.

The policy sets out how the CCG will support staff experiencing the different stages of the menopause. It is applicable to every member of staff within the ICB and provides a framework within which managers can approach, in a consistent and fair manner, a range of situations arising from the impact of the menopause on staff. The policy has been assessed for the equality impact on the protected groups.

Freedom to Speak Up Guardians
Freedom to Speak up Guardians play an important role acting as an independent and impartial outlet for CCG staff to raise issues or concerns confidentially. They support the CCG to develop a culture of learning, openness and transparency. After a recruitment drive across staff champion groups, three new guardians from the LGBTQ+ communities have been recruited and are working with Lewisham Care Partnership to pilot a programme in primary care.

Population Health Programme
To support the system in tackling inequality, South East London Integrated Care System (ICS) and King's Health Partners launched the South East London Coalition for Better Health and Equity. A 'Population Health Programme' has been implemented, focusing initially on three key workstreams:

- 'Population Health Management and Data' to improve population health by data driven planning and delivery of care to achieve maximum impact
- Prevention and inequalities
- 'Making the most of our assets' to bring together local people and communities to understand and address the wider determinants of health

Progress to date is highlighted below.

Population Management and Data

A paper was presented to the ICS Executive proposing areas where health improvements could be made at a population level using patient data to drive decisions have been proposed. The 4 initial areas identified are:

- anticipatory care
- elective recovery
- children and young people and
- prevention through vaccination

Prevention and Inequality work

The ICS has adopted the Core20PLUS5 approach to reducing health inequalities. Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities. The approach defines a target population cohort – the 'Core20PLUS' - which includes the most deprived 20% of the national population and population groups we would expect to see identified) and identifies '5' focus clinical areas requiring accelerated improvement, namely maternity, severe mental illness (SMI), Chronic respiratory disease, early cancer diagnosis and hypertension

Population Health Conference

To further this programme of work, a Population Health Conference was held on 14 June 2022, bringing together an audience that included health and care sector organisations, local authorities, third sector organisations and the south east London community, to build relationships, explore the region's issues, showcase initiatives, share a road map for the future and identify place-based actors to take this work forward.

Discussions at the conference included:

- Case studies of Population Health Management in south east London
- Case studies on prevention in south east London
- Case studies on community engagement in south east London
- Introduction to the Vital 5, demonstrating the work in action across our boroughs and trusts for Smoking, Hypertension, Supporting Good Mental Health, Alcohol, Obesity and Diabetes and Children and Young People's Vital Metrics
- Breakout workshops on the Vital 5 and Clinical Effectiveness, Learning Health Systems, Reviewing systemic bias in commissioning, Population Health Management, Academic strategic partnerships on population health and Community Engagement

Engagement

Building on work initiated by SELCCG, an ICS Strategic Framework for Working with People and Communities has been developed with a view to review and improve current ways of working, standardise good practice and establish priorities.

As part of the mapping work for the strategy, trusted community organisations were commissioned to engage with discrete communities where engagement insights were in short supply. For more detail, please refer to the engagement section of this report.

Provider EDI Compliance monitoring
A review of provider compliance relating to their statutory and mandatory equalities duties and requirements was undertaken and demonstrated good overall compliance by SEL CCG's main provider organisations. Some gaps were identified but explained by the relaxing of reporting duties during the Covid-19 pandemic.

Workforce Race Equality Standard (WRES)
The NHS Workforce Race Equality Standard (WRES) highlights the differences between the experience and treatment of white and black, Asian and minority ethnic staff with the aim of closing any identified gaps. The WRES requires NHS organisations to demonstrate progress against nine race equality indicators.

In September 2021, SEL CCG published its second WRES report for the financial year April 2020-March 2021, covering all six boroughs. The WRES Action Plan has been developed using data and staff lived experience to understand key themes and priority areas for action, with the majority of proposed actions based on staff feedback. Further information on the 2021 WRES Report and Action Plan can be found here.

Since publication of the report, actions have been mapped and incorporated into the Equality Delivery Plan where implementation is currently being monitored.

Workforce Disability Equality Standard (WDES)
The Workforce Disability Equality Standard (WDES), introduced in 2019, is a data-based standard which uses a series of measures (Metrics) to compare the experiences of disabled and non-disabled staff in the NHS.

Results of the annual NHS staff survey show that disabled staff consistently report higher levels of bullying and harassment and less satisfaction with appraisals and career development opportunities. The purpose of the WDES is to improve the experience of disabled staff working in, and seeking employment in, the NHS.

SEL CGG introduced and published its first WDES in November 2021. This report is non-mandatory, and the CCG wanted to demonstrate a clear commitment to promoting disability equality by voluntarily completing this standard. The 2021 WDES Report and Action Plan can be found here.

Since publication of the report, actions have been mapped and incorporated into the Equality Delivery Plan where implementation is currently being monitored.

Gender Pay Gap reporting
All organisations within the United Kingdom with more than 250 employees have been

required since April 2017 to publish details of their gender pay gap. The specific requirements of the Equality Act 2010 Act (Gender Pay Gap Regulations) 2017 are to publish information for six specific measures.

SELCCG reported on the Gender Pay Gap in October 2021 and April 2022, developed through a blend of staff feedback and data analysis. The CCG pays females and males the same pay (equal pay) however there is a 12% average hourly "typical" pay differential. The significant driver for this differential is the disproportionately lower representation of males in lower paid roles at the CCG. Further details can be found in the CCG's 2021-22 Gender Pay Gap Report and Action Plan here.

Since publication of the report, actions have been mapped and incorporated into the Equality Delivery Plan where implementation is currently being monitored.

3.2.8 Staff Engagement and Organisational Development Activities

Organisational development – 1 April to 30 June 2022

The continued focus of organisational development (OD) between April and June 2022 has been on:

- Supporting the workforce during a period of change as the CCG prepared to close down and the new organisation – NHS South East London – was established
- Preparing to welcome more than 100 London Shared Services staff into NHS South East London on 1 July 2022
- Supporting development of the NHS South East London Integrated Care Board prior to their establishment on 1 July 2022

Supporting the workforce during a period of change

On 5 May 2022, the CCG launched its employer consultation on the 'Lift and shift' of NHS South East London CCG employees into the new NHS South East London Integrated Care Board (ICB) with effect 1 July 2022. This was followed by an all staff briefing on Friday 6 May, where staff had the opportunity to ask any immediate questions at the early part of the consultation period.

The consultation document provided information to staff and Trade Union representatives in relation to the arrangements for the transfer of staff, including information on TUPE and an initial set of frequently asked questions (FAQ).

The CCG's executive team acknowledged that change can be a difficult time for people, and even though this particular consultation protected the terms and conditions of employment for staff transferring from the CCG to the ICB, it has been important to ensure staff have regular opportunities to have their say.

Engagement with staff during the consultation period included weekly HR drop-in sessions and following these sessions, the FAQ document was updated and shared on the intranet. CCG colleagues were advised and encouraged to email a dedicated email account with their feedback, comments and questions during the consultation period. No emails were received during the consultation period.

The CCG also held its first, all-staff, in-person development event in Lambeth, which more than 480 staff attended. The event was an opportunity to meet incoming Integrated Care Board (ICB) members, learn more about the ICB and how it differs to the CCG and meet with colleagues – many of whom had not had the opportunity to network in person prior to the pandemic. Feedback from the event was positive and as a result, the CCG agreed to schedule a follow-up event to welcome colleagues into the ICB in early July.

No staff objected to the transfer and no changes were made as a result of consultation. The transfer was due to proceed as agreed on 1 July 2022.

London Shared Services engagement

The organisational development team led the onboarding and induction of more than 107 staff from London Shared Services (LSS) who were due to join NHS South East London on 1 July 2022.

To ensure the welcome messaging and processes were consistent across all London CCGs due to welcome LSS staff, the OD team attended regular meetings with their communications and organisational development (OD) counterparts.

The OD team also supported receiving managers of LSS staff by:

- Providing consistent and regular updates on the LSS consultation and planned transfer
- Creating dedicated managers' checklists and induction packs for managers to enact
- Drop-in sessions for CCG managers to ask questions
- Ensuring all staff were up to date with the LSS consultation via fortnightly newsletters and all-staff briefings

Some of the other OD interventions put in place to support LSS staff included:

- Regular, virtual engagement sessions so that LSS staff could learn more about the CCG and future organisation, ask questions and understand what the induction process was post 1 July. These were facilitated by a number of CCG leads from OD, HR, governance, IT and the chief operating officer and the accountable officer.
- Creation of information packs and FAQs.
- Creation of dedicated induction packs, to support LSS staff with the transition into NHS South East London i.e. from client-facing to stakeholder/patient-facing.

- Arrangement of in-person meetings to visit the CCG's head office and collect ID cards (planned for 1 July 2022).

On 30 June, the LSS consultation was due to proceed and 107 LSS staff were due to join NHS South East London on 1 July.

NHS South East London Integrated Care Board (ICB) development

The OD team worked alongside the ICS development team to support the onboarding of the board ahead of their establishment on 1 July 2022 – with the board's first in-person meeting in public scheduled to take place on the same day. For members who had been appointed, a series of development opportunities were coordinated to help members understand their roles, the development of the ICB and Integrated Care Partnership (ICP), broader context about the NHS and its system partners in south east London and the richly diverse population of south east London. This activity was designed to help the members come together and work as an effective board in preparation for 1 July. Some of the activities included:

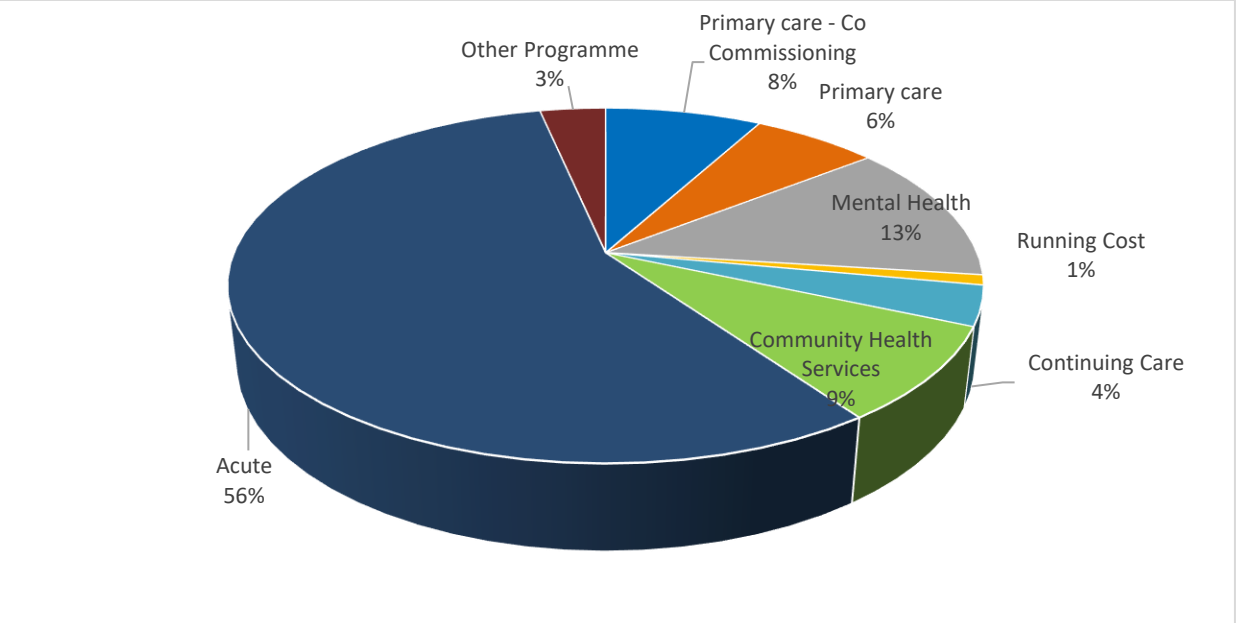
- An induction pack, which was developed and tailored to meet the varying needs of each members' role on the board. The pack included opportunities to meet key staff and visit our six boroughs (places) and learn more about local health, care and voluntary services.
- An ICB executive team session took place face-to-face to enable colleagues build relationships and increase their understanding of the ICB and broader ICS.
- Members were able to attend the CCG's all staff, face-to-face development event to meet colleagues and explain their roles in the new organisation and broader system.
- Three ICB member updates were arranged as 45 minute information exchanges. These sessions provided board members with an opportunity to stay connected and up to date on the preparations ahead of the formal start of the ICB on 1 July.
- Two in-person board development events took place in venues across south east London and they focused on:
    - Session one: building relationships, clarifying ambitions and determining what members wanted for the system. There were discussions about the development of a mission and vision, and an opportunity to learn about the board assurance framework (BAF).
    - Session two: defining how the board will work together in preparation for the ICB launch. There was an opportunity for members to consider what sort of board they want to be and what issues they wanted to focus on in the next nine months.

Board development prepared members for their official responsibilities from 1 July and was agreed that future board development would continue as the ICB emerges.

3.2.9 Financial performance

The CCGs budget for the three months to June 2022 was constructed from the CCG/ICB annual financial plan, with a notified resource allocation for the quarter of £963,657k. The CCG reported expenditure against this allocation of £963,656k, thereby achieving a balanced financial position for the quarter ending June 2022.

The expenditure incurred in the quarter can be analysed as follows:



The CCG is required to meet a number of financial targets, as detailed below:

CCG financial targets Q1 2022/23

		Target (£'000's)	Actual (£000's)	
Deliver statutory financial duties	Agreed Surplus	0	1	Achieved
	Expenditure not to exceed income	973,632	973,631	Achieved
	Operate Under Resource Revenue Limit	963,657	963,656	Achieved
	Not to exceed Running Cost Allowance	8,830	8,830	Achieved
	Operate under Capital Resource Limit	-	-	n/a

Deliver administrative duty under the better payments practice	95% of NHS creditor payments within 30 days	95.0%	99.9%	Achieved
	95% of non-NHS creditor payments within 30 days	95.0%	98.2%	Achieved

As reported above, we are pleased to confirm that the CCG has delivered all its financial performance targets in the quarter.

Annual Accounts

The full annual accounts together with the Statement of Accountable Officer's responsibilities and Independent Auditors Report are included in Sections 4 and 5.

3.2.10 Highlights from our borough teams

Bexley Borough

Covid-19 Vaccination Programme

Bexley has remained one of the highest performing boroughs in London for delivering the Covid-19 vaccination throughout the winter. Place partnership working to deliver the vaccination programme has included:

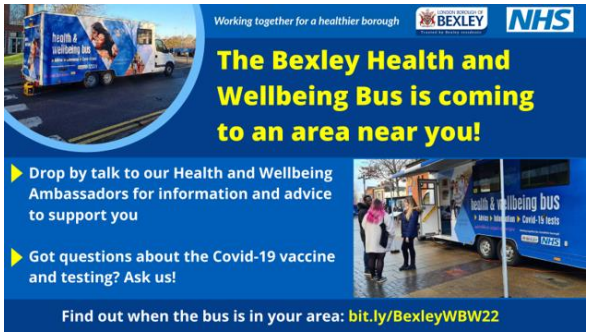
- The delivery of over 443,738 Covid-19 vaccinations by the four Primary Care Networks.
- The vital contribution of the local Bexley community pharmacies in delivering Flu and Covid-19 vaccinations for residents – with one community pharmacy delivering a record 101,551 vaccinations.
- Our local medicines management team have provided clinical and operational support to our vaccine sites including providing hands-on vaccination support.
- We have worked successfully in partnership with our local secondary and Special Education Needs Schools, Guy's & St Thomas' NHS Foundation Trust, community safety, education colleagues from Bexley Council to deliver the 12–15-year-old vaccination programme. This integrated approach resulted in running a number of family vaccination events across the borough with an evergreen offer with a multi-generational take up by local families.
- We have continued to with our every contact counts approach by delivering dedicated vaccination clinics combined with essential services and health checks for vulnerable communities, such as homeless people, travellers and those with learning and physical disabilities.
- We developed a local 'vaccine confidence' programme to reach out to and work with our diverse communities to better understand factors and barriers that influence vaccine take-up. This empowered residents to feel confident and to make informed decisions. This included the 'Let's Talk' vaccine outreach and testing bus and a programme of door knocking in areas of low take, which reached more than 10,000 residents.

Bexley Local Care Partnership

Bexley has strengthened and built on system collaboration through its Local Care Partnership (LCP). The LCP includes 17 local organisations, groups, and stakeholders. This year's programme has been possible due to the resilience, commitment and flexibility of staff and partners across the local health and care system. The partnership has worked together to combine strategically planned activity with reactive work, responding to the second and third waves of the pandemic and meeting national and local priorities.

The LCP has continued to support residents during and post the pandemic, with an emphasis on the critical need to address health inequalities highlighted by the pandemic, including mental health and wellbeing, digital access and supporting our most vulnerable communities:

- Working with voluntary partners and carers to understand carers' experiences of the pandemic and co-produced an action plan to address those emerging needs. In March 2022, we provided free 'coping with caring' and 'caring for yourself' workshops for unpaid carers.
- Our digital inclusion programmes have continued to grow: Bexley's Digital Inclusion Network was re-established in October 2021 by the LCP to address digital inclusion needs across the borough. In partnership with Bexley Mencap and Mind in Bexley, the LCP secured a £60,000 award to help people with learning disabilities or severe mental illness access GP services digitally. Outputs have included people with learning disabilities working with Mencap to produce videos about accessing healthcare, and the development of more accessible GP websites.
- Bexley LCP presented a video on the successful digital inclusion programme to the inaugural meeting of the South-East London Integrated Care Board on the 1st of July 2022: https://www.youtube.com/watch?v=KIppRW01A3o
- The Bexley Mental Health Support team (MHST) completed the scheme's pilot year with a ministerial visit to one of Bexley's local secondary schools, where the Minister for Children & Young families, Will Quince MP, joined students, school staff and the MHST to recognise the impact that the pandemic has had on the mental health of children and young people, and discuss the impact of the programme on the school.



- Following the success of the 'Let's Talk Vaccine' bus, in response to community insights on access to information and support, we relaunched the vaccine bus as the *Health and Wellbeing Bus*. The bus provided residents with general information and advice on their physical health and wellbeing alongside information on the vaccine. The bus focussed on areas in the borough, where communities where are most impacted by health inequalities.

Bromley Borough

In May, over 200 staff from across the One Bromley Local Care Partnership came together for our One Bromley Celebrating Integration Together staff awards. The awards recognise commitment, resilience, collaboration, and hard work and applications were received from across the Bromley local care partnership. Awards covered a range of areas including, reducing inequalities, supporting vulnerable people, the Covid-19 vaccination programme, involving residents in shaping care, primary care, services for young people and more.

At our final Bromley borough based board in June 2022 we shared a number of initiatives delivered over the course of the year. These included:

- Barcoding initiative to make flu clinics run smoothly through the pandemic. This contributed to Bromley being one of the highest performers in London for delivering the vaccine.
- Extended phlebotomy services to reduce waiting times and make services more accessible.
- The homeless healthcare clinic, attached to the Bromley homeless shelter has helped a number of registered homeless persons to receive a wide range of healthcare services in an easy to access and safe environment that would not normally be as available via normal health pathways. Care is provided by a number of clinicians from different organisations working together.
- New Bromley Mental Health and Wellbeing Strategy and a number of improvements around mental health for both adults and children including a new Bromley Community Hub which provides a one stop shop for community mental health provision; new mental health practitioners in primary care and an integrated mental health and wellbeing service for children and young people
- The Bromley All-Age Autism Partnership which brings together representatives including those with Autistic Spectrum Condition, their parents, carers, professionals and the voluntary sector to improve services available in Bromley for young people and adults with autism and to raise awareness of Autistic Spectrum Conditions to the general public.
- Improvements to GP primary care services including investments in digital technology and premises, increased workforce and training, more appointments with virtual flexible access, improved understanding of the demand and use of services.

Greenwich Borough

The Local Care Partnership, Healthier Greenwich Partnership (HGP), have agreed a development programme which will include work on shared identity, purpose and delivery model.

HGP partners continued to progress the development of the Greenwich Mental Health Alliance. The collaboration between the Royal Borough of Greenwich, CCG, Oxleas NHS, voluntary and community accommodation and support providers, South London Partnership, and people with lived experience of mental ill health has developed a formal alliance agreement to progress the first phase of delivering a Mental Health Alliance model in Greenwich. A tender exercise will follow later in the financial year. Significant co-production work has been undertaken between partners to review pathways and data, establish new ways of working, and assess those currently in accommodation-based support services to draw out themes and establish whether they are in the best setting to reach their goals. This is expected to ensure people can access the right community-based solution for them at the right time for their needs and outcomes and ensure best value in decision making.

HGP partners developed proposals for changes to some of the services provided at Eltham Community Hospital. The proposals would see further investment in intermediate care at home (Home First), with intermediate care beds currently provided by Oxleas at Eltham Hospital moving to be with similar beds at Meadowview ward, Queen Mary's Hospital. This would enable the development of a new Community Diagnostic Centre (CDC) at Eltham which will have significant benefits for the residents of Greenwich and beyond. Engagement with the public and staff is planned for late summer/early autumn.

Greenwich has made a strong commitment to develop a joint vision about what 'good' looks like at neighbourhood level. At the heart of this will be a supportive structure that enables collaboration at scale, ensuring general practice adapts to the challenges it faces without losing the essence of effective general practice as part of a wider primary care landscape. This aligns with the recommendations the Fuller Stocktake Report that sets out a vision for integrating primary care and improving access, experience and outcomes for communities. Work is in progress to join up and develop arrangements locally and a set of key milestones have been delivered. During the rest of this financial year, work will include adapting how home care and public health services are commissioned so that more of this is done at a neighbourhood level, as well as developing more integrated neighbourhood services, including strengthening community involvement and asset-based approaches.

The HGP has continued to develop plans to reopen The Source with a new service model. It will offer offering a range of community based services to residents in the Horn Park area including health and wellbeing support and nursing services. Greenwich staff have been working closely with the community to develop these arrangements.

During the quarter, HGP partners ran a task and finish group which developed and agreed joint funding for a number of initiatives to reduce the main health inequalities in the borough. Implementation of these plans is now in progress.

Lambeth Borough

Throughout April to June 2022 the Lambeth Together Care Partnership continued to operate as our borough's Local Care Partnership in shadow form. The agenda for our May 2022 Partnership Board demonstrates the breadth of our scope and how our focused activity has extended beyond traditional commissioning territory to support new system-wide approaches to tackling the underlying causes of poor health, managing demand and offering the highest quality services to meet our residents need. Our discussions included new models for public health nursing to support families with very young children, proposals for improved clinical and community-based support for people living with long-term pain, and initiatives to address the cost of living crisis. We also welcomed twelve new Clinical and Care Professional Leaders to new Lambeth roles that will focus on leading collaborative work across disciplines and across partner organisations to support professionals and local people as part of an integrated health and care system.

Lambeth Together's Delivery Alliance work in the children and young people's space continued, with Emotional Health and Wellbeing and Early Years workstreams meeting regularly, and developing programmes of work. In mental health, the Culturally Appropriate Peer Support Advocacy service went live to referrals in partnership with Black Thrive Lambeth. The Living Well Network Alliance continued work to improve the access, experience, and outcomes of those needing mental health services, with a widened scope to include the determinants of health such as work and the physical health of service users, and a focus on communities in the most deprived areas of Lambeth. Work on the Neighbourhood & Wellbeing Delivery Alliance priorities continued, with multiple projects relating to Thriving Communities (neighbourhood health and care networks), chronic pain and care homes.

Some of the notable achievements for the Lambeth team for this period included:

- being placed second nationally for delivering health checks for people with learning disabilities
- rated second in all of England for our care programme for people with type two diabetes
- Co-Chair of Lambeth Together and GP, Dr Di Aitken, being highly commended at King's Health Partners' Mind and Body Awards for her work to drive improvement in support to people with mental health concerns in physical health environments
- our Living Well Network Alliance being recognised at the HSJ Partnership Awards as commended finalists for the 'Best mental health partnership with the NHS'
- projects focused on reducing health inequalities, in areas including mental health support for unaccompanied asylum seeking children and young people who are not in education, employment or training; wellbeing pop-up clinics'; emotional emancipation circles for the Black community and the wellbeing of Black carers; a series of community health events, and new inequalities champions in Primary Care Networks

Staff across our integrated team and our partners have continued to drive improvement and innovate to meet the challenges we face in improving outcomes for all in Lambeth and fastest for those who benefit and need it most.

Lewisham Borough

CCG staff continued to work closely through Lewisham Health and Care Partners (LHCP) as well as the voluntary and community sector, Healthwatch Lewisham and other stakeholder groups such as our Primary Care Networks, to convey positive public health messages, engage with our local communities and tackle misinformation about the Covid-19 vaccine.

The local Covid vaccination programme has continued with eligible patients able to access the vaccine through PCN sites, pharmacies, Lewisham Hospital and a regular outreach session running from Lewisham shopping centre on Saturdays.

A Frailty Pilot was launched on 29 April with The Lewisham Care Partnership (TLCP) PCN. The pilot will run for 9 months and will work with partners including Lewisham and Greenwich Trust and Adult Social Care. The pilot will proactively identify patients of TLCP with moderate or severe frailty who are at most risk of deterioration. The team will carry out a Comprehensive Geriatric Assessment and develop a care plan with the frail person which the team will support the delivery of.

The CCG in Lewisham has been working with the Council and Social Prescribing Linkworkers to develop the Lewisham Thriving Communities scheme. This initiative supports participants aged 18 and over facing various challenges to engage in creative and community activities across Lewisham, including a Lewisham Borough of Culture activity.

At the September 2021 meeting of the Health and Wellbeing Board, a series of Lewisham Health Inequalities summit events were agreed to plan the next steps to address local health inequalities. From this, alongside joint work between Public Health in Lewisham and Birmingham, a number of workstreams have now been set up including equitable health services, health equality teams, community development and community of practice with investment made available from the CCG and Lewisham Council.

Southwark Borough

The development of Partnership Southwark, our local care partnership as a vehicle for tackling inequalities in health and care plus delivery of core services continued against the background of the pandemic and the vaccination programme.

The Southwark borough team established a set of key transitional priorities for Q1 to help ensure a smooth transfer on the creation of the ICB on 1 July 2022. This framework covered a range of actions to help formally establish our local care partnership, Partnership Southwark, and identified key operational priorities relating to health inequalities, joint commissioning, financial sustainability and workforce. Areas of focus also included refugees and asylum seekers, adult and children's mental health services, primary care access, vaccinations and safeguarding. Progress has also been made on our starting priorities of the community mental health transformation programme and the Partnership's commitment to the actions recommended by the 1001 days project.

A Partnership Southwark Strategic Board has been established and we are co-producing a Lived Experience Assembly with service users, carers and community representatives. A joint statement of intent from the Chief Executive Officer of the Integrated Care System, Chief Executive of Southwark Council and Strategic Chair of Partnership Southwark has confirmed our fundamental commitment to move to more joined up leadership and governance arrangements across health and care.

We successfully recruited a diverse range of care and clinical professional leads to bring expertise to our workstreams within the partnership. This has seen the appointment of 33 professionals from 12 different clinical and professional areas to support our work and provide valuable insight from those delivering care and support directly.

We have been invited to and sought out attendance at community events throughout the summer to directly engage with residents. These events have been a success with communities and people finding out more about Partnership Southwark, receiving Covid vaccines and having their blood pressure checked.

Southwark has also established a joint Liberty Protection Safeguarding Steering Group jointly with the Council. It will formally convene in September 2022 and will enable both organisations to tap into best practice and working collaboratively.

3.2.11 Sustainable development

The CCG has maintained its focus on sustainability as part of the wider south east London health systems contribution to the national NHS targets set in this area. These targets aim to move the NHS to net zero carbon emissions from the activities we directly control by 2040, with a demonstrable 80% reduction by 2032.

Having published an Integrated Care System Green Plan in March 2022, which lays out the sustainability plans for both the CCG (and its successor Integrated Care Board) and the wider system over the next three years, the CCG has been working with provider partners to develop and monitor a delivery plan. A number of exciting projects are already underway, including installation of air quality monitors across both provider and primary care estate, work to encourage active travel for both staff and patients, installation of electric charging points across the provider estate, and roll out of low carbon inhalers.

To ensure these projects deliver, a robust governance structure has been put in place, with board level Senior Responsible Officers appointed within each NHS organisation to ensure very senior visibility and accountability for sustainability. These SROs meet on a regular basis at the system-level Sustainability Oversight Board to share information and review progress against plan, supported by an operational leads network group with representatives from across the CCG, provider organisations and primary care.

3.2.12 Forward View for the rest of 2022-23

Our work as a system to recover from the impact of the Covid-19 pandemic will continue over 2022/23 alongside ensuring we continue to provide an effective response to Covid-19, whether that relates to providing support to those who become ill with Covid-19 of delivering our vaccination offer. We are immensely proud of the way people across south east London have continued to work collaboratively across our health, care and other vital local services in responding to the unprecedented pressures that we have faced since March 2020 as a result of the pandemic, pent up demand and diagnosis and treatment delays and backlogs across multiple services. We remain on a recovery journey and the full restoration of pre Covid-19 access, waiting times and backlogs is going to take some time to secure – we are not there yet.

We recognise the cost to south east Londoners of the last two years. Our entire community has been impacted but we also know that the pandemic has impacted disproportionately on some population groups including older people, people living with one or more long-term conditions or disabilities, those from a black and/or minority ethnic background, people living in areas of existing deprivation, children and young people and key workers. People have been impacted by Covid-19, but experience of the pandemic has shone a light on existing and exacerbated inequalities. A key priority for 2022/23 and beyond is to ensure that we are taking action to reduce inequalities in access,

experience and outcome and to ensure we are taking action that is targeted in support of specific population groups,

Our staff have also been significantly impacted by the pandemic and we will continue our work to provide staff with proactive wellbeing support and to improve staff resilience, recruitment, and retention. This will be vital in the context of our ask of staff to provide full support to our focus on recovery recognising to the very significant pressure the health and care system is under as it seeks to improve access and reduce backlog as well as managing urgent and emergency care demand within finite physical and staffing capacity.

We work as part of the South East London Integrated Care System and will continue to ensure a full and proactive contribution to collaborative system working, recognising that the solutions to the many challenges we are facing rely on system rather than individual organisation solutions. From 1 July 2022 changes were made to organisational structures across the NHS with the disestablishment of CCGs and the establishment of new Integrated Care Boards. The new Integrated Care Board has responsibility for former CCG responsibilities and for managing the south east London health system working alongside Local Authorities and other partners as part of a wider Integrated Care Partnership. Whilst the 1 July represents a formal legislative change south east London has been working as an integrated care system for many years, so we have great foundations from which to build. These include our vibrant borough based Local Care Partnerships, now established as a formal part of our system architecture. Our Local Care Partnerships have specific responsibility for developing out community based care services, secure local solutions to meet population need, reduce inequalities and secure an integrated and responsive community based care offer for local residents. Our Provider Collaboratives and Networks, covering acute, mental health and community services, are continuing to focus on optimise our recovery and capacity through system approaches and solutions and for improving the consistency of our offer, response and outcomes across the system.

Over Quarter 1 of 2022/23 the CCG has been working alongside ICS partners to develop our operational plan for 2022/23, which was finalised in June 2022. This sets out the commitments we are making as a system with regards service delivery, performance, activity and finance. Our improvement commitments have been made against a challenging backdrop of capacity constraints, long waiting list, workforce and recruitment challenges, urgent and emergency care pressures combined with on-going Covid-19 demand and finite financial and staff resources.

A key focus for 2022/23 will be securing the commitments we have made within these operational plans and if we are successful, we will have incrementally improved our access and waiting times, our service offer to patients and our underlying sustainability with regards capacity, workforce and finance.

2022/23 will also see the Integrated Care System start to focus away from the immediate to the medium term. We will work with partners in our Integrated Care Partnership to develop a five year integrated care strategy, using this as a vehicle to deepen our relationship and engagement with our communities, to be clear on our vision, objectives and ambition around health improvement and reducing inequalities plus the key changes we will make to the way we deliver services to ensure they are responsive, support timely and equitable access and drive outcome improvements. Linked to the integrated care strategy NHS partners will work together to agree an underpinning Integrated Care Board medium term plan (our Five Year View) that ensures the NHS is able to implement the key actions required of it to deliver the integrated care strategy, alongside ensuring an ability to respond effectively to wider NHS priorities.

2022/23 will therefore be a year of transition therefore but one in which we will remain steadfastly focussed on ensuring we are working collectively to meet the needs of our population and start to address the challenges that have arisen from or been exacerbated by the pandemic as well as looking after our own staff. In doing so we are committed to taking the best of the CCG as we develop our new system as well as making sure we are harnessing the skills, expertise and full participation of our partners and our population as part of a collaborative endeavour to improve health and health outcomes in south east London.

Andrew Bland
CCG Accountable Officer
June 2023

4 Accountability Report

4.1 Corporate Governance Report

NHS South East London CCG was first authorised on 1 April 2020. The area covered by NHS South East London CCG is coterminous with the boundaries of the London Boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

The CCG is a membership organisation, led by a governing body made up of local GPs drawn from across our boroughs, other clinicians, executives and lay members. All practices that provide primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract in the six boroughs are eligible for membership of this CCG.

4.1.1 Members Report

4.1.1.1 Member profiles

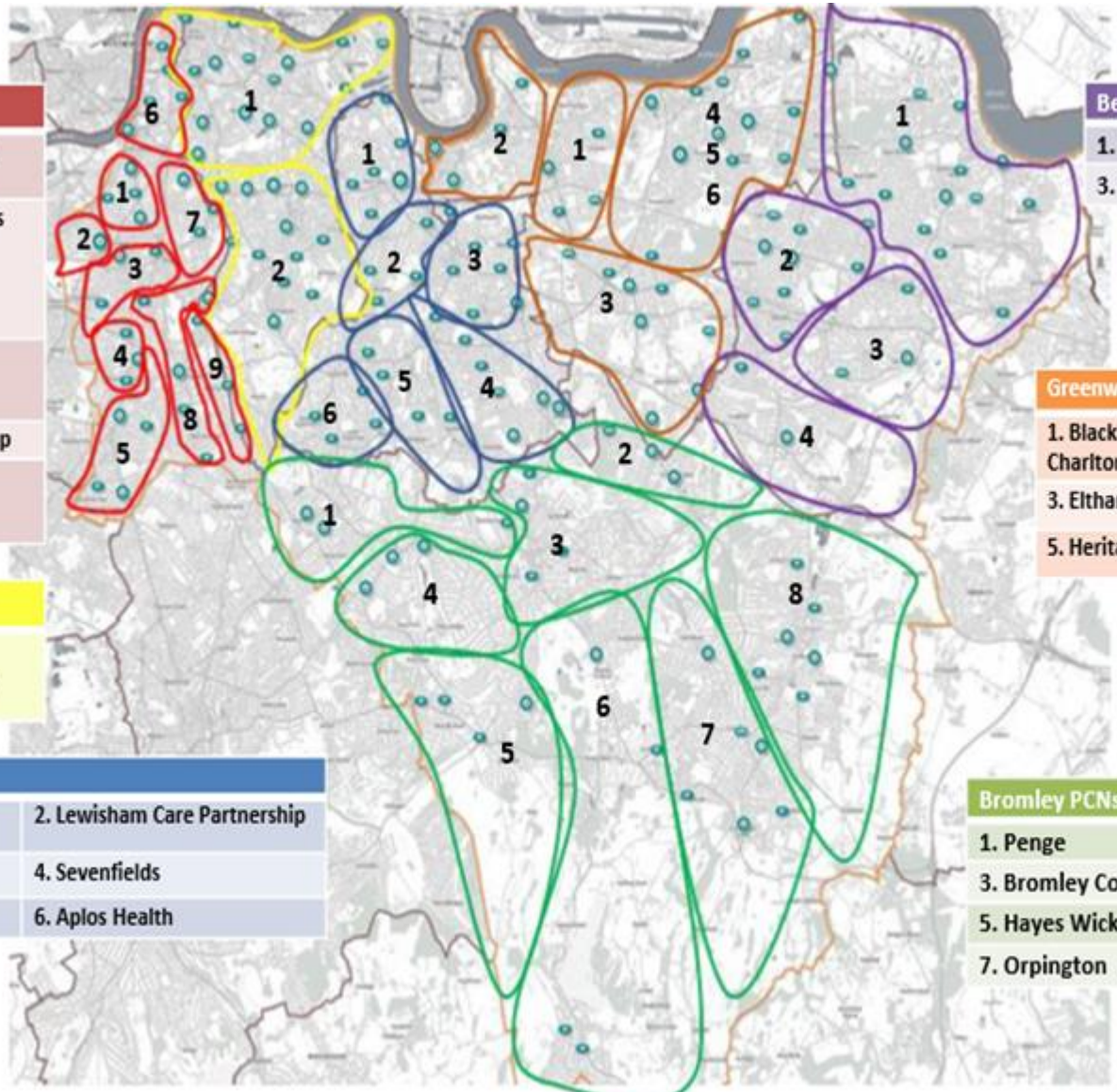
Primary Care Networks (PCNs) in south east London

There are 35 PCNs in South East London spread across the six boroughs as detailed in the table below. The contracts formalising these arrangements between local GP practices went live on 1 July 2019.

As part of a PCN, GPs are recruiting multi-disciplinary teams, including pharmacists, physiotherapists, paramedics, physician associates and social prescribing support workers, freeing up family doctors to focus on the sickest patients.

PCNs aim to optimise the current services available to residents across the network, moving towards delivery of fully integrated community-based care.

Name of SELCCG borough division	No. of practices (including branches)	No. of Primary Care Networks
Bexley	**21 (35)**	**4**
Bromley	**44 (47)**	**8**
Greenwich	**31 (49)**	**6**
Lewisham	**41 (46)**	**9**
Lambeth	**29 (38)**	**6**
Southwark	**32 (40)**	**2**
Total	**198 (255)**	**35**



Lambeth PCNs	
1. StockWellBeing	2. Clapham
3. Brixton & Clapham Park	4. AT Medics Streatham
5. Streatham	6. North Lambeth
7. Fiveways	8. HBD Group
9. Croxted	

Bexley PCNs	
1. North Bexley	2. Clocktower
3. APL	4. Frognal

Greenwich PCNs	
1. Blackheath and Charlton	2. Greenwich West
3. Eltham	4. Riverview Health
5. Heritage	6. Unity

Southwark PCNs	
1. North Southwark	2. South Southwark

Lewisham PCNs	
1. North Lewisham	2. Lewisham Care Partnership
3. Lewisham Alliance	4. Sevenfields
5. Modality Lewisham	6. Aplos Health

Bromley PCNs	
1. Penge	2. MDC
3. Bromley Connect	4. Beckenham
5. Hayes Wick	6. Five Elms
7. Orpington	8. The Crays Collaborative

4.1.1.2 Member practices

The list of member practices (and their branch sites) in our boroughs is as follows:

Bexley:

Name of PCN	Main Practice /Branch Name
North Bexley PCN	❖Northumberland Heath Medical Centre ❖Lakeside Medical Practice ❖Belvedere Medical Centre ❖Bexley Medical Group - Hurst Place Surgery (branch) - Erith Health Centre (branch) ❖Slade Green Medical Centre - Colyers Lane Medical Centre (branch) ❖Riverside Surgery - Mill Road Surgery (branch) - Bulbanks Medical Centre (branch) ❖Crayford Town Surgery
Clocktower PCN	❖The Westwood Surgery - Pickford Lane Surgery (branch) ❖Bellegrove Surgery ❖Welling Medical Practice - 3 Hook Lane (branch) - Holly House Surgery (branch) ❖Bexley Group Practice - Station Road (branch) ❖Dr Davies and Partner
APL PCN	❖The Albion Surgery - Stanley Terrace (branch) ❖Plas Meddyg Surgery ❖Lyndhurst Medical Practice ❖Bursted Wood Surgery
Frognal PCN	❖Barnard Medical Group - Marlborough Park Avenue (branch) ❖Sidcup Medical Centre - Thanet Road Surgery (branch) - Crook Log (branch) - Burnt Oak Lane (branch) ❖Station Road Surgery ❖Woodlands Surgery
Independent	❖Ingleton Avenue Surgery

Bromley:

Name of PCN	Main Practice /Branch Name
Penge PCN	❖Park Group Practice ❖Robin Hood Surgery ❖Highland Medical Practice ❖Anerley Surgery ❖Oakfield Surgery ❖Sundridge Medical Centre
Mottingham, Downham and Chislehurst (MDC) Network PCN	❖Links Medical Practice - 198 Court Farm Road (branch) ❖Chislehurst Medical Practice ❖Woodlands Practice
Bromley Connect PCN	❖South View Partnership ❖Dysart Surgery ❖London Lane Clinic
Beckenham PCN	❖Manor Road Surgery ❖Eden Park Surgery ❖Cornerways Surgery ❖Elm House Surgery ❖St James' Practice ❖Cator Medical Centre
Hayes Wick PCN	❖Station Road Surgery ❖Addington Road Surgery ❖Forge Close Surgery ❖Pickhurst Surgery ❖Wickham Park Surgery
Five Elms PCN	❖Stock Hill Medical Centre ❖Summercroft Surgery ❖Southborough Lane Surgery ❖Bromley Common Practice ❖Norheads Lane Surgery
Orpington PCN	❖Family Surgery ❖Chelsfield Surgery ❖Knoll Medical Practice ❖Tudor Way Surgery - Bromley Park Medical Centre (branch) ❖Ballater Surgery ❖Bank House Surgery – AT Medics ❖Whitehouse Surgery ❖Green Street Green Medical Centre ❖Bromleag Care Practice

	❖Highland Medical Practice, Orpington (branch)
The Crays Collaborative PCN	❖Derry Downs Surgery ❖Broomwood Health Centre ❖Gillmans Road Surgery ❖Poverest Medical Centre ❖St. Mary Cray Practice ❖The Crescent Surgery

Greenwich:

Name of PCN	Main Practice /Branch Name
Blackheath and Charlton PCN	❖Manor Brook PMS ❖Blackheath Standard PMS ❖Vanbrugh Group Practice ❖Fairfield PMS
Greenwich West PCN	❖Primecare PMS (South Street) ❖Burney Street PMS - Wallace Centre (branch) ❖Plumbridge Medical Centre ❖Blackheath PMS ❖Greenwich Peninsula
Eltham PCN	❖Eltham Palace PMS ❖Everest Health Partnership - White Horse Hill (branch) - Coldharbour (branch) - Kidbrooke Village (branch) ❖New Eltham and Blackfen Medical Centre - New Eltham and Blackfen (branch) ❖Elmstead Medical Centre - The Hill Surgery (branch) - Campus Surgery (branch) ❖Eltham Medical Practice - 180 Well Hall Road (branch) - 46 Westmount Road (branch)
Riverview Health PCN	❖Thamesmead NHS Health Centre – AT Medics ❖Royal Arsenal Medical Centre ❖St. Marks PMS Medical Centre - Nightingale Surgery (branch) ❖Valentine Plus PMS - Holburne Road Surgery (branch) ❖Conway PMS - 7 Day Healthcare (branch) ❖Thamesmead Med Associates PMS - Heronsgate Medical Centre (branch)

Heritage PCN	❖Triveni PMS - 34 Plumstead Common (branch) ❖Waverley PMS - The Surgery (branch) ❖Abbeyslade PMS ❖Bannockburn Surgery ❖Abbey Wood Surgery
Unity PCN	❖Plumstead Health Centre - Garland Road (branch) ❖The Trinity Medical Centre ❖All Saints Medical Centre PMS ❖Glyndon PMS - 123 Samuel Street (branch) ❖Mostafa PMS - 253 Wickham Lane (branch) ❖Malling Health at Clover Health Centre

Lewisham:

Name of PCN	Main Practice /Branch Name
North Lewisham PCN	❖The Queens Road Partnership ❖Kingfisher Medical Centre - Kingfisher Surrey Docks (branch) ❖Clifton Rise Family Practice ❖New Cross Health Centre (Hurley Group) ❖Grove Medical Centre ❖Deptford Medical Centre ❖Deptford Surgery ❖Vesta Road Surgery ❖Amersham Vale Training Practice
Lewisham Care Partnership PCN	❖The Lewisham Care Partnership at St John's - The LCP at Hilly Fields (branch) - The LCP at Honor Oak (branch) - The LCP at Morden Hill (branch) ❖The LCP at Belmont Hill (branch)
Lewisham Alliance PCN	❖Lewisham Medical Centre ❖Burnt Ash Surgery ❖Lee Road Surgery ❖Triangle Group Practice ❖Woodlands Health Centre❖Nightingale Surgery
Sevenfields PCN	❖Torridon Road Medical Practice ❖Downham Family Medical Practice ❖Moorside Clinic ICO Health Group - Dr Malik's Practice (branch) - Dr Lingarajah's Practice (branch)

	- Boundfield Surgery (branch) ❖Parkview Surgery ❖Novum Healthcare Partnership - Baring Road Site (branch) ❖Oakview Family Practice ❖SEL Special Allocation Practice
Modality PCN	❖The Jenner Practice ❖South Lewisham Group Practice ❖Bellingham Green Surgery
Aplos Health PCN	❖Sydenham Green Group Practice ❖Woolstone Medical Centre ❖Wells Park Practice ❖The Vale Medical Centre

Lambeth:

Name of PCN	Main Practice /Branch Name
StockWellBeing PCN	❖Stockwell Group Practice ❖Beckett House Practice ❖Binfield Road Surgery ❖Springfield Medical Centre ❖The Grantham Practice
Clapham PCN	❖Clapham Family Practice - Manor Health Centre (branch) ❖Sandmere Practice ❖Grafton Square Surgery ❖Dr Curran & Partners
Brixton & Clapham Park PCN	❖Hetherington Group Practice ❖Clapham Park Group Practice ❖Hetherington at the Pavilion
AT Medics Streatham PCN	❖Streatham High Practice ❖Edith Cavell Practice ❖Streatham Place Surgery (branch)
Streatham PCN	❖Streatham Common Group Practice - 293 Streatham High Street (branch) ❖Prentis Medical Centre ❖Palace Road Surgery ❖Valley Road Surgery ❖The Exchange Surgery ❖The Vale Surgery ❖The Streatham Hill Group Practice
North Lambeth PCN	❖Hurley & Riverside Practices - Hobart House (branch)

	❖Lambeth Walk Group Practice ❖The South Lambeth Road Practice ❖The Vauxhall Surgery ❖Mawbey Group Practice ❖Waterloo Health Centre
Fiveways PCN	❖Vassall Medical Centre (Dr Patel & Cresswell) ❖The Corner Surgery ❖Minet Green Health Practice ❖Herne Hill Road Medical Practice ❖Akerman Medical Practice
Hills, Brooks and Dales (HBD) Group PCN	❖Herne Hill Group Practice ❖North Wood Group Practice at Crown Dale - North Wood Group Practice at Tulse Hill (branch) ❖Brixton Hill Group Practice ❖Knights Hill Surgery ❖The Deerbrook Surgery ❖Lambeth Healthcare Practice
Croxted PCN	❖Brockwell Park Surgery ❖The Old Dairy Health Centre ❖Paxton Green Group Practice

Southwark:

Name of PCN	Main Practice /Branch Name
North Southwark PCN	❖Trafalgar Surgery ❖Falmouth Road Group Practice ❖Princess Street Practice (Nexus Health Group) - NHG - Surrey Docks Health Centre (branch) - NHG - Sir John Kirk Close Surgery (branch) - NHG - Manor Place Surgery (branch) - NHG - Dun Cow Surgery (branch) - NHG - Decima Street Surgery (branch) - NHG - Commercial Way Surgery (branch) - NHG - Artesian Health Centre (branch) ❖Old Kent Road Surgery ❖Penrose Surgery - Penrose Surgery 10 Maddock Way (branch) ❖Silverlock Medical Centre ❖Park Medical Centre ❖Albion Street Group Practice ❖Bermondsey Spa Medical Practice ❖The Villa Street Medical Centre

	❖Blackfriars Medical Practice ❖New Mill Street Surgery ❖301 East Street Surgery ❖Southwark Care Home
South Southwark PCN	❖Forest Hill Road Group Practice ❖Acorn and Gaumont Surgery ❖Camberwell Green Surgery ❖Parkside Medical Centre ❖DMC Chadwick Road ❖Queens Road Surgery ❖St Giles Medical Centre ❖Elm Lodge Surgery ❖3-Zero-6 Medical Centre ❖Sternhall Lane Surgery ❖The Tessa Jowell Surgery ❖ Dr Arumugaraasah's Practice ❖The Gardens Surgery ❖Dulwich Medical Centre - Crystal Palace Road ❖The Lordship Lane Surgery ❖The Nunhead Surgery ❖Lister Practice ❖St Giles Surgery (Dr Rosemen)

4.1.1.3 Composition of Governing Body

Chair and Accountable Officer

The CCG Chair is Dr Jonty Heaversedge.
Andrew Bland is the Accountable Officer for the CCG.

Governing Body Members

The Voting members of our governing body for the quarter April 2022 to June 2022 were as below:

Dr. Jonty Heaversedge	Chair
Andrew Bland	Accountable Officer
David Maloney	Acting Chief Financial Officer
Dr Siddharth Deshmukh	GP Clinical Lead - Bexley
Dr Clive Anggiansah	GP Clinical Lead - Bexley
Dr Andrew Parson	GP Clinical Lead - Bromley
Dr Krishna Subbarayan	GP Clinical Lead - Greenwich
Dr Sabah Salman	GP Clinical Lead - Greenwich

Dr Adrian McLachlan	GP Clinical Lead - Lambeth
Dr Dianne Aitken	GP Clinical Lead - Lambeth
Dr Faruk Majid	GP Clinical Lead - Lewisham
Dr Robert Davidson	GP Clinical Lead - Southwark
Dr Nancy Kuchemann	GP Clinical Lead - Southwark
Shelagh Kirkland	Lay member - Governance and Audit
Joy Ellery	Lay member - Patient and Public Involvement
Peter Ramrayka	Lay member - Primary care and Commissioning
Professor Simon Mackenzie	Secondary Care Specialist
Mary Currie	Registered Nurse
Dr Angela Bhan	Place Based Director - Bromley (joint with Council)
Stuart Rowbotham	Place Based Director – Bexley (joint with Council)
Jackie Davidson	Interim Place Based Director - Greenwich
Martin Wilkinson *	Place Based Director - Lewisham & Southwark
Andrew Eyres	Place Based Director, Lambeth (joint with Council)

Non-Voting Members:

Dr Nada Lemic	Public Health Representative
Folake Segun	Healthwatch Representative
Dr Simon Parton	LMC Representative

Details about the members of the CCG's Governing Body are available on the website:
Our Governing Body - South East London CCG (selondonccg.nhs.uk)

CCG directors

The other non-voting directors of the CCG were as follows:

Sarah Cottingham	Executive Director of Planning and Commissioning
Kate Moriarty-Baker	Chief Nurse and Caldicott Guardian
Theresa Osborne	Director of Commissioning System Reform

Notes

* In response to the increase in activity on vaccinations, Sam Hepplewhite adopted the role of Executive Director of Primary Care and Vaccinations from 6 December 2021, with Martin Wilkinson acting as Borough Director for both Lewisham and Southwark boroughs from this date.

4.1.1.4 Committee(s), including Audit Committee

The members of the Audit Committee are as follows:
Shelagh Kirkland – Lay member for Audit and Governance (Chair)
Joy Ellery – Lay member for Patient and Public Involvement (Vice-Chair)
Peter Ramrayka – Lay member for Primary care (Additional lay member)
Mary Currie – Registered Nurse on Governing Body

In attendance are GP leads (a maximum of one from each borough).

Details of other CCG committees are included on pages 69-73 of this document.

4.1.1.5 Register of Interests

The register of interests for our Governing Body is available here. A register of interests for all staff is maintained by the governance team and is available on request.

4.1.1.6 Personal data related incidents

There have been no CCG data incidents this quarter that have met the threshold of being reportable to the to the Information Commissioner's Office (ICO).

Modern Slavery Act

NHS South East London CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Andrew Bland
CCG Accountable Officer
June 2023

4.1.2 Statement of Accountable Officer's Responsibilities

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

As the 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 NHS South East London CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

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.

Andrew Bland

CCG Accountable Officer

June 2023

4.1.3 Governance Statement

4.1.3.1 Introduction and context

NHS South East London CCG is a body corporate established by NHS England on 1 April 2020 under the National Health Service Act 2006 (as amended). To note, the CCG was dis-established on 30 June 2022 as part of the establishment of Integrated Care Boards under the Health and Care Act 2022.

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

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

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.

4.1.3.2 Governance arrangements and effectiveness

Governance Framework of the CCG:

The CCG is a membership organisation and its member practices are accountable for exercising statutory functions. The CCG has delegated authority to the following, to act on behalf of its member practices in order to discharge its functions and responsibilities:

a) Council of Members;

b) Governing Body;

c) CCG employees;

d) Committees and sub-committees of the Governing Body;

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.

CCG Constitution:

The Constitution sets out the terms on which NHS South East London CCG shall exercise its statutory function of commissioning services for the purposes of the health service in England. It has been agreed by all member practices.

Scheme of Reservation and Delegation (SoRD):

The constitution contains the Scheme of Reservation and Delegation which sets out the key functions of the CCG and to whom the CCG has delegated responsibility for fulfilling them.

Council of Members:

The Council of Members is constituted of healthcare professionals from each of the CCG's member practices (See Member's Report Section 4.1.1). Members choose one healthcare professional per practice (and a deputy) as their representative at Council of Members' meetings. The Chair of Council of Members is currently Dr Sadru Kheraj.

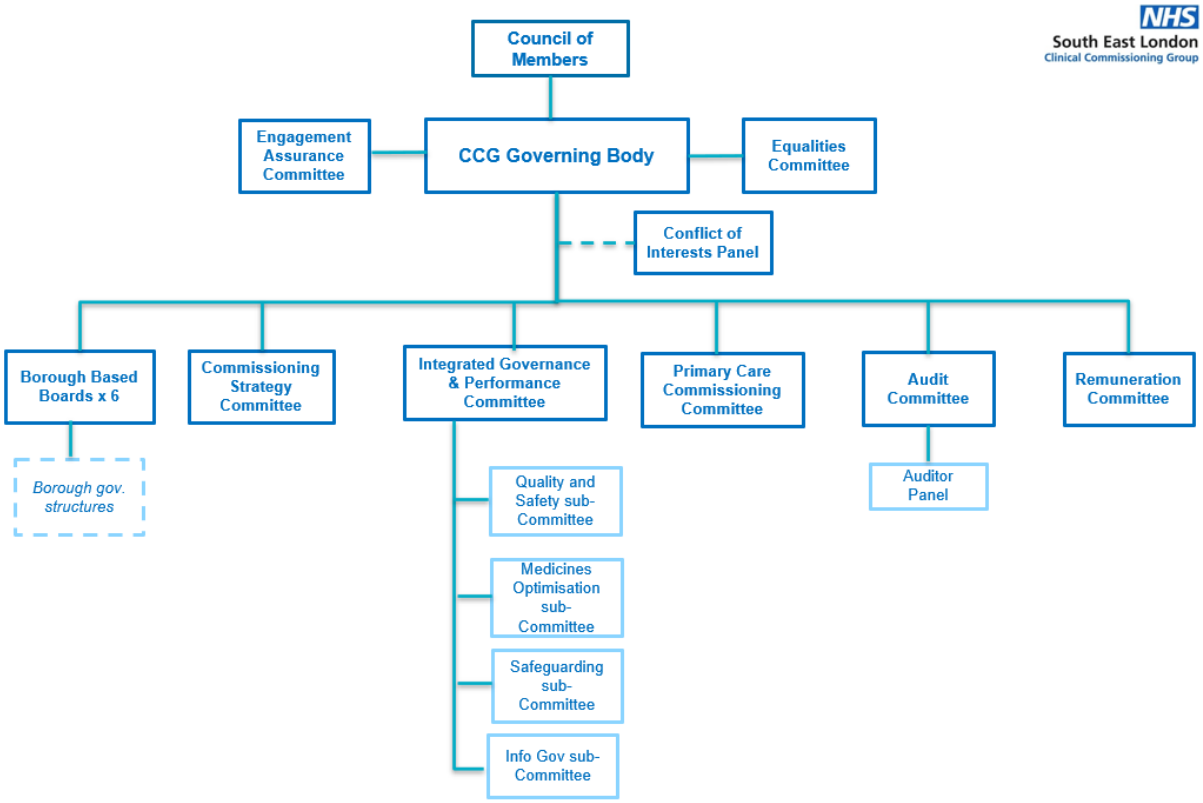
The Council of Members has decision-making powers in relation to the governance and membership arrangements for the CCG, and oversight of the overall strategic direction of the CCG.

The Council of Members are required to meet once annually as a minimum, and this last occurred on 30 September 2021.

To support members to understand the wider views of practice staff, each borough operates a borough divisional membership forum, which is open to all practice staff. The borough-based fora do not form part of the organisation's Schedule of Reservation and Delegation and are not decision making.

Full details on the role of the Council of Members; its membership and the process for convening meetings is detailed in the CCG's Constitution.

Governance Structure:



Governing Body

The CCG's Governing Body has statutory responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance. It also assumes a specific responsibility for determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowances payable under any pension scheme established. (with recommendation from the remuneration committee as appropriate). The CCG's membership has delegated additional functions to the Governing Body, which are detailed in the CCG's Scheme of Reservation and Delegation, Appendix 5 of the CCG's constitution.

Full details on the Governing Body structure and membership as well as its detailed procedures are set out in sections 5.4 to 5.7 of the CCG's constitution; the Standing Orders (Appendix 3 of the constitution) and Standing Financial Instructions (Appendix 4 of the constitution).

Membership of the Governing Body is detailed in Section 4.1.1.3.

During the period April to June 2022, there was one meeting in public of the Governing Body, held in May 2022. In recognition of the ongoing Covid-19 advice, this meeting took place online. However, members of the public were able to submit questions in advance in writing, and these questions were either responded to at the meeting or in written form afterwards and made available on the website. Members of the public were

able to watch the meetings live online and raise written questions during the event via an online messaging portal.

Governing Body Attendance at the meeting was as follows:

Name	Position
Dr Jonty Heaversedge	Chair
Andrew Bland	Accountable Officer
David Maloney	Acting Chief Financial Officer
Dr Clive Anggiansah	GP clinical lead – Bexley
Dr Andrew Parson	GP clinical lead – Bromley
Dr Sabah Salman	GP clinical lead – Greenwich
Dr Krishna Subbarayan	GP clinical lead – Greenwich
Dr Dianne Aitken	GP clinical lead - Lambeth
Dr Adrian McLachlan	GP clinical lead – Lambeth
Dr Nancy Kuchemann	GP clinical lead - Southwark
Folake Segun	Healthwatch representative
Shelagh Kirkland	Lay member – Governance and Audit
Joy Ellery	Lay member – Patient and Public Involvement
Peter Ramrayka	Lay Member Primary Care and Commissioning
Dr Simon Parton	LMC representative
Andrew Eyres	Place Based Director, Lambeth
Martin Wilkinson	Place Based Director, Lewisham & Southwark
Dr Angela Bhan	Place Based Director, Bromley
Jackie Davidson	Acting Place Based Director, Greenwich
Mary Currie	Governing Body Nurse
Prof Simon Mackenzie	Secondary Care Specialist
Kate Moriarty-Baker	Chief Nurse, SELCCG
Theresa Osborne	Director, Commissioning System Reform, SELCCG

Prime Committees:

The CCG operates with six prime committees. The Audit Committee, Primary Care Commissioning Committee and Remuneration Committee are required under statute and their terms of reference are incorporated directly into the CCG's constitution.

The three other prime committees: Integrated Governance & Performance Committee, Commissioning Strategy Committee and the Borough Based Boards (one in each borough) have been established by the Governing Body to enable it to undertake its roles in respect of internal assurance; strategic planning and development and borough involvement & engagement. A summary of the role and purpose of all the CCG's committees is provided below with terms of reference included as appendices where these are not already included as part of the CCG's constitution.

Integrated Governance and Performance Committee (IGPC):

The Integrated Governance & Performance Committee is established to oversee the activities of the CCG and its providers in respect of finance, QIPP, performance, governance, risk management, quality and safety. Associated with this, it is responsible

for assuring the effective functioning of the CCG's operations in respect of safeguarding, information governance, the equality delivery system, emergency planning and business continuity and patient engagement and experience.

The members of the committee are: Lay members (one of whom is the Chair), the secondary care Specialist, our governing body registered nurse, two Governing Body clinical leaders (with a further four invited as optional participants), Accountable Officer, Chief Finance Officer, Executive Director of Commissioning & Planning, Chief Operating Officer, and Chief Nurse.

The committee met twice in the quarter, and received reports on performance, finance, quality, the Board Assurance Framework, emergency planning and workforce matters, as well as reports on the activities of their sub-committees and from Healthwatch.

To ensure sufficient focus is given to all aspects of the wide ranging portfolio of the IGPC, a number of sub-committees of the IGPC operate. These are:

- **Quality and Safety sub-committee** (QSSC) – providing assurance that commissioned services are safe and of high quality and that adequate plans are in place to respond to issues of poor quality. QSSC also provides a forum for promoting quality improvement within the CCG; and identifying, investigating and learning from poor quality via system-wide learning
- **Information Governance sub-committee** (IGSC) - responsible for ensuring that information held and / or processed by the CCG is efficiently managed in line with legal requirements and best practice.
- **Medicines Optimisation Committee** (MOC) - responsible for providing clinically led expert advice and decisions under delegation for matters related to drugs and prescribing on behalf of the CCG.
- **Safeguarding Sub-Committee**: in place to ensure that the CCG fulfils its statutory responsibilities as outlined in the Care Act 2014; Mental Capacity Act 2005; Children Act 2004; and Working Together to Safeguard Children 2013; Children and Social Work Act 2017, and publication of Working Together to Safeguard Children 2018, promoting the safety and welfare of adults and children with care and support needs across all commissioned and contracted services, the health and wellbeing of looked after children in accordance with statutory guidance, and to identify resulting actions following serious case reviews, independent management reviews and other relevant safeguarding incidents and develop policies and procedures relating to safeguarding practice.

Commissioning Strategy Committee (CSC):

The Commissioning Strategy Committee is responsible for overseeing the creation and delivery of a commissioning strategy to deliver the CCG's organisational objectives and improve patient outcomes, in the context of the boroughs' health strategy defined by the health and wellbeing board.

Given the imminent dis-establishment of the CCG, the Committee did not meet during this reporting quarter.

Borough Based Boards:

These boards are prime committees of the Governing Body with delegated responsibility for the commissioning of local services as part of the overall commissioning plans of the merged CCG. In each borough they may meet in common with the Local Authority, however, each organisation (the CCG and the local authority) retains responsibility for their own organisation's budgets.

The borough meetings cover a range of local issues and seek to offer a platform for the local community to engage with and influence their health services.

Primary Care Commissioning Committee (PCCC):

This committee has been established by the CCG and NHS England to enable decisions to be made jointly on the commissioning of primary medical care. It reports to both NHS England and the Governing Body. The membership includes: two Lay Members (excluding the lay member for governance who cannot chair or vice chair the committee), CCG GP Chair, the governing body registered nurse or secondary care doctor (single member), Accountable Officer, Chief Finance Officer, Executive Director for Commissioning and Planning and the six Borough Based Directors.

One meeting was held in public during this quarter, in May 2022. In line with Covid-19 guidance, this meeting took place virtually, with public access to the meeting available online.

Audit Committee:

The Audit Committee provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance, and assurance on risk and fraud issues. The core membership of the Audit Committee consists of the three lay members of the Governing Body, and the Governing Body Registered Nurse. Two Governing Body clinical leads from each borough are invited to attend the meeting. The meeting is also attended by the Director of Finance, Associate Director for Corporate Operations, auditors and counter fraud and security management specialists.

The committee met twice during the quarter, on 22 April and 15 June 2022. The principal purpose of these meetings was to consider and approve submission of the draft and final annual accounts for the CCG for the year ended 31 March 2022 and to receive annual reports from our auditors and specialist advisors.

Remuneration Committee:

The committee is established to determine the remuneration, fees and allowances payable to the employees of the clinical commissioning group or to other persons providing services to it. It also makes recommendations to a private session of the Governing Body regarding the adoption of standard NHS pay and remuneration frameworks and will additionally advise the Governing Body about appropriate remuneration, the appointment, termination and terms and conditions of the Accountable Officer, Executive Directors, Clinical Leads and other senior managers with locally determined contracts described by the NHS Very Senior Managers Pay Framework.

The committee did not meet in the quarter reported.

Advisory and Executive Groups:

Engagement Assurance Committee:

The Engagement Assurance Committee has been established as an advisory committee to the Governing Body to provide advice, monitor and provide assurance to the Governing Body that the CCG is involving and engaging patients and the public in developing its plans and putting in place services; ensuring best practice patient engagement and ensuring statutory duties for engagement are met. It is chaired by the Lay Member for Patient and Public Involvement and membership includes the Clinical Lead for Engagement, Healthwatch, the Assistant Director of Engagement and two local members from each borough.

The committee met once in the quarter, on 23 May 2022.

Equalities Committee:

The Equalities Committee (EC) is established to support the CCG in making demonstrable improvements in equality, diversity and inclusion for the organisations staff, as well as for patients, service users and carers that are affected by the activities of the CCG. The membership includes: the Lay Member for Patient and Public Involvement (co-chair), GP Lead (co-chair); an additional GP Lead; Chief Operating Officer (or delegated deputy); Chief Nurse (or delegated deputy); Healthwatch Representative, Director of HR & OD, Assistant Director of Engagement, NELCSU Equalities Specialist, Head of Equalities and Patient Experience and Freedom to Speak Up Champions (from boroughs).

The Committee continued to meet monthly during the reporting period.

Auditor Panel:

The Local Audit and Accountability Act 2014 specifies that all local public bodies covered by the legislation must have auditor panels to advise on the selection, appointment and removal of external auditors, and on maintaining an independent relationship with them. The auditor panel's key role is to check that:

• The procurement and selection of external auditors are appropriate

• The relationship and communications with the external auditors are professional

• Conflicts of interest are effectively dealt with.

• Establishing and monitoring the CCG's policy on the awarding of non-audit services.

There were no meetings of the Auditor Panel in the quarter.

Conflict of Interests Panel:

The panel's role is to support the CCGs committees to ensure that any actual or perceived conflict of interest to the business of the CCG are managed effectively in an open and transparent way by recommending how to manage any specific conflicts if asked.

There were no meetings in the quarter.

4.1.3.3 UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code that we consider to be relevant to the CCG and best practice.

This Governance Statement is intended to demonstrate how the CCG has regard for the principles set out in the code as considered appropriate for CCGs for the quarter ended 30 June 2022.

4.1.3.4 Discharge of Statutory Functions

In light of recommendations of the 1983 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

NHS South East London CCG's approach to risk management and board assurance is in accordance with legislation, national and local guidance. It seeks to embed recognised and developed best practice through a process of on-going review and improvement and underpins the production of the Annual Governance Statement.

The Integrated Risk Management Framework for the CCG has been established to

ensure that the principles, processes and procedures for best practice in risk management are consistent across the organisation and fit for purpose.

The framework lays down risk management duties and responsibilities for staff at different levels in the organisation as well as Governing Body members including clinical leads. It presents a framework for CCG policies designed for proactive and reactive risk management to the CCG's objectives.

The CCG systematically identifies, at all levels, those risks that could affect these objectives and takes every reasonable step to control risk. This includes a process to monitor and, if necessary, improve how risks are being managed and demonstrate how this is occurring.

The CCG leadership team employs effective techniques for risk management, supported by good information systems, discusses and shares risk information amongst themselves and trains and supports all their staff to an appropriate level of expertise. NHS South East London CCG also requires that the organisations and people it commissions to provide health services operate demonstrably effective risk management systems.

NHS South East London CCG is committed to the application and embedding of best practice principles across all services and actively communicating these principles with NHS stakeholders to share best practice risk management activities.

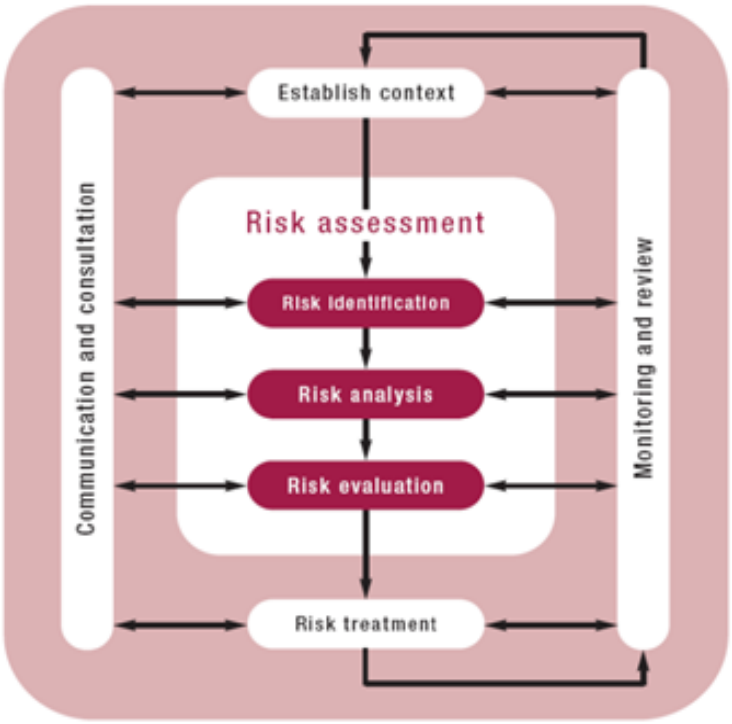
4.1.3.5 Identification and evaluation of risk

The risks to which the CCG is exposed are identified by:

- internal methods – such as audits, evaluating CCG's commissioning plans, QIPP plans, Project Initiation Documents, patient satisfaction surveys, whistle-blowing, complaints and monitoring the quality of commissioned services
- external methods - such as service auditor reports for commissioning support services, CQC inspections, media, national reports, new legislation, reports from assessments/inspections by external bodies, reviews of partnership working
- liaison with practices through Council of members, practice visits, locality meetings, GP Forum meetings, patient engagement forums, practice feedback and practice meetings.

NHS South East London CCG has adopted the Australia/New Zealand (AS/NZS 4360/1999) standard as shown below which it applies to all risk assessment and management including corporate, financial, clinical, operational and reputational risks.

Figure 3 – Risk Management Process



Risk scoring and grading

The CCG has adopted a 5x5 matrix for scoring risks, consistent with the National Patient Safety Agency (NPSA) guidelines (January 2008). The risks scored for likelihood and impact are graded as below:

Grade	Definition	Risk Score
Red	Extreme Risk	15-25
Amber	High Risk	8-12
Yellow	Moderate Risk	4-6
Green	Low Risk	1-3

Extreme risks are those that attract the highest scores, are graded ‘red’ and therefore warrant immediate attention by relevant personnel.

Risk reporting and management structure

The CCG has systems to ensure the identification, analysis, scoring and recording of risks and the consequences of their potential impact. Risk registers are maintained at each level in the organization. Risks which affect the achievement of the CCGs strategic objectives are recorded on the Board Assurance Framework, which is reviewed regularly by each individual director, the Integrated Governance and Performance Committee and the CCG Governing Body. At the 30 June 2022, the highest scoring risks were assessed on the Board Assurance Framework as:

The risk of a growth in waiting times and delay to routine treatment caused by the Covid-19 pandemic	**16**
The risk that SEL does not recover from its performance against the CHC quality premium measures in 2022/23	**15**

Operational risk registers are maintained at borough, directorate and team level. To support operational management, one-to-one meetings take place regularly with risk owners, and an internal Risk Forum group meets monthly to provide a platform for peer challenge and information sharing, supporting consistency approach to risk assessment.

All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the CCG and as professionals working to professional codes of conduct. The Governing Body promotes reporting of incidents, risks and hazards. This is supported by a range of policies which are in place for the CCG.

The CCG utilises a risk management system call Datix, this allows the CCG to actively manage, review and escalate risk across the CCG. The system empowers risk owners and sponsors to manage their risk actively and regularly. This ensures that risks remain current and enables the CCG to highlight areas that require further Risk Management intervention.

Prevention of risk
Prevention is viewed as a key element of risk management and is embedded within the operation of the CCG through:

Policies
Several policies are in place to support risk management within the CCG. These are Information Governance, Counter Fraud, Conflict of Interest policies, Whistleblowing policy, Children and Adult Safeguarding policies, Incident Reporting policy to name a few. These policies are reviewed regularly and are available on the staff intranet. Equality impact assessments are considered for all new policies and policy revisions.

Mandatory Training
CCG staff are required to complete the following mandatory training on an annual basis:

- Conflicts of Interest
- Counter Fraud and Anti-Bribery training
- Equality and Diversity in the Workplace
- Fire safety (face to face, and online)
- Health, Safety and Welfare

- Information Governance – Data Security Awareness training
- Moving and Handling
- PREVENT awareness (training to safeguard vulnerable people from being radicalised to support terrorism)
- Safeguarding Adults – Level 1 and Safeguarding Children – Level 1
- Unconscious Bias in Recruitment Awareness

Equality Impact Assessment

The CCG completes an Equality Impact Assessment for all policies and redesign of services. Equality and Diversity support is provided on incident reporting and management.

Stakeholder involvement

The Engagement Assurance Committee has been established to provide advice and assurance to the governing body on the CCGs approach to stakeholder engagement.

The Annual Governance Statement will be presented to the Audit Committee (including the CCG's internal and external auditors), the Integrated Governance and Performance Committee and the CCG Governing Body before being signed off by the Accountable Officer.

Counter fraud arrangements

NHS South East London CCG has a nominated Local Counter Fraud Specialist and has a risk-based work plan in place to identify and respond to fraud risk.

The Chief Financial Officer is the Executive Lead for counter fraud. The CCG has also appointed the Director of Commissioning System Reform as the organisations Counter Fraud Champion.

NHS South East London CCG has an Anti-Bribery, Fraud and Corruption Policy and a Fraud Response Plan in place to support the CCG's stance of zero tolerance to fraud and corruption. The CCG's counter fraud activities are informed by best practice guidance provided by the NHS Counter Fraud Authority. NHS South East London CCG is compliant with the Bribery Act 2010.

Emergency Planning and Business Continuity

As with all NHS organisations, NHS South East London CCG needs to ensure that it has plans in place to be able to respond to a wide range of incidents that could impact on community health, patient care or the operation of the CCG itself.

As a commissioner of health services, the CCG is classified as a Category 2 responder under the Civil Contingencies Act 2004 and is required to cooperate with and support partner organisations such as the local authority and NHS England in delivering an incident response and co-ordinating activities in the local health economy. The CCG is required to identify an Accountable Emergency Officer to assume executive

responsibility for Emergency Preparedness, Resilience and Response (EPRR) matters, and an independent lay member for support. The CCG is an active member of all six south east London Borough Resilience Forums and liaises regularly with the regional NHS England EPRR team.

The most recent assessment of the CCG resulted in a “full” level of assurance, meeting all NHS England core standards for emergency planning for CCGs.

Conflicts of Interest

The CCG has put in place numerous controls to manage the conflicts of interest risks involved in the course of its commissioning duties. In addition to reviewing its policies, it has put in place a Conflicts of Interest (CoI) panel and is guided by the Conflicts of Interest Guardian, the lay member for governance.

Conflicts of interest Module 1 is part of mandatory training for all staff, Governing Body members and relevant individuals participating in CCG’s committees and sub-committees.

An online system for declaration of interests has been implemented across the CCG to make it easier for staff to declare and review their declarations of interests, gifts and hospitality. Registers of interests, gifts and hospitality and procurement decisions is published on the CCG website, as required by NHSE/I.

PREVENT Awareness

The CCG has a PREVENT programme lead who is also the Head of Safeguarding Adults and Children. All CCG staff are required to complete the PREVENT training as part of annual mandatory training.

Whistleblowing arrangements/ Freedom to Speak Up

The CCG has appointed a Freedom to Speak Up (FTSU) Guardian - Joy Ellery, Lay Member on the SEL CCG Governing Body - and has borough Freedom to Speak Up (FTSU) Champions.

Our team of FTSU Guardians and Champions comprises of individuals from diverse backgrounds in terms of sex, age, ethnicity and professional experience both at work and in their personal lives. The aim of having diversity in the team is to ensure that staff have choice in the guardian they approach for any concerns they might have.

The CCG also has Freedom to Speak Up/ Whistleblowing Policy to comply with national guidance and requirements.

4.1.3.6 Capacity to Handle Risk

Leadership of the risk management process is provided by the Governing Body, its various committees and the directors managing teams and departments.

The Governing Body is responsible for setting the strategic direction for risk management and overseeing the arrangements for identifying and managing risk across their organisation. Management of all risks is delegated to the Integrated Governance & Performance (IGP) committee. The CCG's Governing Body will receive regular reports on risk – including the current status of the organisation's Board Assurance Framework – from the IGP committee as part of the regular prime committee report. Recognising the specialist nature of some risks, the IGP committee uses the expertise of its sub-committees, such as quality and safety, to support the management and monitoring of those related risks.

The Accountable Officer has overall responsibility for ensuring there is an effective risk management assurance framework in place within the CCG, for meeting all statutory requirements, adhering to guidance issued by the Department of Health in respect of Governance, and is required to sign the Annual Governance Statement.

The Accountable Officer is accountable to NHS England. All staff, Executive Directors and Senior Managers are responsible for:

- Ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility.
- Ensuring all staff are made aware of the risks within their work environment and of their personal responsibilities.
- Preparing specific directorate/team policies and guidelines to ensure all necessary risk assessments are carried out within their directorate/team in liaison with appropriate identified relevant advisors where necessary.
- Implementing and monitoring any identified and appropriate risk management control measures within their functions and scope of responsibility.
- Ensuring that in situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, Directors and senior managers are responsible for bringing these risks to the attention of the Executive team and the Governing Body
- Ensuring that all staff are given the necessary information and training to enable them to undertake effective risk management practices.
- Ensuring that a risk register is maintained for each area of responsibility

4.1.3.7 Other sources of assurance

NHS South East London CCG's 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.

The CCG has put in place a suite of policies, processes and reporting procedures to ensure adequate oversight of the CCG's control environment by governing body members. The CCG has put in place various committees and sub-committees to support its internal control framework.

The CCG's Risk Management Framework and Board Assurance Framework are the main mechanisms used by the CCG for providing assurance to the Governing Body that an effective system of internal control is adopted and embedded.

The latest internal audit review has given "substantial assurance" on CCG's controls to ensure effective governance arrangements, which is the highest possible rating.

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.

The CCG's internal auditors conducted an annual internal audit of conflicts of interest management in the year ending 31 March 2022. No audit has taken place in the reported quarter. The annual audit outcome was an assessment of "Reasonable Assurance" received, with one medium and one low action raised as recommendations.

Data Quality

The data provided to the membership body and governing body is generated from a variety of sources and is reported internally and externally through monthly reports and a summary of the year end performance data is included in this report.

The CCG has robust processes and governance arrangements in place to ensure that the quality of data used by the membership body and Governing Body is accurate and fit for purpose. There are processes to ensure that all data that is forwarded to the Governing Body has been sourced from credible sources, discussed, analysed and minuted at committee meetings prior to being submitted for discussion or noting or for a formal decision at the Governing Body.

Governing Body papers are made publicly available through the CCG website.

Information Governance

The NHS Information Governance (IG) 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 the Data Security Protection Toolkit (DSPT). The annual DSPT 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.

There is a complex legal framework governing the way in which the NHS handles information about patients and employees, including personal confidential data. This includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act 2018, UK General Data Protection Regulation, and the Human Rights Act. The DSPT 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. The DSPT allows organisations to measure their performance against the National Data Guardian's ten data security standards and to assist with compliance with the legal framework. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. With the combined efforts of CCG staff NHS SEL CCG achieved Standards Met for the 2021-22 DSPT, publishing on 29th March 2022. The next toolkit assessment will be carried out for the full year 2022-23 and therefore will cover the Q1 CCG and Q2-Q4 ICB periods.

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 DSP Toolkit. We have ensured all staff undertake annual information governance training and continuously update staff information governance guidance on the staff intranet to ensure staff are aware of their information governance roles, responsibilities, and best practice.

We have assigned the roles of Senior Information Risk Owner, Caldicott Guardian, and Data Protection Officer who attend all the monthly Information Governance Sub Committee (IGSC) meetings to monitor IG compliance within the CCG.

There are processes and polices in place for incident reporting and investigation of serious incidents within the CCG. We have also developed an information governance risk register to assess and manage information governance risks to embed an information risk culture throughout the organisation. The documented risks on the information governance risk register are reviewed and updated monthly at the IGSC meetings to ensure appropriate mitigation plans are in place for each risk. We have established policies for information governance, and for the security, management and quality of

information. Information Governance training is mandatory for all CCG staff, whether permanent or temporary. Cyber security training has also been made mandatory for all CCG staff to further bolster their understanding of their information governance roles and responsibilities. We also have a framework in place for the management of information governance.

Business Critical Models
NHS England recognises the importance of quality assurance across the full range of its analytical work. In partnership with analysts in the Department of Health we have developed an approach that is fully consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of government models. The framework includes a programme of mandatory workshops for NHS England analysts, which highlights the importance of quality assurance across the full range of analytical work.

The Macpherson Report on the review of quality assurance (QA) of Government Analytical Models set out the components of best practice in QA making eight key recommendations.

Third party assurances
The CCG uses Service Auditor Reports (SAR) to provide assurance on the services delivered by a number of service organisations, the effectiveness of the control environment and the adequacy and effectiveness of the key controls in operation.

We commission a range of business and contracting services from NEL Commissioning Support Unit (NELCSU). Many of the functions performed by NELCSU are integral to NHS South East London CCG's business operations. NHS England commissions Deloitte LLP to undertake Service Auditor Reporting (SAR) to provide this assurance. The Deloitte's Service Auditor Report sets out whether the controls are operating as described against the control objectives identified. Where control exceptions and qualifications were identified in the SARs they have been addressed by NELCSU.

The CCG also receives Service Auditor Reports for the provision of financial accounting and primary care payments services, the operation of prescription services, payroll infrastructure services and GP payments services.

4.1.3.8 Control Issues

The main risks currently facing the CCG are captured in the Board Assurance Framework which is updated every month. The main issues relate to the impact of the Covid-19 pandemic on achievement of national constitutional standards and recovery trajectories, and on waiting times and delays to routine treatment.

It is the CCG's view that the impact of the Covid-19 pandemic has been to 'prejudice achievement of our priorities' in respect of the below performance standards for the population of south east London: A&E 4 hour standard; ambulance response and

handover standards; RTT waiting time and 52 week long wait standards, diagnostic waiting time standards; cancer 2 week-wait and 62 day waiting time standards.

The CCG has worked with acute trusts and other ICS system partners to plan and implement mitigating detailed actions. In addition, a series of ICS-pandemic response workstreams were established to improve provider performance and enhance resilience in areas including discharge; urgent care; capacity; workforce and estates.

4.1.3.9 Review of economy, efficiency & effectiveness of the use of resources

The CCG has the following key processes in place to ensure that resources are used economically, efficiently and effectively.

The CCG has a clear governance framework which is set out in the CCG scheme of delegation, including an operational scheme of delegation, to ensure the transparency, clarity and robustness of decision making throughout the organisation.

- The CCG's governance structures have a strong focus on the effective use of resources. The Integrated Governance and Performance Committee (IGP) is responsible for bringing together quality, finance and performance in overseeing the delivery of the CCG's activities.

- The CCG has a clearly defined strategic planning process where commissioning intentions underpin strategic programmes which determine investment and implementation plans. These are joint programmes with the local authorities for the integration of health and care through which we can deliver value for money and improved outcomes for our local population.

- The CCG, as part of the South East London Integrated Care System (ICS) works through provider and commissioner leadership groups, and with provider and commissioning finance leads, to deliver plans at scale and at borough level. We are working to deliver a sustainable healthcare system and live within our means by transforming services and maximising collaborative productivity across enablers such as estates.

- The CCG has a robust process for managing financial and performance risk. The CCG must achieve a range of statutory financial duties and ensure that providers deliver services that meet national performance standards.

Assurances are also received from the annual Value for Money audit which is completed by the CCGs' external auditors.

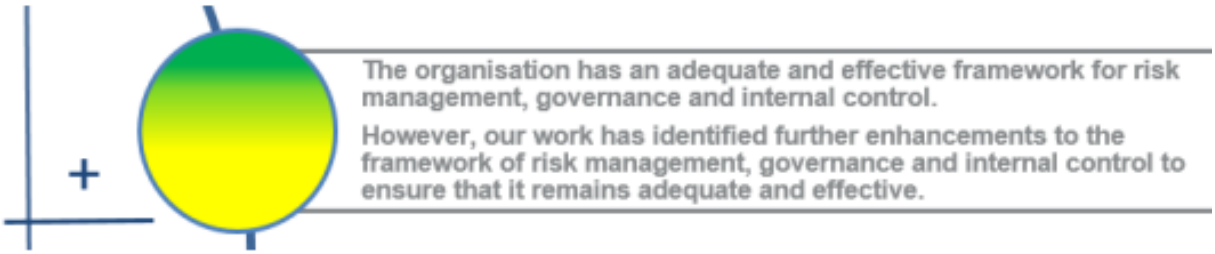
4.1.3.10 Head of Internal Audit Opinion

The following has been received from the CCGs internal auditors in relation to the period 1 April 2022 to 30 June 2022:

The opinion

The opinion takes into consideration the framework in place in the period up to and including 30 June 2022; and our cumulative knowledge of South East London. The opinion does not consider the arrangements of the Integrated Care Board (ICB) or the Integrated Care Partnership (ICP).

For the three months ended 30 June 2022, the head of internal audit opinion for South East London Clinical Commissioning Group is as follows:



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

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

Scope and limitations of our work

The formation of our draft 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 draft 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 draft opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management / lead individual;
- 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 client.

The internal auditors have confirmed that, in the period being reported, they have issued:

- Two positive assurance opinions, on the Data Security and Protection Toolkit (moderate assurance) and Estates (reasonable assurance)
- One advisory review in relation to Due Diligence and ICB Transition

The auditors have not issued any “no assurance” or “partial assurance” opinion reports in quarter 1 2022/23.

The auditors have also confirmed that:

- Based on their work undertaken on the CCGs system of internal control, they do not consider that the CCG should include any issues within its Annual Governance Statement
- Management have agreed actions to address all of the findings reported by the internal audit service in the relevant period. Eight actions remained open as at 30 June 2022 and will be transferred across to NHS South East London ICB for closure.

4.1.3.11 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 and the 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 principle objectives have been reviewed.

I have been advised on the implications of the result of this review by the governing body, the audit committee and quality and safety committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place."

4.1.3.12 Conclusion

There were no significant internal control issues identified.

Andrew Bland
CCG Accountable Officer
June 2023

4.2 Remuneration and Staff Report

4.2.1 Remuneration Report

4.2.1.1 Remuneration Committee

The Remuneration Committee comprises of four members. It did not meet in the quarter being reported. A full list of the NHS SEL CCG members and their roles is below.

Name	Role
Joy Ellery	Lay member for Patient and Public Involvement (Chair)
Peter Ramrayka	Lay member Primary Care & Commissioning
Simon Mackenzie	GB Secondary Care Specialist
and	1 GP clinical lead (depending upon availability)

Details on the work of the committee are given on page 90 under section 4.1.3.2.

4.2.1.2 Policy on the remuneration of senior managers

The Committee's deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures. There are no arrangements in place for additional payments or allowances to staff, at any level, outside of national regulations. The future remuneration policy is not expected to change.

4.2.1.3 Remuneration of Very Senior Managers

4.2.1.3.1 Senior manager remuneration (including salary and pension entitlements)

All members of the Governing Body, plus those "in attendance" are deemed to be individuals with significant financial responsibility during the financial year and are therefore regarded as 'senior managers'. No other CCG senior managers have significant financial responsibility.

Senior Manager Remuneration, including salary and pension entitlements
(for Q1, 2022/23 – April 2022 to June 2022)

Name	Salary (bands of £5,000)	Expenses payments (taxable) (to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long-term Performance Pay & Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Andrew Bland, Accountable Officer	50-55	0	0	0	45-47.5	100-105
Dr Jonty Heaversedge, Chair	20-25	0	0	0	10-12.5	30-35
Sarah Cottingham, Executive Director of Planning and Commissioning	35-40	0	0	0	30-32.5	65-70
David Maloney, acting Chief Finance Officer	35-40	0	0	0	0	35-40
Angela Bhan, Bromley Place Director	20-25	0	0	0	0	20-25
Andrew Eyres, Lambeth Place Director	15-20	0	0	0	0	15-20
Martin Wilkinson, Southwark & Lewisham Place Director	15-20	0	0	0	0	15-20
Samantha Hepplewhite, Director of Primary Care	30-35	0	0	0	0	30-35
Christina Windle, Chief Operating Officer (until 30 April 2022)	10-15	0	0	0	7.5-10	15-20
Kate Moriarty-Baker, Chief Nurse	30-35	0	0	0	0	30-35
Dr Clive Anggiansah, Bexley GP lead	5-10	0	0	0	0	5-10
Dr Siddarth Deshmukh, Bexley GP lead	5-10	0	0	0	0	5-10
Dr Andrew Parson, Bromley GP lead	15-20	0	0	0	0	15-20
Dr Sabah Salman, Greenwich GP lead	15-20	0	0	0	0	15-20
Dr Krishna Subbarayan, Greenwich GP lead	5-10	0	0	0	0	5-10
Dr Dianne Aitken, Lambeth GP lead	20-25	0	0	0	0	20-25
Dr Faruk Majid, Lewisham GP lead	10-15	0	0	0	0	10-15
Dr Rob Davidson, Southwark GP lead	20-25	0	0	0	0	20-25
Professor Simon Mackenzie, Secondary care doctor	5-10	0	0	0	0	5-10
Mary Currie, GB registered nurse	0-5	0	0	0	0	0-5
Joy Ellery, lay member	0-5	0	0	0	0	0-5
Shelagh Kirkland, lay member	0-5	0	0	0	0	0-5
Pater Ramrayka, lay member	0-5	0	0	0	0	0-5

Notes:

1. *The CCG incurred three months worth of salary for the senior managers who are on the payroll. This includes the April 2022 to June 2022 salaries.*

2. *Where the CCG shares the cost of the senior managers salary with other Government bodies, only the cost incurred by the CCG is recognised in the CCGs reports.*
3. *The GPs listed have a contract for service and the above "salary" figure includes employer pension contribution.*
4. *Salary includes any remuneration for non-governing body services.*
5. *Unless otherwise noted, all the individuals listed were in post for the period 1 April 2022 to 30 June 2022.*

Senior Manager Remuneration, including salary and pension entitlements (audited)

Financial Year 2021-22 (April 2021 to March 2022)

Name	Title	Salary & Fees			Taxable Benefits	Annual Performance Related Bonuses	Long-term Performance Related Bonuses	All Pension Related Benefits	Total
		Senior Manager	Other Roles	Total					
		bands of £5,000	bands of £5,000	bands of £5,000	Disclosed in £ to the nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Andrew Bland	Accountable Officer	175-180	-	175-180	0	0	0	37.5-40	210-215
Usman Niazi	Chief Financial Officer	155-160	-	155-160	0	0	0	42.5-45	195-200
Stuart Rowbotham	Place Based Director, Bexley	50-55	-	50-55	0	0	0	-	50-55
Dr Angela Bhan	Place Based Director, Bromley	95-100	-	95-100	0	0	0	-	95-100
Neil Kennett-Brown	Place Based Director, Greenwich	80-85	-	80-85	0	0	0	22.5-25	105-110
Andrew Eyres	Strategic Director Integrated Health and Care, Lambeth	70-75	-	70-75	0	0	0	20-22.5	95-100
Martin Wilkinson	Director of Integrated Care and Commissioning, Lewisham	60-65	-	60-65	0	0	0	17.5-20	80-85
Sam Hepplewhite	Place Based Director, Southwark - From 15th April 2020	130-135	-	130-135	0	0	0	42.5-45	175-180
Sarah Cottingham	Executive Director of Planning and Commissioning	130-135	-	130-135	0	0	0	40-42.5	170-175
Kate Moriarty-Baker	Chief Nurse and Caldicott Guardian	125-130	-	125-130	0	0	0	37.5-40	165-170
Theresa Osborne	Director of Commissioning System Reform	125-130	-	125-130	0	0	0	35-37.5	160-165
Christina Windle	Chief Operating Officer	70-75	-	70-75	0	0	0	22.5-25	110-115
Michael Boyce	Interim Chief Operating Officer	70-75	50-55	125-130	0	0	0	42.5-45	170-175
Dr Jonty Heaversedge	Chair and GP Member of the NHS South East London CCG Governing Body	105-110	-	105-110	0	0	0	-	105-110
Dr Siddharth Deshmukh	GP clinical lead – Bexley	45-50	30-35	80-85	0	0	0	-	80-85
Dr Clive Anggiansah	GP clinical lead – Bexley	45-50	25-30	75-80	0	0	0	-	75-80

Dr Andrew Parson	GP clinical lead – Bromley	55-60	15-20	75-80	0	0	0	-	75-80
Dr Ruchira Paranjape	GP clinical lead – Bromley	45-50	15-20	65-70	0	0	0	-	65-70
Dr Krishna Subbarayan	GP clinical lead – Greenwich	45-50	15-20	65-70	0	0	0	-	65-70
Dr Sabah Salman	GP clinical lead – Greenwich	45-50	40-45	85-90	0	0	0	-	85-90
Dr Adrian McLachlan	GP clinical lead – Lambeth	45-50	-	45-50	0	0	0	-	45-50
Dr Di Aitken	GP clinical lead – Lambeth	45-50	10-15	55-60	0	0	0	12.5-15	70-75
Dr Faruk Majid	GP clinical lead – Lewisham	45-50	-	45-50	0	0	0	-	45-50
Dr Jacky McLeod	GP clinical lead – Lewisham	45-50	-	45-50	0	0	0	-	45-50
Dr Nancy Kuchemann	GP clinical lead – Southwark	45-50	15-20	65-70	0	0	0	-	65-70
Dr Robert Davidson	GP clinical lead – Southwark	45-50	45-50	95-100	0	0	0	-	95-100
Professor Simon Mackenzie	Secondary care doctor	20-25	-	20-25	0	0	0	-	20-25
Mary Currie	Registered nurse	10-15	-	10-15	0	0	0	-	10-15
Shelagh Kirkland	Lay member – governance and audit; also deputy chair	10-15	-	10-15	0	0	0	-	10-15
Joy Ellery	Lay member – patient and public involvement, lead for equalities and engagement: also Freedom to Speak up Guardian	15-20	-	15-20	0	0	0	-	15-20
Peter Ramrayka	Lay member – Primary Care & Commissioning	10-15	-	10-15	0	0	0	-	10-15

Martin Wilkinson was a joint appointment with Lewisham Council. His total salary for these roles was £125,000 to £130,000, and pension related benefits £35,000 to £37,500.

Andrew Eyres position was a joint appointment with Lambeth Council. His total salary for these NHS roles was £145,000 to £150,000, and pension related benefits £42,500 to £45,000.

Stuart Rowbotham was a joint appointment with Bexley Council. His total salary for these roles was £165,000 to £170,000.

Neil Kennett-Brown has held the post of Managing Director for Greenwich, and since 1st November, the post of Winter Director at Lewisham and Greenwich Trust
(0.8wte, with the remaining 0.2wte covering his borough duties).

No Governing Body member, or any other manager, received any performance related pay or bonus, or taxable benefit. No Governing Body member, or any other manager, received any performance related pay or bonus, or taxable benefit.

Pension Benefits Q1, 2022-23 (April 2023 to June 2023)

Name	Real Increase in pension age (bands of £2,500)	Real Increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 30 June 2022 (bands of £5,000)	Lump Sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000)	Cash equivalent Transfer Value at 1 April 2022	Real Increase in Cash Equivalent Transfer Value (to nearest £1,000)	Cash equivalent Transfer Value at 30 June 2022	Employer's contribution to stakeholder pension
	£'000s	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**
Andrew Bland, Accountable Officer	0-2.5	2.5-5.0	45-50	85-90	640	34	699	0
Dr Jonty Heaversedge, Chair	0-2.5	0-2.5	10-15	25-30	224	0	243	0
Sarah Cottingham, Executive director of planning and commissioning	0-2.5	2.5-5	55-60	110-115	1,054	34	1,129	0
David Maloney, acting Chief Finance Officer	0	0	50-55	105-110	1,030	0	1,053	0
Andrew Eyres, Lambeth Place Director	0	0	65-70	175-180	1,539	0	1,571	0
Martin Wilkinson, Southwark & Lewisham Place Director	0	0	50-55	100-105	895	0	920	0
Samantha Hepplewhite, Director of Primary Care	0	0	50-55	110-115	1,008	0	1,033	0
Christina Windle, Chief Operating Officer	0-2.5	0	5-10	0-5	71	1	79	0

Notes:

1. *The increase in pension and cash equivalent transfer has been apportioned to show the increase from 1 April 2022 to 30 June 2022 for SEL CCG.*
2. *The Pensions Related Benefits (PRB) figure is calculated using the method set out in the Finance Act 2004 (1) and includes using the member's current and prior year pension and lump sum figures. Where there has been only a small increase in pension and lump sum benefits current year compared to last year, this formula can sometimes generate a negative figure. Where this is the case, Department of Health guidance states that a zero should be substituted for any negative figures.*
3. *Certain individuals disclosed in the salary and allowances table are not included in the pensions benefits table. The reasons for this include:*
   - *Non-executive members do not receive pensionable remuneration*
   - *An executive director may have opted out of the pension scheme*
   - *For those Governing Body members who are GPs, and who have a contract for service for the Governing Body duties, pensions benefits disclosures are not required.*

Pension Benefits 2021-22 (Full year, April 2021 to March 2022)

Name	Real Increase in pension at age 60 (bands of £2,500)	Real Increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2022 (bands of £5,000)	Lump Sum at age 60 related to accrued pension at 31 March 2022 (bands of £5,000)	Cash equivalent Transfer Value at 31 March 2022	Cash equivalent Transfer Value at 31 March 2020	Real Increase in Cash (Proportion of time in Post) Equivalent Transfer Value	Employer contribution to stakeholder pension
	£'000s	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**
Andrew Bland, Accountable Officer	2.5-5	0-2.5	45-50	80-85	998	934	38	-
Usman Niazi, Chief Financial Officer	2.5-5	-	30-35	-	608	547	43	-
Neil Kennett-Brown, Place Based Director, Greenwich	0-2.5	-	35-40	55-60	792	749	24	-
Andrew Eyres, Strategic Director, Integrated Health & Care, Lambeth	2.5-5	0-2.5	65-70	170-175	1,527	1,462	43	-
Martin Wilkinson, Director of Integrated Care and Commissioning, Lewisham	2.5-5	-	50-55	100-105	1,102	1,047	37	-
Sam Hepplewhite, Place Based Director, Southwark (from 15 April 2020)	2.5-5	2.5-5	50-55	105-110	1,176	1,102	44	-
Sarah Cottingham, Executive Director of Planning and Commissioning	2.5-5	0-2.5	50-55	105-110	1,147	1,078	40	-
Kate Moriarty-Baker, Chief Nurse and Caldicott Guardian	2.5-5	0-2.5	35-40	95-100	886	834	39	-
Theresa Osborne, Director of Commissioning System Reform	2.5-5	0-2.5	55-60	115-120	1,218	1,162	36	-
Christina Windle, Chief Operating Officer	0-2.5	-	5-10	-	167	130	25	-
Michael Boyce, Interim Chief Operating Officer	2.5-5	0-2.5	30-35	45-50	662	600	44	-
Dr Di Aitken, GP clinical lead, Lewisham	0-2.5	-	15-20	35-40	373	353	13	-

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

Professor Simon Mackenzie received no payment in 2020/21 from the CCG for this role.

Neil Kennett-Brown has held the post of Managing Director for Greenwich, and since 1st November 2021, the post of Winter Director at Lewisham and Greenwich NHS Trust (for 4 days per week). As the pension disclosure represents an actuarial valuation of his future benefits these have not been allocated across all organisations but are included in full in each set of financial statements where he has received remuneration.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

4.2.1.4 Cash equivalent transfer values

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.

4.2.1.5 Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

4.2.1.6 Percentage change in remuneration of highest paid director

	Salary and allowances
The percentage change from the previous financial year in respect of the highest paid director	24%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-11%

4.2.1.7 Pay multiples (audited)

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. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid member of the Governing Body in NHS South East London CCG in this quarter was £220,000, a 23.9% increase from 2021-22 (£177,500). This change reflects the increased responsibility associated with the ICB responsibilities for which they are Chief Executive (designate).

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2022/23	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	47,154	60,316	82,971
Salary component of total remuneration (£)	47,154	60,316	82,971
Pay ratio information	4.72	3.69	2.68
2021/22			
Total remuneration (£)	47,154	60,316	81,975
Salary component of total remuneration (£)	47,154	60,316	81,975
Pay ratio information	3.76	2.94	2.17

Between 1 April 2022 and 30 June 2022, no employees received annual remuneration in excess of the highest-paid member of the Governing Body. Remuneration ranged from £23,606 to £220,000 (annualised estimated earnings of highest paid director).

In calculating the relationship between the highest paid person in the organisation and the median remuneration, the CCG has to remove VAT and an estimate of agency premiums from the payments for all contractors and treat all appointments and employments as if they were full-time and for twelve months.

Total remuneration includes salary and pensionable benefits. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Additional guidance for this disclosure requirement is available at Annex 4 of the FReM which cites the Hutton review of Fair Pay – Implementation Guidance.

4.2.2 Staff Report

4.2.2.1 Number of senior managers

Taking this to be Very Senior Managers (VSM) this is a total of 17 individuals of which 9 are female and 8 are male. See tables at 4.2.2.2. and 4.2.2.3.

4.2.2.2 Staff numbers and costs

The table below shows the composition of the CCGs workforce together with their annualised pay costs.

Gender	Pay Band	Headcount	FTE	Basic Annual Pay
Female	Band 3	4	3.00	£65,769
	Band 4	13	10.89	£277,526
	Band 5	30	28.38	£858,963
	Band 6	49	43.88	£1,569,294
	Band 7	62	55.95	£2,494,725
	Band 8A	83	73.59	£3,709,502
	Band 8B	54	48.55	£2,908,656
	Band 8C	43	39.63	£2,831,093
	Band 8D	37	34.32	£2,955,985
	Band 9	11	9.33	£962,972
	VSM	9	8.72	£1,172,264
Female Total		**395**	**356.24**	**£19,806,749**
Male	Band 3	2	2.00	£43,460
	Band 4	5	4.35	£106,511
	Band 5	7	7.00	£195,264
	Band 6	15	15.00	£523,086
	Band 7	26	23.70	£1,051,311
	Band 8A	22	21.28	£1,074,066
	Band 8B	26	25.00	£1,445,951
	Band 8C	18	17.50	£1,260,405
	Band 8D	26	25.10	£2,183,123
	Band 9	8	8.00	£847,120
	VSM	8	7.60	£1,090,712
Male Total		**163**	**156.53**	**£9,821,009**
Grand Total		**558**	**512.77**	**£29,627,758**

4.2.2.3 Staff composition

The CCG's workforce as of 30 June 2022 is set out below by overall employee group and then broken down by male and female, of which the split is 30/70 respectively.

	Female	Male	Grand Total
Clinical Lead	**51**	**27**	**78**
Governing Body	**8**	**8**	**16**

Governing Body Lay Member	**2**	**1**	**3**
Borough Lay Members	**3**	**2**	**5**
Employee	**386**	**155**	**541**
VSM (inc. ICS chair)	**9**	**8**	**17**
Grand Total	**459**	**201**	**660**

Approximately one third of the CCG's workforce are on part-time contracts, broken down as below.

Employee Category	Headcount	FTE
Full Time	220	91.13
Part Time	440	440.00
Grand Total	**660**	**531.13**

The tables below show the CCG's workforce broken down by other protected characteristics.

Disability

Disability	Headcount	%	FTE
No	567	85.9	471.87
Not Declared	18	2.7	4.05
Prefer Not To Answer	10	1.5	7.90
Unspecified	14	2.1	3.19
Yes	51	7.8	44.12
Grand Total	**660**	**100.0**	**531.13**

Gender

Gender	Headcount	%	FTE
Female	459	69.5	367.77
Male	201	30.5	163.36
Grand Total	**660**	**100.0**	**531.13**

Sexual Orientation

Sexual Orientation	Headcount	%	FTE
Bisexual	5	0.8	4.60
Gay or Lesbian	23	3.5	19.40
Heterosexual or Straight	553	83.8	465.96
Not Disclosed	67	10.2	38.87
Other sexual orientation not listed	1	0.1	1.00
Unknown	11	1.6	1.30
Grand Total	**660**	**100.0**	**531.13**

Ethnicity

Ethnic Group	Headcount	%	FTE
A White - British	343	52.0	281.92
B White - Irish	12	1.8	11.50

C White - Any other White background	30	4.5	26.24
CA White English	1	0.15	1.00
CB White Scottish	1	0.15	1.00
CC White Welsh	1	0.15	1.00
CJ White Turkish Cypriot	1	0.15	1.00
CU White Croatian	1	0.15	1.00
CY White Other European	2	0.3	2.00
D Mixed – White & Black Caribbean	1	0.15	1.00
E Mixed - White & Black African	3	0.5	2.20
F Mixed - White & Asian	5	0.8	3.89
G Mixed - Any other mixed background	9	1.4	7.00
H Asian or Asian British - Indian	56	8.5	36.81
J Asian or Asian British - Pakistani	7	1.1	5.40
K Asian or Asian British - Bangladeshi	10	1.5	9.10
L Asian or Asian British - Any other Asian background	22	3.3	14.33
LE Asian Sri Lankan	1	0.15	0.14
LF Asian Tamil	1	0.15	0.20
LH Asian British	1	0.15	0.05
M Black or Black British - Caribbean	28	4.2	24.81
N Black or Black British - African	71	10.8	67.60
P Black or Black British - Any other Black background	5	0.7	3.70
PD Black British	2	0.3	0.70
R Chinese	15	2.3	9.41
S Any Other Ethnic Group	9	1.4	6.40
SA Vietnamese	1	0.15	1.00
SD Malaysian	1	0.15	1.00
Z Not Stated	20	3.0	9.73
Grand Total	**660**	**100.00**	**531.13**

Religion

Religious Belief	Headcount	%	FTE
Atheism	108	16.4	91.95
Buddhism	7	1.1	5.72
Christianity	258	39.1	224.04
Hinduism	36	5.4	22.74
Islam	29	4.4	27.90
Jainism	1	0.1	1.00
Judaism	5	0.8	3.40
Not Disclosed	161	24.40	108.58
Other	44	6.7	35.55
Sikhism	11	1.6	10.25

Grand Total	660	100.0	531.13

Age Band

Age Band	Headcount	%	FTE
<=20 Years	2	0.3	2.00
21-25	13	2.0	13.00
26-30	35	5.3	32.23
31-35	84	12.7	72.14
36-40	79	12.0	62.07
41-45	109	16.5	81.41
46-50	85	12.9	69.80
51-55	100	15.2	84.49
56-60	95	14.4	75.63
61-65	43	6.5	31.74
66-70	10	1.5	5.52
>=71 Years	5	0.7	1.10
Grand Total	**660**	**100.0**	**531.13**

Marital Status

Marital Status	Headcount	%	FTE
Civil Partnership	8	1.2	6.70
Divorced	38	5.8	33.72
Legally Separated	6	0.9	5.30
Married	325	49.2	243.57
Single	224	33.9	195.26
Unknown	56	8.5	43.58
Widowed	3	0.5	3.00
Grand Total	**660**	**100.0**	**531.13**

4.2.2.4 Sickness absence data

NHS sickness absence and the absence cost is always calculated on a rolling 12-month basis and is for substantive staff only. The table below shows the sickness absence rates and cost for the quarter April 2022 to June 2022.

Absence FTE %	Absence FTE	Available FTE
2.8	**1,168.8**	**42,176.5**

4.2.2.5 Staff engagement percentages

The CCG does not participate in the Civil Service People Survey; instead it participates in the annual national NHS staff survey. For the latest survey the CCG obtained an engagement rate of 84.9%, which was the highest across London CCGs, as reported in the 2021/22 annual report.

4.2.2.6 Staff policies

The CCG has continued to monitor its staff policies against legislation and guidance to ensure it is appropriate and compliant and meets the needs of the workforce and the

CCG. As part of the transition planning for the establishment of the ICB from 1 July 2022, the organisation has taken the opportunity to conduct a full review and refresh of all organisational policies.

The HR and OD function have also undertaken a self-assessment against the NHS People Plan and this will form the basis of an OD plan for the new ICB.

4.2.2.7 Trade Union Facility Time Reporting Requirements

The CCG's Staff Partnership Forum continues to meet regularly and at each meeting there is an update from the Chief Operating Officer (or deputy) and the Director of HR and OD. There are no full-time officers within the CCG; however, one member of staff is a representative for Managers in Partnership (MiP). This involvement represented two hours of their paid time per week, this accounts for 0.01% of the CCG total paybill.

4.2.2.8 Other employee matters

The CCG has provided consistent health and wellbeing support and guidance to staff during the pandemic, as well as regular communications and staff briefings, all of which have been undertaken virtually.

The CCG continues to make progress against the objectives in its equality delivery plan. Details of this can be found in our latest public sector equality duty (PSED) report.

The work of the staff network and champion groups continues to add value to the work of the CCG, particularly as regards the equality delivery plan but also in relation to return to office planning, a sustainable lease car scheme and a broad suite of training programmes for network group members. Please refer to the organisational development section for more details.

Funded training is made available to all staff, operated via a training request panel, which assesses each request on its merits and ensures the demographic information of those requesting training is captured and presented to the equalities committee on a 6-monthly basis.

Staff continue to be supported to work safely at home, with ergonomic needs met through the occupational health referral process. Staff who have preferred to be in the office have been accommodated to do so for a range of personal reasons.

4.2.2.9 Expenditure on consultancy

A total of £0.8m was spent on consultancy during this quarter. This relates to services commissioned around the development of the Integrated Care System (£0.3m), services relating to South East London CCG acting as host for a number of pan London projects (£0.4m) and in addition a further £0.1m was spent supporting various adhoc projects.

4.2.2.10 Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

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

	Number
Total number of existing engagements as of 30 June 2022	45
Of which the number that have existed:	
for less than one year at the time of reporting	43
for between one and two years at the time of reporting	2
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

All existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2022 and 30 June 2022 for more than £245[(1)] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	47
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)]	47
No. subject to off-payroll legislation and determined as out of scope of IR35[(2)]	0
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 engagement of Governing Body members and senior officials with "significant financial responsibility" between 1 April 2022 and 30 June 2022:

Number of off-payroll engagements of Governing Body members, and senior officials with "significant financial responsibility" during the financial year	2
Number of individuals who have been deemed Governing Body members, and senior officials with "significant financial responsibility", during the financial year (payroll and off-payroll)	25

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

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of Agenda for Change Terms and Conditions. Exit costs in this note are accounted for in full in the year of departure. Where NHS SEL CCG has agreed early retirements, the additional costs are met by NHS SEL CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 2: Analysis of Other Departures

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	**£000s**
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
TOTAL	0	0

Zero (0) non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

I hereby sign off the Remuneration Report element of the NHS South East London CCG Annual Report for the quarter April 2022 to June 2022.

Andrew Bland

CCG Accountable Officer

June 2023

5. Annual accounts

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS SOUTH EAST LONDON INTEGRATED CARE BOARD IN RESPECT OF NHS SOUTH EAST LONDON CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS South East London Clinical Commissioning Group ("the CCG") for the three month period ended 30 June 2022 which comprise the. Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the [accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 30 June 2022 and of its income and expenditure for the three month period then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 22 June 2022 as being relevant to CCGs in England and included in 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).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG and NHS South East London Integrated Care Board ("the ICB") in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1 to the financial statements which explains that on 1 July 2022, NHS South East London CCG was dissolved and its services transferred to NHS South East London Integrated Care Board. Under the continuation of service principle the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in respect of this matter.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis as the CCG has been dissolved and its services transferred to another public sector entity, the ICB, and the Accountable Officer has not been informed by the relevant national body of the intention to cease the services previously provided by the CCG. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the CCG and transferred to the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and

- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the services provided by the CCG will continue to be provided by the successor body.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee of the successor ICB and internal audit and inspection of policy documentation as to the CCG's high-level policies and procedures to prevent and detect fraud , including the CCG's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Governing Body minutes of the CCG and, Board and Audit Committee minutes of the ICB.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls, in particular the risk that CCG management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity.

We did not identify any additional fraud risks

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual account code combinations and unexpected journal entries.
- Evaluating the business purpose of significant unusual transactions.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board of the CCG and ICB and other management (as required by auditing standards), and from inspection of the CCG's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the CCG is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the CCG is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the regulated nature of the CCG's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by 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") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 65, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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 either cease the services provided by the CCG or dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

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 conform to the authorities which govern them.

Report on 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 if we identify any significant weaknesses in the arrangements that have been made by the CCG to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 65, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. 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 the use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the CCG had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England 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.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS South East London Integrated Care Board in respect of NHS South East London CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS South East London CCG for the three month period ended 30 June 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Fleur Nieboer
for and on behalf of KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL

29 June 2023

Statement of Comprehensive Net Expenditure for the year ended 30 June 2022

	Note	2022-23 £'000	2021-22 £'000
Income from sale of goods and services	2	(9,975)	(37,978)
Other operating income	2	-	(203)
Total operating income		**(9,975)**	**(38,181)**
Staff costs	4	11,007	46,761
Purchase of goods and services	5	962,202	4,034,804
Depreciation and impairment charges	5	134	1,144
Provision expense	5	-	856
Other Operating Expenditure	5	274	4,495
Total operating expenditure		**973,617**	**4,088,060**
Net Operating Expenditure		**963,642**	**4,049,879**
Finance expense	7	14	653
Net expenditure for the Year		**963,656**	**4,050,532**
Total Net Expenditure for the Financial Year		**963,656**	**4,050,532**
Comprehensive Expenditure for the year		**963,656**	**4,050,532**

Statement of Financial Position as at 30 June 2022

	Note	2022-23 £'000	2021-22 £'000
Non-current assets:			
Property, plant and equipment	8	0	0
Right-of-use assets	9	1,339	-
Intangible assets	10	(0)	(0)
Total non-current assets		1,339	(0)
Current assets:			
Trade and other receivables	11	6,092	14,847
Cash and cash equivalents	12	815	660
Total current assets		**6,907**	15,507
Total assets		**8,246**	15,507
Current liabilities			
Trade and other payables	13	(187,579)	(208,719)
Lease liabilities	9	(1,345)	-
Borrowings	15	(23,864)	-
Provisions	14	(6,613)	(6,614)
Total current liabilities		**(219,402)**	(215,333)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(211,156)**	(199,826)
Financed by Taxpayers' Equity			
General fund		(211,156)	(199,826)
Total taxpayers' equity:		**(211,156)**	(199,826)

The accompanying notes on pages 116 to 147 form part of these financial statements.

The financial statements on pages 112 to 115 were approved by the Audit Committee on behalf of the Governing Body on 15 June 2023 and signed on its behalf by:

Andrew Bland
Chief Accountable Officer
27 June 2023

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23				
Balance at 01 April 2022	(199,826)	0	0	**(199,826)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(199,826)**	**0**	**0**	**(199,826)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23				
Total transition adjustment for initial application of IFRS 16	0			**0**
Net operating expenditure for the financial year	(963,656)			**(963,656)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(963,656)**	**0**	**0**	**(963,656)**
Net funding	952,326	0	0	**952,326**
Balance at 30 June 2022	**(211,156)**	**0**	**0**	**(211,156)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(208,663)	0	0	**(208,663)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(208,663)**	**0**	**0**	**(208,663)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating costs for the financial year	(4,050,532)			(4,050,532)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(4,050,532)**	**0**	**0**	**(4,050,532)**
Net funding	4,059,369	0	0	4,059,369
Balance at 31 March 2022	**(199,826)**	**0**	**0**	**(199,826)**

The notes on pages 116 to 147 form part of this statement.

Statement of Cash Flows for the year ended 30 June 2022

	Note	**2022-23 £'000**	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(963,656)	(4,050,532)
Depreciation and amortisation	8	134	402
Impairments and reversals	8	0	742
Interest paid	7	14	0
Other Gains & Losses	7	0	653
(Increase)/decrease in trade & other receivables	11	8,754	23,775
Increase/(decrease) in trade & other payables	13	(21,139)	(34,848)
Increase/(decrease) in provisions	14	0	856
Net Cash Inflow (Outflow) from Operating Activities		**(975,893)**	(4,058,952)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(975,893)**	(4,058,952)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		952,326	4,059,369
Other loans received		23,864	0
Repayment of lease liabilities		(142)	0
Net Cash Inflow (Outflow) from Financing Activities		**976,048**	4,059,369
Net Increase (Decrease) in Cash & Cash Equivalents	12	**155**	418
Cash & Cash Equivalents at the Beginning of the Financial Year		**660**	242
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**815**	660

The notes on pages 116 to 147 form part of this statement.

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual (GAM) for 2022-23 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**

NHS South East London CCG's annual report and accounts have been prepared on a going concern basis. However, the CCG was dissolved on 30th June 2022; this follows the Health and Care Act receiving royal assent on 28th April 2022. The Act allowed for the establishment of Integrated Care Boards (ICB) across England and the abolishment of CCGs. ICBs took on the commissioning functions of CCGs. As a result, the functions, assets and liabilities of the CCG have transferred to NHS South East London Integrated Care Board. 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 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 a going concern basis.

Alongside the Long Term Plan, NHSEI also published indicative CCG allocations covering the 5 years to 2023-24. In February 2021, the Department of Health and Social Care published the White Paper "Integration and innovation: working together to improve health and social care for all", setting out proposals for integration and collaboration in health and care. Following parliamentary approval, the White Paper was implemented on 1st July 2022. ICB's have become statutory bodies, responsible for NHS strategic planning and allocation decisions, and accountable to NHS England. Whilst CCGs were abolished their functions and staff have transferred to the new ICB NHS body. It is also intended that ICB's will additionally take on some of the commissioning responsibilities of NHS England, during the 2023/24 financial year.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

1.2 **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. 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 **Pooled Budgets**

The Clinical Commissioning Group has entered into a pooled budget arrangement with each of the 6 local boroughs, namely Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark in accordance with section 75 of the NHS Act 2006. Under the arrangements, funds are pooled for Better Care Funds for each borough plus some smaller arrangements and Note 17 provides details of the income and expenditure.

Some of the pools are hosted by NHS SEL CCG and some by the individual Local Authorities, the details are provided in Note 17. 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 agreement.

1.5 **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. NHS SEL CCG only has one reporting segment, namely, the Commissioning of Healthcare Services.

1.6 **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.

The majority of the Clinical Commissioning Group's other income relates to transactions with the six London Boroughs in respect of Better Care Fund and other Section 75 arrangements.

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.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the financial statements

1.7 **Employee Benefits**

1.7.1 **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 non-consolidated performance pay earned but not yet paid.

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.

1.7.2 **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.

Some employees within the Clinical Commissioning Group's Borough Integrated Commissioning teams work across NHS SEL CCG and the relevant London Borough. Some of these employees are also members of the Local Government Pension Scheme which is a defined benefit pension scheme and have a contract of employment with relevant London Borough. The scheme assets and liabilities attributable to those employees cannot be identified and are not recognised in the CCG accounts, however they form part of the disclosure within the accounts of the relevant London Boroughs.

1.8 **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.

1.9 **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.

1.10 **Property, Plant & Equipment**

1.10.1 **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.

1.10.2 **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

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

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.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. 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. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

Notes to the financial statements

1.10.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 **Intangible Assets**

1.11.1 **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.

1.11.2 **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.

1.12 **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 financial year end, the clinical commissioning group checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, 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 at the financial year end.

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.

Notes to the financial statements

1.13 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.13.1 **NHS South East London 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.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.14 **Cash & Cash Equivalents**

Cash, bank and overdraft balances are recorded at current values. 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.

Notes to the financial statements

1.15 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 1.30% (2020-21: negative 0.95%) in real terms

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.16 **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 clinical commissioning group.

1.17 **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.

1.18 **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.

Notes to the financial statements

1.19 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

Financial assets at amortised cost;

- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.19.1 **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.

1.19.2 **Financial assets at fair value through other comprehensive income**

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect 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.

1.19.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.19.4 **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 expected credit losses on the financial instrument.

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.

1.20 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.20.1 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 **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.

1.22 **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).

Notes to the financial statements

1.23 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.23.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The Governing Body does not consider the activity of the Charitable Funds pertaining to Greenwich to represent a significant risk to the group's accounts. The charitable funds activity represent approximately 0.1% of the revenues outturn position of NHS SE London CCG. Accordingly the Governing Body has decided not to consolidate these Charitable accounts with that of the CCG.

1.23.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

● The largest estimated cost in the clinical commissioning group's accounts relates to the May and June 2022 prescribing accrual totalling £36.3m. The prescribing accrual however is not deemed to have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year. This is consistent with previous year's accounting.

1.24 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.25 **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 of low value.

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.

As of 1 April 2022, the group recognised £1.47m or right-of-use assets and lease liabilities of £1.47m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was no 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.

1.26 **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

	2022-23 Total £'000	2021-22 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**-**	299
Non-patient care services to other bodies	**8,230**	31,434
Other Contract income	**1,745**	6,245
Total Income from sale of goods and services	**9,975**	**37,978**
Other operating income		
Other non contract revenue	**-**	203
Total Other operating income	**-**	**203**
Total Operating Income	**9,975**	**38,181**

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

	Non-patient care services to other bodies £'000	Other Contract income £'000
Source of Revenue		
NHS	2,594	71
Non NHS	5,636	1,674
Total	**8,230**	**1,745**

	Non-patient care services to other bodies £'000	Other Contract income £'000
Timing of Revenue		
Point in time	85	1,721
Over time	8,145	24
Total	**8,230**	**1,745**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		**2022-23**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**8,134**	**263**	**8,397**
Social security costs	**1,068**	**-**	**1,068**
Employer Contributions to NHS Pension scheme	**1,502**	**-**	**1,502**
Apprenticeship Levy	**40**	**-**	**40**
Gross employee benefits expenditure	10,744	263	11,007
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	10,744	263	11,007
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	10,744	263	11,007

4.1.1 Employee benefits

	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**32,285**	**4,123**	36,408
Social security costs	**4,039**	**-**	4,039
Employer Contributions to NHS Pension scheme	**5,991**	**-**	5,991
Apprenticeship Levy	**163**	**-**	**163**
Termination benefits	**160**	**-**	**160**
Gross employee benefits expenditure	42,638	4,123	46,761
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	42,638	4,123	46,761
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	42,638	4,123	46,761

4.1.2 Recoveries in respect of employee benefits

			2022-23	2021-22
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	-	-	-	-

4.2 Average number of people employed

	2022-23			2021-22		
	Permanently employed Number	**Other Number**	**Total Number**	**Permanently employed Number**	**Other Number**	**Total Number**
Total	**519.78**	**43.49**	**563.27**	**516.00**	**27.81**	**543.81**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

	2022-23 Compulsory redundancies		2022-23 Other agreed departures		2022-23 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	6,635	-	-	1	6,635
£10,001 to £25,000	1	10,667	-	-	1	10,667
£25,001 to £50,000	1	35,561	-	-	1	35,561
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	1	106,667	-	-	1	106,667
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**4**	**159,530**	**-**	**-**	**4**	**159,530**

	2022-23 Departures where special payments have been made		2021-22 Departures where special payments have been made	
	Number	**£**	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	2022-23 Other agreed departures		2021-22 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Total	**-**	**-**	**-**	**-**

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 30 June 2022, is based on valuation data as 30 June 2022, updated to 30 June 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

	2022-23 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	4,351	20,010
Services from foundation trusts	498,625	2,157,065
Services from other NHS trusts	202,811	789,916
Provider Sustainability Fund	-	-
Services from Other WGA bodies	-	-
Purchase of healthcare from non-NHS bodies	110,519	501,134
Purchase of social care	808	3,160
General Dental services and personal dental services	-	-
Prescribing costs	54,184	213,691
Pharmaceutical services	378	962
General Ophthalmic services	179	1,626
GPMS/APMS and PCTMS	78,095	314,146
Supplies and services – clinical	168	584
Supplies and services – general	3,780	4,843
Consultancy services	789	3,803
Establishment	2,990	11,103
Transport	13	82
Premises	1,236	7,332
Audit fees	192	242
Other non statutory audit expenditure		
· Internal audit services	-	0
· Other services	-	30
Other professional fees	2,526	4,066
Legal fees	29	209
Education, training and conferences	529	799
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	-	-
Total Purchase of goods and services	**962,202**	**4,034,803**
Depreciation and impairment charges		
Depreciation	134	402
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	742
Impairments and reversals of right-of-use assets	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**134**	**1,144**
Provision expense		
Change in discount rate	-	-
Provisions	-	856
Total Provision expense	**-**	**856**
Other Operating Expenditure		
Chair and Non Executive Members	85	599
Grants to Other bodies	-	2,804
Clinical negligence	7	74
Research and development (excluding staff costs)	-	-
Expected credit loss on receivables	(39)	(160)
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	222	1,179
Total Other Operating Expenditure	**274**	**4,496**
Total operating expenditure	**962,611**	**4,041,299**

In accordance with S1 2008 NO.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the Clinical Commissioning Group is required to disclose the liability of KPMG, its members, partners and staff (whether in contract, negligence, or otherwise) shall in no circumstances exceed £2m, aside from where the liability cannot be limited by law. This is in aggregate in respect of all services. The audit fees above excluding VAT is £192,470.

The Clinical Commissioning Group will be required to obtain assurance from the external auditor over reported compliance with the requirements of the Mental Health Investment Standard.

Total operating expenditure includes administration expenses of £8,830k (21/22: £36,602k) which in line with the administration expenses allocation for the period.

6 Better Payment Practice Code

Measure of compliance	**2022-23 Number**	**2022-23 £'000**	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	12,847	214,148	57,544	904,328
Total Non-NHS Trade Invoices paid within target	12,477	210,356	55,833	886,421
Percentage of Non-NHS Trade invoices paid within target	**97.12%**	**98.23%**	**97.03%**	**98.02%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	377	685,489	1,600	2,963,569
Total NHS Trade Invoices Paid within target	371	684,689	1,562	2,963,434
Percentage of NHS Trade Invoices paid within target	**98.41%**	**99.88%**	**97.63%**	**100.00%**

7. Other gains and losses

	2022-23 £'000	2021-22 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	-	653
Total	**-**	**653**

7.1 Finance costs

	2022-23 £'000	2021-22 £'000
Interest		
Interest on lease liabilities	14	-
Total interest	**14**	**-**
Total finance costs	**14**	**-**

8 Property, plant and equipment

2022-23	Buildings excluding dwellings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	1,008	13	517	3	1,541
Disposals other than by sale	(1,008)	-	-	(3)	(1,011)
Cost/Valuation at 30 June 2022	**-**	**13**	**517**	**(0)**	**530**
Depreciation 01 April 2022	1,008	13	517	3	1,541
Disposals other than by sale	(1,008)	-	-	(3)	(1,011)
Depreciation at 30 June 2022	**-**	**13**	**517**	**(0)**	**530**
Net Book Value at 30 June 2022	**-**	**-**	**0**	**-**	**0**

8 Property, plant and equipment cont'd

8.1 Cost or valuation of fully depreciated assets

	2022-23 £'000	2021-22 £'000
Information technology	-	-
Total	**-**	**-**

8.2 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Buildings excluding dwellings	5	20
Information technology	3	5
Furniture & fittings	3	3

9 Leases

9.1 Right-of-use assets

2022-23	Buildings excluding dwellings £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-	-
IFRS 16 Transition Adjustment	1,409	64	1,473
Cost/Valuation at 30 June 2022	**1,409**	**64**	**1,473**
Depreciation 01 April 2022	-	-	-
Charged during the year	129	5	134
Depreciation at 30 June 2022	**129**	**5**	**134**
Net Book Value at 30 June 2022	**1,280**	**59**	**1,339**

9 Leases cont'd

9.2 Lease liabilities

2022-23	**2022-23 £'000**	2021-22 £'000
Lease liabilities at 01 April 2022	-	-
IFRS 16 Transition Adjustment	1,473	-
Interest expense relating to lease liabilities	14	-
Repayment of lease liabilities (including interest)	(142)	-
Lease liabilities at 30 June 2022	**1,345**	-

9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23 £'000	2021-22 £'000
Within one year	-	-
Between one and five years	-	-
After five years	-	-
Balance at 30 June 2022	**-**	**-**
Effect of discounting	(1,345)	-
Included in:		
Current lease liabilities	(1,345)	-
Non-current lease liabilities	-	-
Balance at 30 June 2022	**(1,345)**	**-**

9 Leases cont'd

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	**2022-23**	2021-22
	£'000	£'000
Depreciation expense on right-of-use assets	134	-
Interest expense on lease liabilities	14	-

22a.5 Amounts recognised in Statement of Cash Flows

	2022-23	2021-22
	£'000	£'000
Total cash outflow on leases under IFRS 16	(142)	-

10 Intangible non-current assets

2022-23	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2022	-	**-**
Cost / Valuation At 30 June 2022	**-**	**-**
Amortisation 01 April 2022	0	**0**
Charged during the year	-	**-**
Amortisation At 30 June 2022	**0**	**0**
Net Book Value at 30 June 2022	**(0)**	**(0)**
Purchased	-	**-**
Total at 30 June 2022	**-**	**-**

10 Intangible non-current assets cont'd

10.1 The cost or valuation of fully depreciated assets still in use was as follows:

	2022-23 £'000	2021-22 £'000
Computer software: purchased	-	-
Total	**-**	**-**

10.2 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Computer software: purchased	1	3

11.1 Trade and other receivables	**Current 2022-23 £'000**	**Non-current 2022-23 £'000**	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS receivables: Revenue	822	-	3,469	-
NHS prepayments	-	-	1,732	-
NHS accrued income	-	-	1,334	-
Non-NHS and Other WGA receivables: Revenue	2,900	-	4,311	-
Non-NHS and Other WGA prepayments	1,027	-	2,055	-
Non-NHS and Other WGA accrued income	1,264	-	1,399	-
Expected credit loss allowance-receivables	(26)	-	(66)	-
VAT	100	-	608	-
Other receivables and accruals	5	-	5	-
Total Trade & other receivables	**6,092**	**-**	**14,845**	**-**
Total current and non current	**6,092**		**14,845**	

11.2 Receivables past their due date but not impaired

	2022-23 DHSC Group Bodies £'000	**2022-23 Non DHSC Group Bodies £'000**	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	695	2,022	3,396	3,678
By three to six months	23	227	5	387
By more than six months	1	185	1	188
Total	**719**	**2,434**	**3,402**	**4,253**

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 2020	(66)	-	**(66)**
Lifetime expected credit losses on trade and other receivables-Stage 2	40	-	**40**
Total	**(26)**	**-**	**(26)**

12 Cash and cash equivalents

	2022-23 £'000	2021-22 £'000
Balance at 01 April 2022	660	242
Net change in year	155	418
Balance at 30 June 2022	**815**	**660**
Made up of:		
Cash with the Government Banking Service	815	660
Cash and cash equivalents as in statement of financial position	**815**	**660**
Bank overdraft: Government Banking Service	-	-
Total bank overdrafts	**-**	**-**
Balance at 30 June 2022	**815**	**660**

13 Trade and other payables	**Current 2022-23 £'000**	Current 2021-22 £'000
NHS payables: Revenue	1,551	8,177
NHS accruals	28,280	3,551
Non-NHS and Other WGA payables: Revenue	6,381	47,210
Non-NHS and Other WGA accruals	87,791	81,241
Social security costs	636	592
Tax	550	594
Other payables and accruals	62,390	67,354
Total Trade & Other Payables	**187,579**	**208,719**
Total current and non-current	**187,579**	**208,719**

Other payables include £2,830k outstanding pension contributions at 30 June 2022.

In year the CCG has worked with its providers to improve the timeliness of billing, this has led to an improved position relating to Non-NHS and Other WGA accruals.

14 Provisions

	Current 2022-23 £'000	Non-current 2022-23 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
Continuing care	6,613	-	6,614	-
Total	**6,613**	**-**	**6,614**	**-**
Total current and non-current	**6,613**		**6,614**	

	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2022	**6,613**	**-**	**6,614**
Arising during the year	-	-	**-**
Balance at 30 June 2022	**6,613**	**-**	**6,614**
Expected timing of cash flows:			
Within one year	6,613	-	**6,614**
Between one and five years	-	-	**-**
After five years	-	-	**-**
Balance at 30 June 2022	**6,613**	**-**	**6,614**

£4.45m of the provision for Continuing care relates to the impact of pausing assessments in relation to the Hospital Discharge Scheme. A further £2.16m has been provided for relating to retrospective Continuing care claims received outside of the previous period. These are expected to be validated within 1 year.

15 Financial instruments

15.1 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 the 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 its internal auditors.

15.1.1 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.

15.1.2 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.

15.1.3 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.

15.1.4 Liquidity risk

The 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.

15.1.5 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.

15 Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 2022-23 £'000	Total 2022-23 £'000
Trade and other receivables with NHSE bodies	666	666
Trade and other receivables with other DHSC group bodies	1,367	1,367
Trade and other receivables with external bodies	2,960	2,960
Cash and cash equivalents	815	815
Total at 30 June 2022	**5,807**	**5,807**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2022-23 £'000	Total 2022-23 £'000
Loans with external bodies	23,864	**23,864**
Trade and other payables with NHSE bodies	1,738	**1,738**
Trade and other payables with other DHSC group bodies	28,321	**28,321**
Trade and other payables with external bodies	157,679	**157,679**
Total at 30 June 2022	**211,602**	**211,602**

16 Operating segments

The CCG has one operating segment, the commissioning of healthcare services.

17 Joint arrangements - interests in joint operations

NHS South East London has entered into Section 75 agreements with its South East London Boroughs (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark). These are signed by both organisations. The purpose of these documents is to act as an overarching document for a number of lead commissioning arrangements as well as the pooled fund for the six Better Care Fund agreements. In 2021/22, the agreements were adjusted to account for the arrangements around the Hospital Discharge Programme as part of the response to the Covid-19 pandemic.

17.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2022-23				Amounts recognised in Entities books ONLY 2021-22			
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Better Care Fund	South East London CCG & London Borough of Bexley	Provision of Integrated Health & Social Care Services in Bexley	0	0	0	22,637	0	0	85,699	82,058
Better Care Fund	South East London CCG & London Borough of Bromley	Health and Social Care	0	0	0	6,385	0	0	29,098	29,098
Pooled Budget	South East London CCG & Royal Borough of Greenwich	Better Care Fund	0	0	3,224	5,956	0	0	25,879	25,894
Better Care Fund	South East London CCG & London Borough of Lambeth	Better Care Fund	0	0	0	7,164	0	0	30,570	30,790
Living Well Network Alliance	South East London CCG & London Borough of Lambeth, South London and Maudsley NHS FT, Certitude, Thamesreach	Provision of Adult Mental Health Services	0	0	0	17,241	0	0	68,966	68,966
Better Care Fund	South East London CCG & London Borough of Lewisham	Pooled Budgets	0	0	0	6,493	0	0	27,301	27,301
Better Care Fund	South East London CCG & London Borough of Southwark	Health and Social Care	0	0	0	7,298	0	0	28,176	28,235

18 Related party transactions

Details of related party transactions with individuals are as follows:

	2022-23			
	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
Relating to interests declared by the Governing Body members				
Brixton and Clapham Park PCN (Dr Adrian McLachlan)	4	-	-	(4)
Hetherington Group Practice (Dr Adrian McLachlan)	639	-	-	(78)
Seldoc Ltd (Dr Adrian McLachlan and Dr Faruk Majid)	113	-	60	-
Chislehurst Medical Practice (Dr Andrew Parson)	595	-	-	(69)
Bromley GP Alliance (Dr Andrew Parson)	1,929	-	291	-
Bromley Healthcare (Dr Andrew Parson)	12,031	(452)	2,598	-
Clocktower Healthcare Ltd (Dr Clive Anggiansah)	1,118	-	229	-
Lyndhurst Medical Centre (Dr Clive Anggiansah)	437	-	-	(62)
Bexley Health Ltd (Dr Clive Anggiansah And Dr Sid Deshmukh)	-	-	-	-
Bexley Health Neighbourhood Care (Dr Clive Anggiansah And Dr Sid Deshmukh)	830	(23)	-	(176)
AstraZeneca (Dr Dianne Aitken)	-	(15)	-	(47)
Vassall Medical Centre (Dr Dianne Aitken)	543	-	-	-
Northwood Group Practice (Dr Dianne Aitken And Dr Jonty Heaversedge)	1,306	-	-	(221)
Sidcup Medical Centre (Dr Sid Deshmukh)	823	-	-	(63)
One Health Lewisham (Dr Faruk Majid)	1,415	-	933	-
Healthwatch Greenwich Ltd (Ms Folake Segun)	(209)	-	-	-
Healthwatch Lambeth Ltd (Ms Folake Segun)	-	-	-	-
Greenwich Primary Care Collaborative (Dr Krishna Subbarayan)	-	-	-	-
Eltham PCN (Dr Krishna Subbarayan and Dr Sabah Salman)	44	-	-	(8)
Sherard Road Medical Centre (Dr Krishna Subbarayan and Dr Sabah Salman)	10	-	-	-
Community Health Partnerships Ltd (P. Andrew Eyres)	1,862	-	-	-
Quay Health Solutions (Dr Robert Davidson)	1,618	-	-	-
Knoll Medical Practice (Dr Ruchira Paranjape)	473	-	-	-
	25,582	**(490)**	**4,110**	**(728)**

The GPs individually named as above are clinical commissioners on the Governing Body

The payments above are not made to the individuals themselves but to their General Practice for clinical services commissioned by the CCG. These payments to the GP Practices exclude funding for prescribing.

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example

- NHS England and NHS Improvement
- NHS Foundation Trusts
- NHS North East London CSU
- NHS Property Services

The NHS organisations listed below are those where transactions over the year 2022-23 have exceeded £2m:

BARTS HEALTH NHS TRUST
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST
CROYDON HEALTH SERVICES NHS TRUST
DARTFORD AND GRAVESHAM NHS TRUST
EPSOM AND ST HELIER NHS TRUST
GUYS & ST THOMAS HOSPITAL NHS FOUNDATION TRUST
IMPERIAL COLLEGE HEALTHCARE NHS TRUST
KING`S COLLEGE HOSPITAL NHS FOUNDATION TRUST
LEWISHAM & GREENWICH NHS TRUST
LONDON AMBULANCE SERVICE NHS TRUST
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
OXLEAS NHS FOUNDATION TRUST
ROYAL FREE LONDON NHS FOUNDATION TRUST
ROYAL HOSPITAL FOR NEURO DISABILITY
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
THE ROYAL MARSDEN NHS FOUNDATION TRUST
UNIVERSITY COLLEGE LONDON NHS FOUNDATION TRUST

19 Events after the end of the reporting period

On 28th April 2022 the Health and Care Act received royal assent. This confirms the establishment of Integrated Care Boards in England. As a result of this the CCG was dissolved on 30th June 2022, and NHS South East London Integrated Care Board was formed on 1st July 2022. As explained in note 1.1 the CCG's accounts are still prepared on a going concern basis due to the continued provision of the CCG's commissioning functions by the ICB.

20 Losses and Special Payments

The CCG has undertaken a review of all fixed assets this year in advance of moving to ICB status in 2022/23; and determined that it has not incurred in year impairment loss on the building asset on the balance sheet.

	2022-23 Number	**2022-23 £'000s**	2021-22 Number	2021-22 £'000s
Administrative Write Offs	0	0	1	742
Total Losses	**-**	**-**	1	742

21 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:

	2021-22 Target £'000s	**2021-22 Performance £'000s**	2021-22 Target £'000s	2021-22 Performance £'000s
Expenditure not to exceed income	973,632	973,631	4,089,175	4,088,713
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	963,657	963,656	4,050,994	4,050,532
Revenue administration resource use does not exceed the amount specified in Directions	8,830	8,830	36,863	36,602

The CCG is reporting a £1k underspend against both its income and notified allocation.

22 IFRS 16 Leases

NHS SEL CCG has applied IFRS 16 Leases which is effective from 1st April 2022. Management has in all material respects concluded its review and analysis of the impending changes resulting from this new standard.
The CCG's Internal and External Auditors have been and are fully engaged in the processes undertaken by the CCG in reviewing and analysing the impact of IFRS 16 Leases and implementation on 1st April 2022.
The change in lease accounting requires capitalisation of operational lease contracts, which will have an impact on total assets and a corresponding impact on the total liabilities. Hence this will affect the financial ratios related to the balance sheet. IFRS 16 requires the lease payment to be split between a depreciation charge included in operating costs and an interest expense on lease liabilities.
Accounting policies will be continuously reviewed and updated in the 2022/23 financial statements following implementation. All entities applying the FReM shall recognise the cumulative effects of initially applying IFRS 16 recognised at the date of initial application as an adjustment to the opening balances of taxpayers' equity. Comparatives do not need to be restated.
The CCG has conducted an impact analysis on the Financial Statements upon adoption of IFRS 16. Based on the contractual obligations on 31 March 2022, an increase in total assets and total liabilities of a£1.4m has been recognised on 1 April 2022. The adoption of IFRS 16 does not have a material impact on the net result in the Income and Expenditure Statement.