NHS
Harrow
Clinical Commissioning Group

Annual Report 2014/15

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1 FOREWORD FROM THE CHAIR AND ACCOUNTABLE OFFICER

This report gives an overview of our achievements in 2014/15 and our priorities for the year ahead. It has been a year of intense work with a number of significant developments for which we would like to thank all of our staff, member practices, providers and partners.

Key priorities for 2014/15 have been improving health services available to people outside hospital and making sure we offer Harrow residents joined up support across the local NHS and with social care. Highlights from the last year have included increasing the number of community beds available to local people; extending our rehabilitation and re-ablement service; and reducing delayed transfers of care (i.e. people ready to leave hospital but needing support to be in place from other health and social care services before they can do so)..

We have also worked closely with Harrow GPs to make it easier for residents to get appointments at times that suit them. We have expanded GP walk-in services and more practices are now able to offer morning, evening and weekend appointments.

Our financial position remains difficult with another year of spending on local services exceeding the money we receive. However, a joint financial strategy with the seven other North West London Clinical Commissioning Groups (CCGs) and higher than average growth in national funding for 2014/15 and 2015/16 are helping to address this.

We hope this report provides a useful summary of our work. If you would like to find out more, please visit our website www.harrowccg.nhs.uk and come along to our regular public meetings of the Governing Body.

We look forward to working with all our partners to drive further improvements in health services across Harrow in 2015/16.

Dr Amol Kelshiker
Chair and local GP
Harrow Clinical Commissioning Group

Rob Larkman
Accountable Officer
Brent, Harrow and Hillingdon
Clinical Commissioning Groups

2 STRATEGIC REPORT

2.1 Who we are

Harrow Clinical Commissioning Group (CCG) was set up in April 2013 under Section 1H National Health Service Act 2006 as amended by Section 11 Health and Social Care Act 2012.

The CCG is made up of the 34 GP practices in Harrow and is responsible for the planning and design of many of the health services needed by the 239,100 people who live in Harrow. In 2014/15, Harrow CCG had a health commissioning budget of £263 million. Our Governing Body includes local GPs, a hospital doctor, nurse, lay members and officers. It meets in public every other month with dates published on our website.

We are organised into a network of six peer groups which are arranged on a geographical basis across the borough. This enables practitioners in their respective peer group to meet as GP commissioners and collectively commission new services and share best practice.

Although we do not directly commission primary care services (i.e. GPs, dentists, pharmacists and optometrists) we recognise our role in helping to develop primary care and improving access to these services. During 2014/15 we have worked with NHS England to develop plans for co-commissioning of primary care which will be implemented through 2015/16.

2.2 Vision and strategic objectives

Harrow CCG's vision is to work in partnership to ensure local residents receive high quality, modern, sustainable, needs-led and cost effective care within the financial budgets available.

Our overarching purpose is to improve the health and wellbeing of the local residents of Harrow by commissioning a sustainable model of high quality health care within the resources we have available. We want patients to receive health care which is right the first time, in hospital when this is appropriate, but closer to their home when possible.

Each year we publish a set of Commissioning Intentions which sets out our priorities, expected outcomes, and the services we intend to commission in order to achieve them. A copy is on our website at www.harrowccg.nhs.uk and there is more information about our priorities for the year ahead in section 2.5 below.

2.3 The health of our borough

People in Harrow are, in general, healthier and live longer than the average for England and London. However, there are a number of underlying health issues that affect many of the population of the borough. People living in different social circumstances experience differences in their health and wellbeing, and in their life expectancy.

The annual Joint Strategic Needs Assessment (JSNA) is carried out by Harrow Council, in partnership with the NHS and community representatives, and is founded on a strong evidence base of need.

Men in west Harrow can expect to live for five and a half years longer than men in Greenhill ward. Women in inner south Harrow can expect to live more than 10 years

longer than women in Wealdstone. However, although there are big variations in life expectancy, Harrow compares favourably to London as a whole.

Harrow's population is projected to grow over the next ten years, with the greatest growth in the older age groups (45-59 and 60+). There is also a predicted increase in numbers of children aged 0-15 but a predicted reduction in the 15-44 age group.

More than 50% of Harrow's population is from black, Asian and minority ethnic (BAME) groups, making Harrow one of the most ethnically diverse boroughs in the country. The largest group, after white, is Indian.

Less than half the children in schools in Harrow speak English as a first language. The second most commonly spoken language is Guajarati.

For more information on the Harrow JNSA health report visit the Harrow Council website: http://www.harrow.gov.uk/info/100010/health_and_social_care/130/harrow_s_joint_strategic_needs_assessment

2.4 Tackling inequalities in Harrow

All CCGs publish equality objectives which ensure we promote and meet the rights of protected groups of patients and their carers, as well as those who work in the CCG.

Harrow CCG published its equality and diversity objectives in October 2013, set within the framework of the NHS Equality and Delivery System. The CCG worked closely with Healthwatch Harrow, Harrow Mencap, and the Council's public health team to agree the following priorities:

- Improve data collection for service users with protected characteristics. Current data is very limited other than for age and ethnicity which makes it hard to measure success of any objectives.
- To book basic training for all CCG staff, and training for all managers on Equality Impact Analysis completion. GPs to be encouraged to undertake training and ensure their practice staff are trained.
- Improve awareness and signposting for women and families using maternity services. Evidence shows women from BAME communities more likely to present late for use of maternity services.
- Improve health outcomes in patients with diabetes by making earlier interventions and preventing avoidable hospital presentations and admissions, in line with the CCG's Out of Hospital Strategy.
- Increase the proportion of patients with learning disabilities who have access to an annual health check at their GP practice.

We are committed to having our objectives embedded in our day to day work, so that we address inequalities and that health services can be positively accessed by all people who need them.

Harrow CCG is committed to upholding the Human Rights Act 2000. The human rights values of fairness, respect, equality, dignity and autonomy are central to what we do and ensure we commission the best possible health care services for the people of Harrow.

2.5 Achievements in 2014/15

2014/15 has been a busy, challenging yet productive year, with achievements including new and improved community based health services, strengthening partnerships with commissioners and providers of health and social care, and improving our financial position. Listed below are some of our highlights from 2014/15.

2.5.1 Out of hospital strategy achievements

A key priority for Harrow CCG is taking forward our out of hospital strategy. This work aims to improve both the quality and capacity of community based services, including primary care. People should only go to hospital when it is absolutely necessary. If they do go to hospital we want to keep their stay as short as possible.

Where we can safely provide the care people need through community-based services we should. This approach is essential to delivering high quality convenient healthcare for our residents and helping to ensure the local NHS is both cost effective and sustainable.

In 2014/15 out of hospital service developments include:

- **Improving access to primary care**

Two practices now offer weekend and bank holiday access to patients across Harrow. The Pinn Medical Centre offers 8am to 8pm access seven days a week; and Alexandra Avenue offers weekend and bank holiday access to patients from 9am to 4pm.

In 2014/15, we commissioned more walk-in primary care appointments – making over 14,000 appointments available compared to a previously commissioned capacity of 9,700. Walk-in services are available at both the Pinn Medical Centre and Alexandra Avenue Health Centre.

Twenty practices also offer extended access during the week. 28 practices offer telephone consultations and one practice is offering email consultations. 25 practices offer online appointment booking and 24 offer longer appointments to those that need them.

- **New primary care IT system**

We have improved the IT systems in Harrow GP surgeries allowing patient data to be shared across practices more easily to support GPs working in groups to provide better care to local people. All practices will move onto a single IT system which will link up to acute and community services helping them to give patients more joined up care and a better experience.

These improvements will allow, where required, patients to receive e-prescriptions rather than having to make face to face appointments with the practice. Once established with our wider providers (i.e. acute and community services) discharge summaries will be issued faster to GP surgeries which will benefit on-going care for patients and carers.

- **Integrated Care Planning**

Our Integrated Care Planning programme has grown stronger in the last two years. The service currently holds over 6,000 care plans to support vulnerable adults. For 2014/15 the service was expanded to include care navigators who proactively support patients with their care plans.

- **Increase in community beds**

We have increased the number of community beds available for Harrow residents by funding enhanced discharge teams which has increased the number of accepted referrals from 30 to 40 per month. This has supported shorter stays in hospital for patients, helping the hospitals to manage increasing demand within A&E departments and for admissions into the main hospital.

- **Short term assessment rehabilitation and re-ablement service (STARRS)**

We have commissioned and rolled out an integrated team to provide short term intensive support to people both to avoid hospital admissions and to help people return home more quickly after a stay in hospital. Based in the hospital but working extensively with primary and community care, STARRs has helped reduce non-elective admissions by 1,700 and A&E admissions by 1,000 in the last financial year. For 2014/15, we have grown this to support an additional 300 non-elective avoided admissions and 150 A&E avoided attendances.

This service also provides discharge support and a community rehabilitation function, which has helped reduce delayed transfers of care for Harrow residents in the last year.

- **Gynaecology, cardiology and ophthalmology**

These services have been redesigned in 2014/15 to ensure more care is available in the community so fewer people need to go to hospital for treatment. Community based services will help to reduce waiting times and provide a more responsive and accessible service for patients.

- **Mental health and wellbeing**

We have established a psychiatric liaison service working with a single point of access and a supported discharge service to provide better care for people with mental health illnesses at the right time in the right care settings.

We established the Harrow Dementia Action Alliance, a partnership of local organisations to plan and improve dementia services. A new Memory Assessment Service in primary care has reduced waiting times from 37 to 13 weeks and improved the diagnosis of dementia.

- **End of life care**

With our three key providers of end of life care we are developing an integrated care model with a shared palliative care single point of access pilot so patients get an agreed care plan that supports them to die in dignified settings.

2.5.2 Strengthening partnerships

Effective commissioning requires excellent partnerships with providers, fellow commissioners and the broad range of local stakeholders. These stakeholders include the council, voluntary and community and individual patients and residents.

Throughout 2014/15, we have strengthened our working relationships with all our stakeholders, shown by the range of achievements above. Sections 2.6 and 2.7 below give more detail on how we work with patients, the public and our partners.

2.5.3 Finances

Harrow planned to deliver a break-even position in 2014/15. This has been achieved through financial support from other CCGs within north west London as part of the North West London Financial Strategy (£29.1m). The outturn position for 2014/15 is a breakeven position but with an underlying deficit (after taking account of one-off items) of £20.1m. For 2015/16, Harrow CCG set an initial deficit budget of £5.2m, after planned support from the North West London Financial Strategy (£13.3m).

The increase in national funding to areas like Harrow, which is under its funding target based on the NHSE's national allocation formula, has been a key factor, along with the North West London Financial Strategy, in helping to get the CCG's financial position to break-even and to ensure that Harrow CCG continues to be a going concern. Section 2.10 below gives more information on our financial position.

2.6 Priorities for 2015/16

Looking forward, our priorities remain focussed on improving and increasing the health services available to Harrow residents from their GP and other community settings; alongside supporting improvements across hospital and mental health services.

Priorities for 2015/16 include:

2.6.1 Developing integrated care services

Our Whole Systems Integrated Care work is crucial to improving the health and wellbeing of Harrow residents. It will help us ensure high quality, safe services are available when people need them and where they need them – from convenient locations as close to their home as possible. We are continuing work to integrate services across health and social care, with voluntary sector organisations, and between the different parts of the NHS. Some key plans for the future are summarised below.

- **Virtual ward**

We will pilot and roll out weekly virtual ward meetings to provide better care for patients considered at high risk of hospital admission. Consultants will be available to assess patients and provide expert advice, as well as carrying out home visits if necessary. This will be piloted in one area from March 2015 and rolled out across the borough over the course of 2015/16.

- **Community nursing services**

We will re-commission and reconfigure our community nursing services. Six multi-disciplinary teams (bringing together staff from the NHS and social care) will work across the borough so patients get more joined up care between GP, hospital, community and social care.

- **Enhanced nurse pilot project**

We are investing in the Enhanced Nurse Pilot project to increase nursing capacity within the community and provide better care management and coordination for our most vulnerable patients.

2.6.2 Improving access to primary care

In April 2014, along with our neighbouring North West London CCGs, we were awarded £5m from the Prime Minister's Challenge Fund to help make it easier for patients to access GP services. In 2015/16, we have been allocated further funding that will contribute to CCG investment plans to extend access to primary care services. Our plans for improving primary care in the year ahead include:

- **New GP hubs**

Expanding Harrow's community walk-in centres by developing new sites in the east/north east of the borough to provide better coverage for all residents, and ensuring all sites are open 8am to 8pm, seven days a week.

- **Establishing a single GP provider network**

Setting up a single Harrow-wide GP provider network to support the integration of primary care services and help ensure that consistently high standards of care are available to all residents. The network, made up of all 34 GP practices, will provide a structure to support primary care to manage current, and future, demand levels and have the ability to work collaboratively with partner services.

2.6.3 Primary care co-commissioning

Primary care is currently commissioned by NHS England, with very limited local influence. A number of options for co-commissioning were developed by NHS England and across North West London all eight CCGs opted to explore the potential of the joint commissioning option.

Co-commissioning brings CCGs into the commissioning process for GP services and provides the potential for its alignment to local plans. Only with expanded influence through co-commissioning can the CCG be sure that primary care can act as a driver for our ambitious plans for transforming the local health and care economy.

Specifically, co-commissioning provides the opportunity for the North West London CCGs to commission new primary care services that meet specific local needs; to develop additional incentives for GPs to work to local health priorities; and to exert increased influence over quality improvement and primary care premises.

By aligning this with the rest of our ongoing transformation work, we believe that we can secure the following patient benefits:

- Services that are joined up, coordinated, and easily navigated, with more services available closer to people's homes;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities, and better patient experiences; and

- Enhanced local patient and public involvement in developing services, with a greater focus on prevention, staying healthy, and patient empowerment.

In March 2015 all member practices were asked to vote on whether they wish the CCG to enter into joint primary care co-commissioning arrangements with NHS England. Of those who voted, the result was 100% in favour.

A joint co-commissioning committee has been established with NHS England, which has decision-making power over primary care in our area. It includes a range of clinical, executive, and lay members and it will be advised by our local Healthwatch committee and Health and Wellbeing Board. Londonwide LMC was consulted throughout the design of the co-commissioning structure and will also advise the joint committee on its work.

2.6.4 Mental health

- **Improving access to psychological therapies (IAPT)**

Harrow is one of the pilot sites for the "Big White Wall" initiative where people can self-refer - or be referred from a relevant service – for IAPT support so Harrow residents can get help early to maintain their psychological wellbeing.

- **Harrow primary care mental Health Service (PCMHS)**

We have established the Harrow Primary Care Mental Health Service (PCMHS) providing screening, assessment, comprehensive and evidence based interventions, advice and signposting for people aged 18 and above who are experiencing mental health problems.

2.6.5 Risks and challenges for 2015/16

There are a number of key issues that could have an impact on our work. The CCG has a board assurance framework which sets out the principal risks we face, the measures in place to manage these risks, and an overall risk rating. The assurance framework is regularly presented to the Governing Body so members can review the risks and mitigations, and record any actions or events which mean the risk rating for each issue may need to be amended.

Details on the financial pressures facing Harrow CCG are set out in 2.10.2 and 2.10.3 shows progress against financial targets.

2.7 Working with public and patients

Harrow CCG is committed to working with the public and patients in order to get their views and feedback on health services, so that they can be taken into account when designing new care pathways. We hold regular events across a wide spectrum of service areas, which are well attended. Issues discussed include improving access to primary care, our Commissioning Intentions, mental health services and the 'Shaping a Healthier Future' programme.

We have ensured patients had a say in their own care through a range of consultations including:

- Commissioning Intentions 2015/16 resident feedback
- Improve wheelchair services workshops

- Expressions of interest for a partner to build a new health hub
- The CCG held two public engagement meetings which gave the chance for residents to voice their opinions on plans to bring care closer to home, enhancing GP services and development of a wider range of services in the community.
- Working with Service Users and Carers to receive their feedback and views on Learning Disability Services as part of the 'Big Health Day' programme.

We have an Equality and Engagement Committee which is made up of representatives from Healthwatch and the voluntary sector, and is chaired by our Governing Body lay member for public and patient engagement. It meets bi-monthly and oversees the engagement work carried out by the CCG to ensure it is open and inclusive.

The CCG has also made strides to connect with local community groups who have experienced difficulties in accessing healthcare and navigating through the local health system. One example has been engagement work undertaken with the local Gurkha Community who were given the opportunity to voice their feedback and concerns. Consequently the CCG was able to provide bespoke support and advice through community leaders and representatives.

2014/15 has been a digitally eventful year for the CCG with the launch of various initiatives to connect and engage with wider audiences in the borough via:

- A new website, comprising useful information on local health services, self-care, emerging developments, news and much more. The website continues to develop as a patient-friendly 'one stop shop' for all health related queries.
- The launch of a quarterly newsletter entitled 'Patients First.' The newsletter has served as a very important piece of external communication, covering areas such as health tips, updates from the CCG, seasonal self-care advice, interviews with local NHS staff and key contacts for service users.
- Increasing our online presence via social media and using Twitter to effectively share healthcare messages to the wider population.

We certify that Harrow CCG has complied with the statutory duties for Patient and Public Engagement as laid down in the National Health Service Act 2006 (as amended).

2.8 Working with our partners

Our aim is to improve the health and wellbeing of all residents of Harrow, and in particular those groups of people who are disadvantaged, are hard to reach, or are vulnerable – whether young or old. We work closely with a wide range of partner organisations to achieve this, as we all have a part to play in helping people to lead the best possible healthy and happy lives.

2.8.1 London Borough of Harrow

Harrow CCG is working more closely with Harrow Council to commission health and social services, so that people who require both health and social care can receive it as an integrated service. This means services are more tailored to their individual needs, and can be delivered more efficiently and effectively.

Harrow's Health and Wellbeing Board (HWB) is the principal forum for the main organisations in Harrow overseeing work to improve health and social outcomes in the borough, and Harrow CCG is a major partner on the board. Harrow CCG has also actively

participated in key council-led boards such as children's and adults' safeguarding boards where decisions are made on how we collectively support vulnerable and at-risk people.

The HWB has agreed that priorities for Harrow should reflect three important criteria:

- They affect the wellbeing and quality of life of the people of Harrow
- They will lead to a reduction in the health inequalities gap
- They will have long term impact

Seven local priority areas have been agreed:

- Long term conditions: the HWB initially agreed to focus on cardiovascular disease (heart disease, stroke and hypertension), respiratory disease and diabetes
- Cancer
- Worklessness
- Poverty
- Mental health and well-being
- Supporting parents and the community to protect children and maximise their life chances
- Dementia

Implementation plans will identify what we want to achieve within the year and how we will achieve it.

2.8.2 Our key providers

There is no major acute hospital located in the borough of Harrow. Patients are mainly referred to Northwick Park Hospital in Brent which is run by London North West Healthcare NHS Trust. Our community and mental health services are provided by Central and North West London NHS Foundation Trust.

2.8.3 The Brent, Harrow and Hillingdon federation of CCGs

Harrow CCG works in a federation with Brent and Hillingdon CCGs. Working in a federation means we can share senior posts, which saves on management costs. The CCGs work closely together on issues that affect all three CCGs, as well as sharing knowledge and experience on specific projects.

Shared teams support the three CCGs in key areas, including quality, performance and finance, working alongside the local management teams to ensure our strategic objectives are met.

2.8.4 The North West London Collaboration of CCGs

We are part of the North West London Collaboration of Clinical Commissioning Groups, which includes eight CCGs (Brent, Harrow, Hillingdon, Central London, West London, Hammersmith & Fulham, Hounslow and Ealing). We work together on a range of programmes to improve the quality of health services and share a number of support services to help deliver effective and efficient commissioning.

Shaping a Healthier Future is the core transformational programme being led by the eight CCGs. The programme touches on all aspects of health services provided to a population of nearly two million people across the eight CCGs. It includes reconfiguration of hospitals, developing mental health services, driving whole system integrated care (integrating health

and social care services) and transforming primary and community care to allow more services to be delivered outside of hospitals.

The reconfiguration work in 2014/15 has focused on changes to urgent care services and the planning for future changes to maternity services:

- Accident and Emergency Departments at Central Middlesex and Hammersmith Hospitals were closed in September 2014 and replaced by 24/7 Urgent Care Centres and additional capacity at the other A&E units across North West London.
- There are plans to close Ealing maternity unit and transfer services from there to other units in North West London. Work in 2014/15 has focussed on designing the new models of care and engaging with the people affected. The final decision on the timing of the closure will be made by Ealing CCG, all other CCGs in the collaboration having formally delegated authority for them to do so.

There is more information on the Shaping a Healthier Future programme online at www.healthiernorthwestlondon.nhs.uk

2.9 Performance against national indicators

Harrow CCG has a statutory duty to report on the performance of a number of services defined nationally within the NHS Constitution, Everyone Counts Guidance for 2014/15 (Operating Framework) and the NHS Mandated Outcomes Framework.

In 2014/15 Harrow CCG met the following performance standards

National performance standards

- 18 weeks referral to treatment – non-admitted performance within 18 weeks
- 18 weeks referral to treatment – incomplete pathways performance within 18 weeks
- Cancer two week wait – percentage seen within two weeks of an urgent GP referral for suspected cancer
- Cancer 31 day wait - percentage of patients receiving first definitive treatment within one month of a cancer
- Number of 52 week referral to treatment pathways (incomplete pathways)
- Clostridium difficile: reducing the number of outbreaks
- Mental Health (access) – IAPT – proportion of people with depression and/or anxiety disorders referred for and receiving psychological therapies
- Mental Health – CPA – proportion of patients on care programme approach (CPA) discharged from inpatient care who are followed up within seven days.

Harrow CCG did not fully meet the following performance standards:

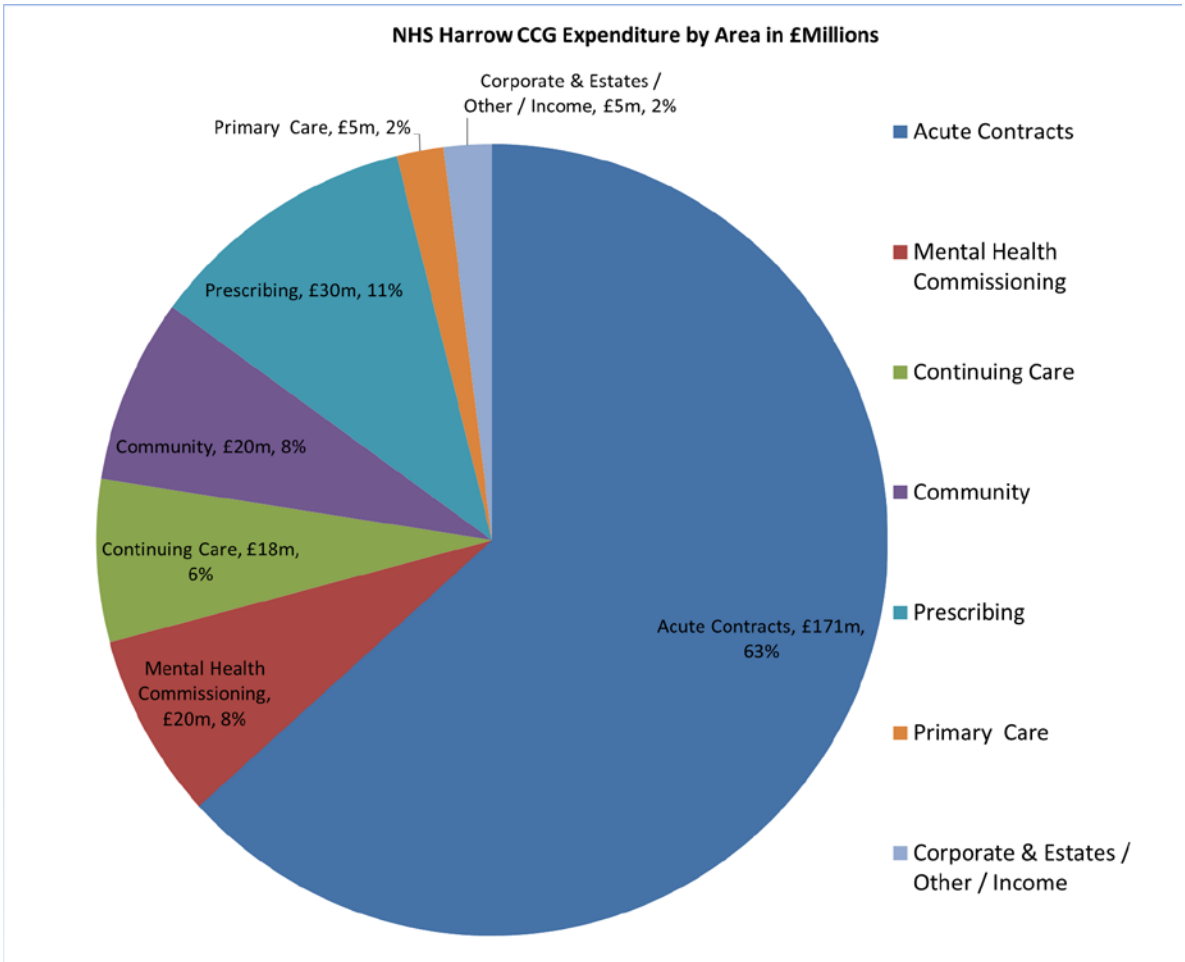
NHS performance standards

- 18 weeks referral to treatment – admitted performance within 18 weeks
- Cancer 62 day wait - percentage treated in 62 days from urgent GP referral for suspected cancer
- MRSA: reducing the number of outbreaks
- Patients waiting more than six weeks for a diagnostic test
- Mixed sex accommodation (MSA) breaches

- Mental Health (recovery) – IAPT – proportion of people with depression and/or anxiety disorders receiving psychological therapies who are moving to recovery
- Mental health – dementia diagnosis of 50.30% against a target of 67%LAS handover times greater than 30 mins
- LAS handover times greater than 60 mins
- LAS category A, red 1 responses within 8 mins
- LAS category A, red 2 responses within 8 mins
- LAS central London (category A 8 performance)
- Total time spent in A&E over four hours (LNWHT)
- Mental Health (recovery) – IAPT – proportion of people with depression and/or anxiety disorders receiving psychological therapies who are moving to recovery.

2.10 How we spent your money

The CCG's full annual accounts in Section 5 have been prepared under a direction issued by NHS England under the National Health Service Act 2006 (as amended). NHS England has directed that the financial statements of CCGs shall meet the accounting requirements of the Manual for Accounts issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCGs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.



2.10.1 Overview of the CCG's finances

From 1 April 2013, Harrow CCG has been responsible for commissioning (planning and purchasing) local health services; excluding primary care and specialised services, which are commissioned by NHS England. Previously primary care trusts (PCTs) had responsibility for the full range of services.

The CCG agreed a breakeven plan for 2014/15 with support from NWL Financial Strategy (£29.1m). The CCG's final outturn position for 2014/15 is a net under-spend of £83k. This is a result of an over-spend of £0.68m on programme budgets offset by an under-spend against its running cost allocation of £0.77m. The outturn position for 2014/15 is a surplus of £83k, with an underlying deficit (after taking account of one-off items) of £20.1m.

2.10.2 Funding allocations

NHS England has been working to address historical inequities in funding across Primary Care Trusts. New funding calculations for CCG allocations (the money the CCG receives from NHS England for its local health services) includes population growth (based on 2011 census information and GP patient list sizes), the effect of relative deprivation and poverty on health need, the impact of an ageing population and geographical cost differences across England.

For 2014/15 Harrow received one of the highest increases in the country for 2014/15, amounting to 4.20% on the 2013/14 funding baseline of £224.7m. This meant Harrow CCG received just under £9.5m growth funding in 2014/15.

For 2015/16 the CCG has received another above average increase in our allocation amounting to 7.56%on the 2014/15 funding; equivalent to £18.085m. With this additional funding the CCG remains 5.04% away from the target funding allocation.

2.10.3 Performance against financial targets

CCGs have a number of financial duties under the National Health Service Act 2006 (as amended) regarding the use of its resources. For 2014/15 Harrow CCG's performance against each is summarised below:

- **Expenditure not to exceed its income**
  For 2014/15 Harrow CCG had a surplus of £0.1m
- **Capital resource use not to exceed the amount specified in directions**
  For 2014/15 Harrow CCG did not have a capital allocation
- **Revenue resource use not to exceed the amount specified in directions**
  For 2014/15 Harrow CCGs net revenue expenditure totalled £269.5m, against a revenue resource limit of £269.6m.

In addition NHS England has placed the following additional controls on CCGs' use of resources:

- **Capital resource use on specified matters not to exceed the amount specified in directions**
  For 2014/15 Harrow CCG did not have a capital allocation
- **Revenue resource use on specified matters not to exceed the amount specified in directions**
  For 2014/15 Harrow CCG did not have any resources allocated with specified directions

- **Revenue administration resource use not to exceed the amount specified in directions.**
  For 2014/15 Harrow CCG had a surplus of £0.8m (running cost).

Programme and running costs together equal Harrow CCG's surplus of £0.1m.

2.11 Sustainability report

As part of the 2013 authorisation process, the CCG self-certified compliance to the statement:

"We declare that at the point of authorisation our CCG will demonstrate commitment to promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner."

Sustainability continues to become increasingly important as the impact on peoples' lifestyles and business choices is changing the world in which we live. We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

We are currently drafting a Sustainable Development Management Plan which will be presented to our Governing Body for consideration. This plan will help embed sustainability throughout the organisation and outlines the CCG's commitment to creating a sustainable future. Initiatives within this plan include:

- Staff awareness campaign for recycling and saving energy
- Sustainable commuting campaign - bike to work scheme and season ticket loans

Furthermore, climate change brings new challenges to our organisation both in direct effects to healthcare estates and to patient health. The Governing Body approved the CCG winter resilience plans which were put in place to ensure that pressures on the system during the winter period do not affect the standards of service for patients.

Approval of Strategic Report

The Strategic Report has been approved by the Governing Body of Harrow CCG.

Signed:

Rob Larkman
Accountable Officer
Brent, Harrow and Hillingdon Clinical Commissioning Groups

Date: 28 May 2015

3 MEMBERS' REPORT

3.1 List of member practices of Harrow CCG

Harrow CCG member practices	
• Aspri Medical Centre HA3 5LE • Bacon Lane Surgery HA8 5AT • Belmont Health Centre HA3 7LT • Charlton Medical Centre HA3 9HT • Circle Practice HA3 7LT • Civic Medical Centre HA1 1SE • Elliott Hall Medical Centre HA5 4EA • Enderley Medical Centre HA3 5HF • Enterprise Practice HA3 7LT • GP Direct HA2 0RQ • Harness Harrow HA8 5QL • Hatch End Medical Centre HA5 4RD • Headstone Lane Medical Centre HA2 6LY • Headstone Road Surgery HA2 1PG • Honeypot Medical Centre HA7 1PJ • Kenton Bridge Medical Centre (Dr Golden) HA3 0YX • Kenton Bridge Medical Centre (Dr Raja) HA3 0YX	• Kenton Clinic HA3 0UQ • Kings Road Surgery HA2 9JH • Northwick Surgery HA1 2NU • Pinn Medical Centre HA5 3EE • Pinner Road Surgery HA1 4JS • Pinner View Medical Centre HA1 4QG • Ridgeway Surgery HA2 7DU • Roxbourne Medical Centre HA2 0UE • Savita Medical Centre HA1 1RQ • Shaftesbury Medical Centre HA2 0AH • Simpson House HA2 8RS • St Peters Medical Centre HA1 4BS • Stanmore Medical Centre HA7 1HS • Stanmore Surgery HA7 4AU • Streatfield Health Centre HA3 9BP • Streatfield Medical Centre HA3 9BL • Wasu Medical Centre* HA2 9LG • Zain Medical Centre HA8 6BH

* The Wasu Medical Centre was closed by official receivers in February 2015

3.2 Harrow CCG Governing Body and committee members

3.2.1 Governing Body members

The main function of the Governing Body is to ensure that Harrow CCG has appropriate arrangements in place to ensure it exercises its functions effectively, efficiently, economically and in accordance with any generally accepted principles of good governance that are relevant to it. The Governing Body leads on the setting of vision and strategy, approves commissioning plans, monitors performance against plan and provides assurance of strategic risks. Members of the Governing Body are:

GP members	Officer members	Lay members
Dr Amol Kelshiker, Chair Dr Kaushik Karia, Vice Chair Dr Lawrence Gould Dr Dilip Patel Dr Kanesh Rajani Dr Irfan Sayed* Dr Genevieve Small	Rob Larkman (Accountable Officer) Jonathan Wise (Chief Finance Officer) Javina Sehgal (Chief Operating Officer) Professor Ursula Gallagher (Nurse Consultant and Director of Patient Quality and Safety) Dr Sandy Gupta (Secondary Care Consultant)	Sanjay Dighe Tom Challenor + Gerald Zeidman (Deputy Lay Chair) Chandresh Somani ~

* Resigned in March 2015 +Appointed 1 July 2014 ~Resigned 30 June 2014

3.2.2 Audit committee members

Harrow CCG holds meetings in common with Brent and Hillingdon CCGs. Harrow CCG's membership of its audit committee is as follows:

- Chandresh Somani (Chair to July 2014)
- Tom Challenor (Chair from July 2014)
- Gerald Zeidman (Lay Member)
- Dr Dilip Patel (GP)

Further information on the Governing Body and other committees are set out in Harrow CCG's annual governance statement.

3.2.3 Statement as to disclosure to auditors

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

- So far as the member is aware, that there is not relevant audit information of which the CCG's external auditor is unaware; and
- That the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the CCG's auditor is aware of
  that information.

3.2.4 Directors/Members' interests

Harrow CCG maintains a register of interests that details names of individuals and details of their interest. Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the CCG as soon as they are aware of it and in any event no later than 28 days after becoming aware. The register of interests is available at www.harrowccg.nhs.uk

3.2.5 Pension liabilities

Details of the treatment of pension liabilities is included in Note 4 of the financial statements and also in the Remuneration Report.

3.3 Employee related issues

3.3.1 Equality

The CCG is committed to equality of opportunity for all employees and is committed to employment practices, policies and procedures which ensure that no employee, or potential employee, receives less favourable treatment on the grounds of sex, race, ethnic or national origin, sexual orientation, marriage and civil partnership, religion or belief, age, pregnancy and maternity, trade union membership, disability, offending background, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or any other personal characteristic.

Diversity is viewed positively and, in recognising that everyone is different, the unique contribution that each individual's experience, knowledge and skills can make is valued equally.

The promotion of equality and diversity is actively pursued through policies and ensures that employees receive fair, equitable and consistent treatment. It also ensures that employees, and potential employees, are not subject to direct or indirect discrimination.

The CCG works with Access to Work when appropriate and abide by the principles of the 'Two Ticks' system in relation to recruitment, whereby disabled applicants get a guaranteed interview.

It is a condition of employment that all employees respect and act in accordance with our Equality and Diversity Policy. Failure to do so will result in the disciplinary procedure being instigated, which could result in termination of employment.

3.3.2 Employee gender information

	Female	Male
Governing Body	3	12
Other senior managers and clinical leads (not included in Governing Body figures)	0	0
CCG staff	18	21

Information correct at 28/02/2015

The membership body of the CCG is made up of the individual member practices and are not employees of the CCG, as such we do not record information on the gender of staff in general practices.

3.3.3 Employee consultation

Harrow CCG did not run any formal consultation with its directly employed staff during 2014/15.

During 2014/15 the eight CCGs across North West London brought the functions formerly provided by North West London Commissioning Support Unit (NWLCSU) in-house.

On 1 July 2014, staff TUPE transferred from the NWLCSU to Brent CCG, as host employer for commissioning support services serving the North West London Collaboration of CCGs. Immediately after the transfer and in agreement with the Trade Unions and other relevant stakeholders, a formal consultation was launched to engage with those staff who transferred from the CSU about proposed changes to structures, jobs, reporting lines, and ways of working including potential changes to base locations. Existing CCG staff were invited to comment on the proposals but their structures were not changed and their roles were not formally affected by the in-housing of CSU services.

The consultation closed on 5 September 2014 and changes were implemented on 1 October 2014. This process resulted in a very small number of redundancies - seven in total including four with a redundancy payment.

3.3.4 Sickness absence data

A table is included in the employee benefits note (note 4.3) to the financial statements.

With a relatively small office based workforce, sickness absence is not a significant issue for the CCG. The management and reporting of sickness is supported by a comprehensive absence management policy and advice from the Human Resources team which covers the eight North West London CCGs. Human Resources have undertaken process training

for CCG managers including the efficient use of sickness absence management protocols to refresh knowledge and remind mangers of their role in the management of absence.

In April 2015 we are moving to a new payroll provider and this will include the provision of a new sickness reporting system.

3.3.5 Health and safety performance

Brent, Harrow and Hillingdon CCGs have a nominated health and safety lead who is undertaking nationally recognised training qualification. A training needs analysis was undertaken by the HR department and health and safety training forms part of the core mandatory training identified for all CCG staff. The modules provided are as follows:

- Fire safety,
- Moving and handling
- Health, safety and welfare

Additional face to face training has been provided within each CCG on fire training and general health and safety. The CCGs will continue to provide training, and monitor the uptake by staff during 2015/16.

3.4 Policy on countering fraud and corruption

Harrow CCG does not tolerate fraud and bribery within the NHS. The intention is to eliminate all NHS fraud and bribery as far as possible. The aim of the Anti-Fraud and Anti-Bribery Policy is to protect the property and finances of the NHS and of patients in our care.

The CCG is committed to taking all necessary steps to counter fraud and bribery. To meet its objectives, it has adopted the seven-stage approach developed by NHS Protect:

- Creation of an anti-fraud culture
- Maximum deterrence of fraud
- Successful prevention of fraud which cannot be deterred
- Prompt detection of fraud which cannot be prevented
- Professional investigation of detected fraud
- Effective sanctions, including appropriate legal action against people committing fraud and bribery, and
- Effective methods of seeking redress in respect of money defrauded.

The CCG will take all necessary steps to counter fraud and bribery in accordance with this policy, the NHS Counter Fraud and Bribery Manual, the policy statement 'Applying Appropriate Sanctions Consistently' published by NHS Protect and any other relevant guidance or advice issued by NHS Protect.

Harrow CCG along with Brent and Hillingdon CCG also produce a Standards of Business Conduct and Gifts, Hospitality & Commercial Sponsorship Policy which can be found at www.harrowccg.nhs.uk/publications.

3.5 Better payments practice code

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the code are given in note 6.1 of the financial statements.

3.6 External audit

External audit services during 2013/14 were provided to Harrow CCG by Deloitte. Audit fees paid to the organisation's external auditors amounted to £68,900 plus VAT.

3.7 Setting charges for information

Harrow CCG certifies that the CCG has complied with HM Treasury's guidance on setting charges for information.

3.8 Incidents related to disclosure of personal data

Harrow CCG did not report any personal data related incidents in 2014/15.

3.9 Emergency preparedness, resilience and response

Emergency preparedness, resilience and response is defined by a series of statutory responsibilities under the Civil Contingencies Act 2004 and Health and Social Care Act 2012 which require NHS organisations to maintain a robust capability to plan for, and respond to, incidents or emergencies that could impact on their communities.

In accordance with the aforementioned legislation, Harrow CCG works with Brent and Hillingdon CCGs to develop incident response and threat specific plans, e.g. cold weather plans and severe weather plans to ensure we continue to deliver critical business operations and support our partners in the event of a major incident or emergency.

Furthermore, the CCG operates a robust on-call system 24 hours a day, seven days a week, 365 days a year to further ensure resilience across the local health economy. Our organisation is fully part of the local and regional emergency planning structure with regular representation at borough resilience forums and participates in multi-agency exercises, ensuring a proactive and coordinated approach to emergency preparedness.

Brent, Harrow and Hillingdon CCGs are committed to collaboratively implementing an integrated and dynamic business continuity management system and emergency prevention, preparedness and response capability to ensure the continued delivery of safe and effective healthcare commissioning and management across outer North West London.

We certify that Harrow CCG has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The CCG regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

3.10 Complaints and principles for remedy

Harrow CCG recognises that complaints, expressions of concern and compliments from the users of health services provides insight into the performance and efficiency of the services it commissions. Every person's experience counts. The BHH Federation uses this valuable first hand intelligence on the services it commissions to ensure that quality, patient focused services are at the heart of its work.

The CCG manages complaints and concerns raised with it and aims to be compliant with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The regulations specify the requirements for the handling of complaints by NHS organisations which include:

- The need to identify a 'responsible person' (the regulations state that this should be the Chief Executive Officer. For CCGs this will be the person who undertakes the Accountable Officer role) and a 'Complaints Manager' (who may be the same person) to deal with complaints
- The time limit for making a complaint
- The requirement for organisations to co-operate when dealing with a complaint that spans more than one organisation
- What the response must include
- The requirement to tell the complainant of their right to put the complaint to the Ombudsman if dissatisfied and
- The recording of complaints.

We are committed to the key principles in the Francis and Keogh reports including:

- Openness, transparency and candour throughout the system;
- Importance of narrative as well as numbers within the data;
- There should be visibility of themes at board level and evidence of response to both individuals and themes.

Complaints and concerns come from a number of sources and may be dealt with in different ways: These include:

- Complaints made by the individual patient or person with authority to act on behalf of the patient
- Concerns that may be raised either where the patient does not wish them to be treated as a formal complaint, anonymously or without the consent of the patient to be investigated as a complaint
- Issues raised by the CCG or other NHS staff who must report incidents of concern for patient safety and failure to comply with fundamental patient healthcare standards. The management of staff complaints/concerns will be dealt with under the Whistle Blowing Policy in conjunction with the Complaints Policy, if appropriate

Harrow CCG aims to ensure that complaints are dealt with efficiently and that they are risk assessed in line with the NHS National complaints procedure. The NHS complaints procedure adheres to the Principles for Remedy published by the Parliamentary and Health Service Ombudsman. It is imperative that investigations take into account the views and wishes of the complainant. Each complaint response is prepared in order to identify areas for improvement and to implement procedures to ensure clarity of roles and responsibilities in the CCG and between organisations.

From 1 April 2014 to 31 March 2015 the CCG received a total of 31 complaints.

- 17 of these related to the commissioning decisions taken by the CCG and were investigated and responded to under the NHS Complaints Procedure.
- One complaint concerned primary care contractors and was forwarded to NHS England for investigation and response.
- 13 complaints were about other providers and were forwarded to the appropriate organisations for investigation and response. Where appropriate, the CCG requests a copy of the final response for monitoring purposes.

Of the 31 complaints investigated and responded to by the CCG:

- Three related to the individual funding request process and
- Five concerned NHS Funded Healthcare.

3.11 Exit packages

Harrow CCG has not agreed any exit packages in the year.

3.12 Off payroll arrangements

Table 1
For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2015	9
Of which, the number that have existed:	
for less than one year at the time of reporting	8
for between one and two years at the time of reporting	1
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

Confirmation that all existing off-payroll engagements 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

For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	2
Number of new engagements which include contractual clauses giving the CCG the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	2
Of which:	
• assurance has been received	2
• assurance has not been received	0
• engagements terminated as a result of assurance not being received	0

	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements.	0

Off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months are as follows:

	Number
The number that have existed:	
• For less than one year at the time of reporting	0
• For between one and two years at the time of reporting	0
• For between two and three years at the time of reporting	0
• For between three and four years at the time of reporting	0
• For four or more years at the time of reporting	0
Total number of existing engagements as of 31 March 2014	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.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	0
Number of the above which include contractual clauses giving the CCG the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which, the number:	
• For whom assurance has been received	0
• For whom assurance has not been received	0
• That have been terminated as a result of assurance not being received	0
Number of off-payroll engagements of membership body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed " Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year (this figure includes both off-payroll and on-payroll engagements)	0

Approval of Members' Report

The Member's Report has been approved by the Governing Body of Harrow CCG.

Signed:

Rob Larkman
Accountable Officer
Brent, Harrow and Hillingdon Clinical Commissioning Groups

Date: 28 May 2015

4 REMUNERATION REPORT

4.1 Remuneration Committee

The remuneration committee meets in common across Brent, Harrow and Hillingdon Clinical Commissioning Groups. Membership comprises the chair of each CCG and a lay member from each CCG. The committee met four times during 2014/15 with attendance as follows:

Member	Present	Absent
Tom Challenor (chair), Brent, Harrow and Hillingdon CCG lay member +	3	0
Chandresh Somani (chair), Brent, Harrow and Hillingdon GCG lay member ~	1	0
Dr Amol Kelshiker, Harrow CCG Chair	2	2
Gerald Zeidman, Harrow CCG lay member	4	0
Dr Ethie Kong, Brent CCG Chair	2	2
Lindsey Wishart, Brent CCG lay member	4	0
Dr Ian Goodman, Hillingdon CCG Chair	2	2
Allison Seidlar, Hillingdon CCG lay member	4	0

+Appointed 1 July 2014
~Resigned 30 June 2014

The committee advised the Governing Body on appropriate remuneration and terms of service for the Chief Officer, senior managers and members of the Governing Body.

The committee reported the basis for its recommendations to the Governing Body which used the committee's report as the basis for its decisions on remuneration. However, the board remained accountable for taking final decisions on the remuneration and terms of service for the Chief Officer and senior managers.

4.2 Chair and clinical directors

The Chair and clinical directors have a fixed term Governing Body contract, and there is a three year rolling programme of elections to the Governing Body. Once elected for a term they are subject to a three month notice period. There is no provision in their contract for compensation for early termination upon the expiry of the initial period or after re-election.

Details of the clinical directors are stated below. Contracts became effective on the dates shown below. Where no end dates are shown individuals are currently still in post.

Clinical Director	Role	Contract start dates	Contract end date	Term of office expires
Dr Amol Kelshiker	Chair	1 April 2013		1 June 2015
Dr Kaushik Karia	Vice Chair	1 April 2013		1 June 2015
Dr Kanesh Rajani	Clinical Director	1 April 2013		1 June 2015
Dr Laurence Gould	Clinical Director	1 April 2013		1 June 2015
Dr Dilip Patel	Clinical Director	1 April 2013		1 June 2015
Dr Genevieve Small	Clinical Director	1 April 2013		1 June 2015

Dr Sandy Gupta	Secondary Care Member	1 April 2013		1 Dec 2015
Dr Irfan Sayed	Clinical Director	1 April 2013	March 2015	

4.3 Lay members

The lay members listed below are not employees of the CCG but have a letter of engagement stating the duties and accountabilities of the organisation and themselves. The lay members are subject to a four week notice period. On termination of the appointment, they are only entitled to accrued fees as at the date of termination together with reimbursement of any expenses properly incurred prior to that date.

Contracts became effective on the dates shown below. Where no end dates are shown individuals are currently still in post.

Name	Role	Contract start date	Contract end date	Term of office expires
Gerald Zeidman	Lay Member	1 April 2013		30 April 2017
Sanjay Dighe	Lay Member	1 April 2013		1 April 2016
Tom Challenor	Lay Member	1 July 2014		n/a
Chandresh Somani	Lay Member	1 April 2013	30 June 2014	

4.4 Senior managers

Details of the senior managers are stated below. Contracts became effective on the dates shown below. Where no end dates are shown individuals are currently still in post.

Senior Manager	Role	Contract start date	Contract end date
Rob Larkman	Chief Officer	1 April 2013	
Jonathan Wise	Chief Finance Officer	1 April 2013	
Ursula Gallagher	Director of Quality and Safety	1 April 2013	1 May 2015
Bernard Quinn	Director of Delivery and Performance	1 April 2013	
Javina Sehgal	Chief Operating Officer	1 April 2013	

Senior managers are on the senior managers pay framework, have a permanent contract and are subject to a six month notice period except in the case of summary or immediate dismissal. Compensation for loss of office is based on the terms and conditions laid out under Agenda for Change.

4.4.1 Senior managers performance related pay

The performance of all CCG staff, including directors and senior managers, is reviewed at intervals of 12 months in accordance with the CCG's annual appraisal and performance management scheme. Except as stated below, the CCG does not operate any system of performance related pay and no proportion of remuneration is dependent upon performance conditions.

Those employed on very senior pay arrangements (the Chief Officer and those reporting to the Chief Officer) are covered by the nationally determined arrangements for bonus

payments in certain circumstances. No directors received performance rewards in 2014/15.

The performance of clinical directors and the Chief Officer is appraised by the Chair. The performance of CCG executive officers and other directors is appraised by the Chief Officer.

4.4.2 Payments to past senior managers (subject to audit)

There have been no payments made to past senior managers.

4.5 Senior managers Salaries and allowances (subject to audit)

			2014/15				2013/14			
Name	Title	Note	Salary & Fees (bands of £5,000) £000	Expense Payments (taxable) (to nearest £00) £00	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000	Salary & Fees (bands of £5,000) £000	Expense Payments (taxable) (to nearest £00	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Dr Amol Kelshiker	Chair		80 - 85	-	7.5 - 10	90 - 95	80 - 85	-	180 - 182.5*	**
Dr Lawrence Gould	Clinical Director		50 - 55	-	15 - 17.5	65 - 70	50 - 55	-	202.5 - 205*	**
Dr Kaushik Karia	Vice Chair		55 - 60	-	-	55 - 60	50 - 55	-	-	50 - 55
Dr Dilip Patel	Clinical Director		50 - 55	-	-	50 - 55	50 - 55	-	115 - 117.5*	**
Dr Kanesh Rajani	Clinical Director		50 - 55	-	0 - 2.5	50 - 55	50 - 55	-	152.5 - 155*	**
Dr Irfan Sayed (Left 17 March 2015)	Clinical Director		50 - 55	-	-	50 - 55	50 - 55	-	145 - 147.5*	**
Dr Genevieve Small	Clinical Director		50 - 55	-	-	50 - 55	50 - 55	-	175 - 177.5*	**
Dr Sandy Gupta	Secondary Care Consultant		0 - 5	-	5 - 7.5	10 - 15	5 - 10	-	142.5 - 145*	**
Sanjay Dighe	Lay Member		10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Hilary Barnes (Commenced 7 August	Associate Lay Member	1	0 - 5	-	-	0 - 5	-	-	-	-
Mukesh Panchal (Commenced 7 August	Associate Lay Member	1	0 - 5	-	-	0 - 5	-	-	-	-
Gerald Zeidman	Deputy Chair & Lay Member		10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Rob Larkman	Chief Officer and Accountable Officer	1	40 - 45	-	2.5 - 5	45 - 50	35 - 40	-	10 - 12.5	45 - 50
Javina Sehgal	Chief Operating Officer		105 - 110	1	2.5 - 5	105 - 110	110 - 115	-	50 - 52.5	160 - 165
Jonathan Wise	Chief Finance Officer	1	35 - 40	-	-	35 - 40	30 - 35	-	40 - 42.5	70 - 75
Bernard Quinn	Director of Delivery and Performance	1	25 - 30	-	0 - 2.5	25 - 30	20 - 25	-	32.5 - 35	55 - 60
Professor Ursula Gallagher	Nurse Consultant and Director of Patient Quality & Safety	1	25 - 30	-	0 - 2.5	25 - 30	20 - 25	-	0 - 2.5	20 - 25
Chandresh Somani (Left 30 June 2014)	Vice Chair & Lay Member	1	0 - 5	-	-	0 - 5	0 - 5	-	-	0 - 5
Tom Challenor (Commenced 1 July 2014)	Vice Lay Chair, Lay Member Audit, Remuneration and Conflict of Interest	1	0 - 5	-	-	0 - 5	-	-	-	-

Notes

1. Joint appointments - see section 4.6 below.
2. There were no "performance pay and bonuses" or "long term performance pay and bonuses" during 2014/15 or 2013/14.

* For these GPs the all pensions benefit figure is based on the pension figures supplied by NHS Pensions Agency and is based on their last officer employment uplifted for inflation. For the majority, this could have been many years ago and does not therefore correctly reflect the increase in pension benefits as a result of their position on the Governing Body. This is an anomaly caused by the formation of the CCGs.

** The total has not been included as this would be misleading for readers of the report.

Definition of Columns

- **Salary & fees** – All amounts paid or payable by the clinical commissioning group, including recharges from any other health body but excludes recharges to other health bodies.
- **Expense payments** – Expenses allowances that are subject to UK income tax and paid or payable to the person in respect of qualifying services.
- **Performance pay and bonuses** – These comprise money or other assets received or receivable for the financial year as a result of achieving performance measures and targets relating to a period ending in the relevant financial year.
- **Long term performance pay and bonuses** – These comprise money or other assets received or receivable for periods of more than one year.
- **All pension related benefits** – This is a requirement of the Government Financial Reporting Manual to disclose all benefits in year from participating in pension schemes. These are the aggregate input amounts, calculated using the method set out in section 229 of the Finance Act 2004(1). This figure will include those benefits accruing to senior managers from membership of the NHS Pensions Scheme which is a defined benefit scheme (although accounted for by NHS bodies as if it were a defined contribution scheme). Zero amounts are shown for individuals who:
    - the CCG does not pay into a pension scheme, or
    - the all pension benefit figure is a negative number.
- **Total** – This is the total of all the above columns and does not necessarily represent the total the individual personally received from the organisation.

4.6 Joint appointments (subject to audit)

The following senior members of staff all work across Brent, Harrow and Hillingdon CCGs and their costs have been shared across other organisations. The salaries and allowances table only show Harrow CCG's share of the amount. This table gives their total salary and allowances.

		2014/15				2013/14			
Name	Title	Salary & Fees (bands of £5,000) £000	Expense Payments (taxable) (to nearest £00) £00	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000	Salary & Fees (bands of £5,000) £000	Expense Payments (taxable) (to nearest £00) £00	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Rob Larkman	Chief Officer and Accountable Officer	160 -165	-	7.5 - 10	170 - 175	165 - 170	-	52.5 - 55	220 - 225
Jonathan Wise	Chief Finance Officer	130 -135	-	-	130 - 135	145 - 150	-	190 - 192.5	335 - 340
Bernard Quinn	Director of Delivery and Performance	100 - 105	2	2.5 - 5	105 - 110	100 - 105	-	152.5 - 155	255 - 260
Professor Ursula Gallagher	Nurse Consultant and Director of Patient Quality & Safety	100 - 105	-	5 - 7.5	105 - 110	95 - 100	-	0 - 2.5	95 - 100
Hilary Barnes (Commenced 7 August 2014)	Associate Lay Member	5 - 10	-	-	5 - 10	-	-	n/a	n/a
Mukesh Panchal (Commenced 7 August 2014)	Associate Lay Member	0 - 5	-	-	5 - 10	-	-	n/a	n/a
Chandresh Somani (Left 30 June 2014)	Vice Chair & Lay Member	0 - 5	1	-	5 - 10	15 - 20	-	-	15 - 20
Tom Challenor (Commenced 1 July 2014)	Vice Lay Chair, Lay Member Audit, Remuneration and Conflict of Interest	10 - 15	-	-	10 - 15	-	-	-	-

Notes:

There were no "performance pay and bonuses" or "long term performance pay and bonuses" during 2014/15 or 2013/14.

The share is calculated on the relative population of each CCG and costs were shared as follows:

39%of cost remains in NHS Brent CCG, 28%of the cost recharged to NHS Harrow CCG and 33%of the cost recharged to NHS Hillingdon CCG

4.7 Pensions benefits (subject to audit)

Name	Title	Note	Real increase / (decrease) in pension at age 60 (bands of £2,500) £000	Real increase / (decrease) in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2015) (bands of £5,000 £000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2014 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Employer's contribution to partnership pension £00
Dr Amol Kelshiker	Chair	1	0 - 2.5	2.5 - 5	10 - 15	30 - 35	190	25	221	-
Dr Lawrence Gould	Clinical Director	1	0 - 2.5	2.5 - 5	15 - 20	45 - 50	275	33	316	-
Dr Dilip Patel	Clinical Director	1	0 - 2.5	0 - 2.5	5 - 10	20 - 25	171	13	189	-
Dr Kanesh Rajani	Clinical Director	1	0 - 2.5	0 - 2.5	5 - 10	25 - 30	135	10	149	-
Dr Irfan Sayed (Left 17 March 2015)	Clinical Director	1,3	-	-	-	-	105	-	-	-
Dr Genevieve Small	Clinical Director	1	0 - 2.5	0 - 2.5	10 - 15	30 - 35	150	9	163	-
Dr Sandy Gupta	Secondary Care Consultant	1	0 - 2.5	0 - 2.5	40 - 45	120 -125	700	26	745	-
Javina Sehgal	Chief Operating Officer		0 - 2.5	-	10 - 15	-	121	14	138	-
Rob Larkman	Chief Officer and Accountable Officer	2	0 - 2.5	2.5 - 5.0	40 - 45	125 - 130	863	59	945	-
Jonathan Wise	Chief Finance Officer	2	(2.5 - 5)	(12.5 - 15)	50 - 55	160 - 165	1,096	(50)	1,076	-
Professor Ursula Gallagher	Nurse Consultant and Director of Patient Quality & Safety	2	0 - 2.5	2.5 - 5	35 - 40	110 - 115	627	37	681	-
Bernard Quinn	Director of Delivery and Performance	2	0 - 2.5	0 - 2.5	25 - 30	85 - 90	572	33	620	-

Notes to pensions table:

1. Please note the figures are supplied by NHS Pensions Agency and are based on their employment as Governing Body members of the CCG only. Pension relating to practitioner employments have not been included.
2. The disclosure for these individuals who are shared across organisations is the gross amount and not the proportion applicable to each individual CCG
3. Opted out of pension scheme 28/2/2014
4. Certain members do not receive pensionable remuneration or have opted out of the pension scheme and therefore there will be no entries in respect of pensions for these members.

4.7.1 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. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

4.7.2 Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

4.8 Senior managers' remuneration – pay multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The mid-point of the banded remuneration of the highest paid Governing Body member in Harrow CCG during the financial year 2014-15 was £107.5k (2013/14: £112.5k). This was 2.15 (2013/14: 4.6) times the median remuneration of the workforce, which was £50,146 (2013/14: £24,713). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind and severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

In 2014/15 the workforce median calculation is based on the average cost of staff on the Harrow CCG payroll. This includes staff directly working for Harrow CCG as well as a small number of in-housed CSS staff costs shown in full. In 2013/14 staff recharged from Brent for the BHH federation were included in this calculation at the percentage charged to each CCG, which effectively reduced the median value.

Approval of Remuneration Report

The Remuneration Report has been approved by the Governing Body of Harrow CCG.

Signed:

Rob Larkman
Accountable Officer
Brent, Harrow and Hillingdon Clinical Commissioning Groups

Date: 28 May 2015

4.9 Statement of the Accountable Officer's responsibilities

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

The responsibilities of an Accountable Officer, including 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 CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the CCG Accountable Officer Appointment Letter.

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Manual for Accounts issued by the Department of Health 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 Manual for Accounts issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements, and
- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my CCG Accountable Officer Appointment Letter.

Signed:

Rob Larkman
Accountable Officer
Brent, Harrow and Hillingdon Clinical Commissioning Groups

Date: 28 May 2015

NHS
Harrow
Clinical Commissioning Group

Annual Governance Statement 2014/15

5 ANNUAL GOVERNANCE STATEMENT 2014/15

Introduction & Context

Harrow Clinical Commissioning Group (CCG) was licensed from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

As at 1 April 2014, Harrow CCG was licensed with the condition

- The CCG must have a clear and credible integrated plan that meets authorisation requirements.

The final authorisation condition, that Harrow CCG must have a clear and credible integrated plan that meets authorisation requirements, was lifted in October 2014 and the CCG is therefore now licensed without conditions.

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 in my CCG Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice. This Governance
Statement is intended to demonstrate how the CCG had regard to the principles set out in the Code considered appropriate for CCGs for the financial year ended 31 March 2015.

The CCG Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L (2) (b) states:
The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

The overarching governance arrangements are set out in the constitution which includes standing orders, prime financial policies instructions and the scheme of reservation & delegation. The CCG has delegated to the Governing Body decision making and responsibility for the delivery of all its duties with the exception of

- determine the arrangements by which the members of the group approve those decisions that are reserved for the membership.
- consideration and approval of applications to the NHS England on any matter concerning changes to the group's constitution, including terms of reference for the group's Governing Body, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.

- Approve the arrangements for
    - identifying practice members to represent practices in matters concerning the work of the group; and
    - appointing clinical leaders to represent the group's membership on the group's Governing Body, for example through election (if desired).
- Approve the appointment of Governing Body members, the process for recruiting and removing non-elected members to the Governing Body (subject to any regulatory requirements) and succession planning.

The Governing Body has supplemented the governance framework by the formal adoption of: the Nolan Principles on standards in public life; the code of conduct and accountability for NHS boards; the CCG code of conduct; standards of business conduct policy; gifts and hospitality policy; anti-bribery policy; and, a conflicts of interest policy. In addition, jointly with Hillingdon and Brent CCGs, the CCG has appointed two associate lay members whose primary role is to enable clearly independent decision making in relation to procurement choices where otherwise a conflict of interest could be perceived.

Using the NHS England guidance "The Functions of Clinical Commissioning Groups" and published legal guidance, the CCG has reviewed its statutory duties and is satisfied that it has in place all the necessary complete and lawful arrangements to ensure the proper discharge of those functions.

As part of the approved internal audit plan for 2014/15, internal auditors were asked to undertake an audit of the CCG's governance arrangements. The purpose was to test compliance with legislation and sector good practice, and guard against inadequate governance arrangements which could result in inability to meet statutory duties and delivery of objectives which could damage to the CCG's reputation. The Auditors concluded there was reasonable assurance that the controls upon which the organisation relies were suitably designed, consistently applied and effective. However, recommendations for improvement were made in some areas; those issues have been addressed.

To undertake and ensure the systematic discharge of its functions and duties, the CCG established a Governing Body and complementary sub committees. Details of their roles are set out below.

<u>Governing Body</u>

The functions of the Governing Body are:

- Commissioning community and secondary healthcare services (including mental health services) for:
    - All patients registered with its member GP practices and
    - All individuals who are resident within the London Borough of Harrow who are not registered with a member GP practice (e.g. unregistered)
- Commissioning emergency care for anyone in the London Borough of Harrow
- Paying its employees' remuneration, fees and allowances in accordance with the determinations made by the NHS Harrow CCG Governing Body and determining any other terms and conditions of service of the CCG's employees
- Determining the remuneration and travelling or other allowance of members of its Governing Body.

To discharge these duties, it has met on seven occasions during the year with attendance as follows:

	Present (Deputy)	Absent
Dr Amol Kelshiker, Chair	5	2
Gerald Zeidman, Deputy Chair	7	0
Dr Genevieve Small	7	0
Dr Kaushik Karia	7	0
Dr Kanesh Rajani	6	1
Dr Dilip Patel	6	1
Dr Irfan Sayed*	5	2
Dr Lawrence Gould	6	1
Dr Sandy Gupta	6	1
Sanjay Dighe, Lay Member	7	0
Tom Challenor+ Lay Member	6	0
Jonathan Wise Chief Finance Officer	7	0
Rob Larkman, Accountable Officer	7	0
Ursula Gallagher, Director of Quality and Safety	6 (1)	0
Sarah Crouch, Public Health Representative	2	2
Chandresh Somani, Lay member~	1	0

***** Resigned in March 2015
+ Appointed 1 July 2014
~ Resigned 30 June 2014

Audit Committee

The purpose of the Audit Committee is to ensure effective assurance of CCG processes and it has been directed by the Governing Body to:

- review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, for each of the activities that support the achievement of the CCG's objectives
- ensure that there is an effective internal audit function that meets mandatory public sector internal audit standards and provides appropriate independent assurance to the accountable officer and Governing Body
- review the work and findings of the external auditors and consider the implications and management's responses to their work
- review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the clinical commissioning group
- satisfy itself that the CCG has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.
- review reports and positive assurances from members of the Governing Body, Directors and managers on the overall arrangements for governance, risk management and internal control.
- monitor the integrity of financial statements and any formal announcements relating to the CCG's financial performance
- ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to each CCG
- review the annual report and financial statements before submission to the Governing Body

In discharging these responsibilities the Audit Committee has focussed on the establishment of effective policies and procedures to control financial performance and to ensure compliance with relevant regulatory and legal requirements. This work has included overseeing counter fraud arrangements, reviewing systems to monitor the performance of the 'in housed' support services and directing the internal audit plan.

At each meeting, the committee also reviewed the risk management and assurance framework arrangements to ensure effective management of the CCG's strategic, operational and collaboration risks. The committee also recognised that conflicts of interest posed a particular challenge for the CCG as they could arise not only in actuality but where there was a perception of impaired judgment or undue influence. To ensure that all dealings were beyond reproach, it oversaw: the ongoing development and implementation of the conflicts of interest policy, specific arrangements to oversee the co-commissioning of primary care services with NHS England and transparency in the management of conflicts of interest. In so doing, the Committee met on six occasions with attendance as follows.

	Present	Absent
Chandresh Somani ~	2	0
Tom Challenor *	4	0
Gerald Zeidman (Lay Member)	4	2
Dr Dilip Patel (GP)	4	2

~Resigned 30 June 2014
*Appointed 1 July 2014

Remuneration Committee

The purpose of the Remuneration Committee is to develop and keep under review the remuneration and terms of service policies for the CCG by:

- agreeing the remuneration package, including performance-related pay and other terms of service, of the Accountable Officer
- with the Accountable Officer, agreeing the remuneration packages, including performance-related pay and other terms of service, of the Chief Financial Officer and any other senior employee as appropriate (directors, chief officers, Governing Body lay and clinical members)
- agreeing criteria annually, in line with available guidance, for the level of performance-related pay for the Accountable Officer and, with the Accountable Officer, for other eligible staff;
- reviewing and agreeing the grading and remuneration package of any senior post that falls vacant prior to the vacancy being advertised
- agreeing the remuneration policy and its application for clinical members supporting the work of the CCG, in line with national guidance
- reviewing and agreeing processes and controls for termination of employment to ensure probity, value for money and compliance with statutory guidance
- approving severance and settlement payments within delegated limits
- considering and agreeing the elements to be included in remuneration packages for all members of staff, including chairs, lay members and other clinical members of the CCG. (eg lease cars, season ticket loans, recruitment and retention payments) outside of national arrangements.

During the year, the focus of the committees work has been on: the development of an appraisal process for members of the Governing Body; reviewing pay awards; and the development of a suite of human resources policies. The Committee met on four occasions with attendance as follows.

	Present	Absent
Chandresh Somani (Chair) ~	1	0
Tom Challenor (Chair)*	3	0
Dr Amol Kelshiker (Clinical Member)	2	2
Gerald Zeidman (Lay Member)	4	0

~Resigned 30 June 2014
*Appointed 1 July 2014

Quality, Innovation Productivity & Prevention Research and Finance Committee

The purpose of the Quality, Innovation Productivity & Prevention, Research and Finance Committee is to:

- promote innovation and promote research and the use of research by providing assurance and oversight against this duty
- promote collaborative working
- continuously assess financial and non-financial risks relating to the QIPP plans and ensure measures and mitigation to manage risk.
- ensure that the QIPP plan is supported by robust financial planning.
- review annual budget and medium term financial plans.
- review performance of key objectives and targets as set in the annual outcomes framework.
- receive and review business cases and procurement procedures as required.

To discharge these responsibilities, the Committee met on twelve occasions during the year.

Quality, Safety and Risk Committee

The purpose of the committee is to:

- seek assurance that the Commissioning Plan and strategy for the CCG fully reflects all elements of quality (patient experience, effectiveness and patient safety
- provide assurance that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the CCG does and continuously support the improvement of quality in primary care services. This includes jointly commissioned services
- work with the NHS England to improve the quality of specialised services. It will also use the existing patient and member practice feedback mechanisms in place to monitor the quality of specialised services
- oversee and be assured that effective management of risk is in place to manage and address clinical governance issues. Ensure effective identification of clinical risks and clear mitigation plans are in place
- oversee and be assured that effective management of the equality duties is in place to manage and address equality issues

- provide oversight and assurance of the process and compliance issues concerning serious untoward incidents
- seek assurance on the performance of NHS organisations in terms of the Care Quality Commission, Monitor and other relevant regulatory bodies.
- receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans
- ensure a clear escalation process is in place to enable appropriate engagement of external bodies on areas of concern
- review annual provider quality accounts
- review patient experience through surveys and complaints and make recommendations for improvement
- have the overall responsibility for corporate health and safety.
- have responsibility for CCG information governance compliance and monitoring provider information governance compliance.

To discharge these responsibilities, the Committee met on twelve occasions during the year.

Equality and Engagement Committee

The purpose of the Equality and Engagement Committee is to:

- meet the public sector equality duty by:
  - providing oversight and assurance that the CCG is eliminating unlawful discrimination harassment and victimisation and their conduct prohibited in the 2010 Act
  - advancing equality of opportunity between people who share a protected characteristic and those who do not
  - foster good relations between people who share a protected characteristic and those who do not
- make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements
- have regard to the need to reduce inequalities by:
  - providing oversight and assurance that the CCG acts in accordance with the CCG's Equality and Diversity Engagement Policy which specifies the CCG's approach to reducing inequalities and states how this will be reflected in the CCG's planning and delivery of services
- receive an annual assessment of performance against these objectives from the CCGE.
- promote the involvement of patients, their carers and representatives in decisions about their healthcare

To discharge these responsibilities, the Committee met on nine occasions during the year.

CCG Executive Committee

The purpose of the CCG Executive Committee is to ensure the strategic and operational arrangements of the CCG, enable the CCG to achieve the objectives and performance requirements within capital and resource limits set out in the secretary of State's mandate during the period specified. It will:

- ensure the CCG has arrangements in place to comply with the processes to review and measure performance set out in the mandate.
- work in partnership with its local authority to develop joint strategic needs assessments and jot health and well-being strategies
- promoting awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution
- act with a view to securing continuous improvement to the quality of services
- assist and support the NHS England relation to the Board's duty to improve the quality of primary medical services
- promote the involvement of patients, their carers and representatives in decisions about their healthcare
- secure continuous improvement to the quality of services
- act with a view to enabling patients to make choices
- obtain appropriate advice from persons who, taken together, have a broad range of professional expertise in healthcare and public health
- promote innovation, research and the use of research
- act with a view to promoting integration of both health services with other health services and health services with health-related and social care services where the group considers that this would improve the quality of services or reduce inequalities.

To discharge these responsibilities, the committee met on twelve occasions during the year.

Procurement Panel

The role of the Panel is, if requested by the Governing Body, to undertake any or all of the following:

- receive proposals for service change and scrutinise rather than query them
- review service specifications.
- identify the best sourcing route.
- consider pricing and costing issues for Any Qualified Provider and proposed single tender sourcing.
- oversee the sourcing and implementation of the any new service.
- establish the rationale for selecting any given procurement route and provider.
- make recommendations to the Governing Body on procurement routes for contracts.
- approve the administrative arrangements for the procurement.
- where authority has been delegated, to make decisions on behalf of the Governing Body.

Membership of the panel is determined on a case-by-case basis, by the Governing Body and must include non-conflicted members of the Governing Body. Other non conflicted individuals of the CCG, Local Authority and NHS organisations may be invited to the panel, as voting or non voting members, at the discretion of the Governing Body. During the past year the Panel has met on twelve occasions.

The Governing Body has considered the means by which it can review its effectiveness and has adopted an annual programme of self-assessment. The outcome of the self-assessment is formally reported at a meeting of the Governing Body and an associated action plan developed. Committees and sub committees will follow a similar process with the outcomes considered by the Governing Body as part of a wider annual review of performance.

The CCG Risk Management Framework

The CCG recognises that every activity it undertakes or commissions others to undertake on its behalf, brings with it some element of risk that has the potential to threaten or prevent the achievement of its objectives. It has responded to this by:

- encouraging a culture where risk management is viewed as integral to daily activity
- ensuring structures and processes are in place to support the assessment and management of risks
- assuring the Governing Body, the public and patients that the CCG manages risk effectively.

These aims have been achieved through the development and implementation of an integrated risk management framework which enables:

- a clear view of the risks affecting each area of its activity
- clarity on how those risks are being managed,
- assessment of the likelihood of a risk occurring and its potential impact.

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

- internal methods – such as complaints, claims, identification of trends, audits, QIPP-related risks, project risks, patient satisfaction surveys, whistle-blowing and monitoring the quality of commissioned services
- external methods – such as HM Coroner reports, media, national reports, new legislation, NPSA surveys, reports from assessments/inspections by external bodies, reviews of partnership working
- liaison through practice visits, locality meetings, GP Reference Group meetings, patient engagement forums, practice feedback forms and practice manager meetings.

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

- the incident reporting policy which recognises that the vast majority of NHS patients receive high standards of care but acknowledges that incidents do occur and encourages prompt reporting as a key part of risk management.
- the risk evaluation of every decision the Governing Body and its committees are asked to make
- the impact assessment of all policies, practices, procedures and decisions to ensure equality and diversity compliance.

Although internal controls are in place, reliance on external organisations to perform key functions exposes the CCG to some risk of fraud and bribery. Measures to mitigate these risks are included in the Counter Fraud workplan 2014/15.

Risks are recorded and managed through the corporate risk register or through the assurance framework if they could impact on the achievement of strategic objectives. The risks in both documents record the risk, its causes and the effects, and are rated according to severity which is calculated using weighted values for the likelihood of the risk occurring and the consequences if it does occur. Risks are categorised as either low, moderate, high or extreme.

The CCG defines an acceptable risk as a potential hazard that is either small enough to have an immaterial effect on the achievement of organisational objectives, or a significant

risk that has been mitigated by the establishment of effective controls to minimise the likelihood of the risk occurring, or to minimise the adverse consequences should the risk identified occur. Using the rating system, the senior management team assign each risk a target score to be classified as an acceptable risk. The CCG risk appetite, the amount of risk it is prepared to accept before it takes action, is as follows:

- Low and moderate risks - represent low levels of threat and action is limited to contingency planning rather than active risk management action.
- High risks - represent medium levels of threat which may have a short-term adverse impact and have defined actions. They are regularly reviewed and re-assessed at senior management meeting and monitored by relevant committees.
- Extreme risks - represent higher levels of threat which may have a major or long term adverse impact on CCG strategic goals. Such risks have individual action plans and are proactively managed. They are regularly reviewed and re-assessed, and are reported to the Governing Body, Audit Committee and relevant lead committee on a monthly basis.

In the review and monitoring process there is particular focus on the Controls that have been applied to each risk and the extent of the assurances that the actions are proving effective.

The CCG Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG 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 Chief Operating Officer is accountable for ensuring that appropriate controls are in place and that the controls are being monitored. This involves maintaining systems to:

- identify and assess risk
- ensure risk owners are nominated to populate and update risk registers
- implement effective risk mitigations
- report risk in accordance with the integrated risk management strategy
- ensure all managers and staff are aware of their responsibilities under the integrated risk management strategy.

In addition to the leadership of the risk management process, each strategic risk is owned by both a clinical member of the Governing Body and an executive Mmember of the Governing Body, and is overseen by the Director of Quality & Safety in respect of clinical risks, the Chief Finance Officer in respect of financial risks and by the Chief Operating Officer in respect of all other risks. In this way, leadership of, and commitment to, the risk management process is demonstrated at the highest level.

Information Governance

The CCG has policies and controls in place to ensure that we are able to protect and maintain the confidentiality, integrity and availability of our electronic data, as well as our physical and information assets. The CCG seeks assurances from our IT department

regarding the robustness of our network infrastructure, and also the back up and business continuity processes in the event of a loss of service.

The CCG has migrated its email to NHS Mail, to ensure that all emails are fully encrypted. All CCG issued laptops and mobile devices are fitted with encryption software, and all laptops and desktops are configured to ensure that only encrypted memory sticks are able to function. This reduces the risk of viruses being brought into the system, and provides greater control over the information that staff are able to transfer remotely.

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and that there are processes in place for incident reporting and investigation of serious incidents. We have developed information risk assessment and management procedures, and a programme to fully embed an information risk culture throughout the organisation has commenced.

Risk Assessment in Relation to Governance, Risk Management & Internal Control

Using the risk and control framework described above, risk assessment is conducted in a systematic manner across all aspects of the CCG's strategic and operational goals. The major risks confronting the organisation are set out below; the risks and the controls applied to them are actively scrutinised throughout the year by the Governing Body, responsible committees and the senior management team. Each risk is assigned a target risk rating and if the Governing Body is satisfied that the level of risk has reduced to that level, it may direct that the risk be removed from the assurance framework; during the course of the year one such risk was removed on that basis.

	Strategic Objective		**Risks to delivery of this Objective**
1	Improve the health and wellbeing of residents in line with commissioning plans	1a	Failure to deliver the Harrow Health and Wellbeing Strategy
2	Engage patients and the public in decision-making	2a	Failure to refresh and implement the E&D action plan
		2b	Failure to actively engage patients and public in timely manner
3	Manage resources effectively	3a	Inability to maximise CCG and CSU resources to deliver QIPP Plan and manage contracts effectively
		3b	Failure to agree robust medium term financial plan to deliver financial sustainability
		3c	Failure to deliver 2014/15 Financial Plan

	Strategic Objective		Risks to delivery of this Objective
		3d	Failure to provide accurate information in a timely fashion, impacting on CCG decisions
		3e	CSU processes and services are not transferred on time or to the standard required
		3f	The secondment of the Accountable Officer to NHS Barnet CGG for 1 day a week could adversely impact on the leadership and management of this CCG. Removed November 2014.
4	Implement our Out of Hospital Strategy	4a	Delay to implementation of SaHF
		4b	Lack of estate to support out of hospital service delivery
		4c	Inability to engage primary and community care to deliver out of hospital model
5	Develop robust and collaborative commissioning arrangements	5a	Untested commissioning arrangements
		5b	Delays in decision making due to new organisational structure
		5c	Failure to achieve authorisation without conditions
6	Improve performance against priority targets	6a	Challenged health economy unable to deliver improvements
		6b	CCG lacks direct control or resources to deliver some targets, e.g. Public Health related targets
		6c	The CCG fails to achieve 18 week RTT target
		6d	The CCG fails to achieve the national A&E 4 hour target
		6e	CQC Intervention at London North West Healthcare NHS Trust
7	Ensure people have a positive experience of care	7a	Failure of providers to prioritise and deliver improvements in patient experience
8	Improve the quality and safety of the treatment and care provided to patients	8a	Lack of formal process to address issues in non commissioned services, including primary care
		8b	Financial pressures adversely impact or prevent improvements in quality and safety
		8c	Failure to protect all at risk children and adults in Harrow from harm

In February 2014, following consultation with the Shaping a Healthier Future Programme Board, the CCG concluded that the SaHF strategic objective to

'Improve quality and safety of health and care across NW London by delivering the Shaping a healthier future programme to localise settings of care, centralise settings of most serious acute care and provide seamlessly integrated care across all settings'

was so fundamental to the CCG strategic objectives that the following associated risks were incorporated into, and remain part of, the assurance framework:

- precipitate poorly planned change adversely impacts on patient safety and quality of care
- the programme fails to deliver expected benefits of improved quality and safety of health and care.
- These risks are subjected to particular scrutiny and the Governing Body will only approve the implementation of SaHF changes upon the recommendation of the Quality Safety and Clinical Risk Committee.

The principal risks to compliance with the CCG's licence are identified through the review of four domains, each of which is assessed on a broad range of performance measures

- Are local people getting good quality care?
- Are patient rights under the NHS Constitution being promoted?
- Are health outcomes improving for local people?
- Is the CCG commissioning services within its financial allocation?

A named director is accountable for the risks in each domain and the process is overseen through the CCG governance arrangements Every month, the senior management team, responsible Committee and the Governing Body receive and scrutinise performance in this area. Further assurance on the effective management of risks to compliance with the CCG's licence is obtained from the NHS England Self Assessment process and regular review meeting with NHS England. I am satisfied that risks to compliance with the CCG's licence are managed effectively.

Review of Economy, Efficiency & Effectiveness of the Use of Resources

Jointly with Brent and Hillingdon CCGs, we have established a collaborative arrangement to share a leadership team and work together to become effective commissioners. This collaborative agreement enables:

- the joint commissioning high quality care
- the CCG to tackle cross borough issues
- maximum influence in negotiating and managing contracts
- shaping of the provider landscape in North West London economies of scale
- more effective management of the performance of the Commissioning Support Service.

In addition, the CCG is one of eight North West London CCGs working collaboratively to deliver improvements to services across the area. Initiatives have included joint approaches on:

- the 'in housing' of Shared Support Services;
- Primary Care Co-commissioning with NHS England; and
- a common financial strategy to deliver Shaping a Healthier Future.

<u>Underlying financial position</u>

The CCG agreed a breakeven plan for 2014/15 with support from the NW London Financial Strategy (£29.1m). The outturn position for 2014/15 is a breakeven position but with an underlying deficit (after taking account of one-off items) of £20.1m.

For 2015/16, Harrow CCG set an initial deficit budget of £5.2m, after planned support from the NW London Financial Strategy (£13.3m).

Review of the Effectiveness of Governance, Risk Management & Internal Control

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

Capacity to Handle Risk

As the Accountable Officer I have overall responsibility for risk management and discharge this by:

- continually promoting risk management and demonstrating leadership, involvement and support
- ensuring an appropriate committee structure is in place and ensuring each receives regular risk reports
- ensuring that the Governing Body, executive team, clinical directors and senior managers are appointed with managerial responsibility for risk management.

All risk owners have been trained in the risk management process and this has been supplemented with written guidance. In addition, on a regular basis, the Head of Governance assists risk owners to review the controls and assurances in respect of each risk, and by this means good practice is shared between all BHH CCGs.

The Governing Body is responsible for the performance management of the integrated risk management strategy and systems of clinical, financial and organisational control. It oversees the overall system of risk management and assurance to satisfy itself that the CCG is fulfilling its organisational responsibilities and is supported in that function by its committees:

- The Audit Committee, in line with the NHS Audit Committee Handbook, ensures the CCG has an effective process is in place with regards to risk management and monitors the quality of the assurance framework, referring significant issues to the Governing Body.
- The Quality, Safety & Clinical Risk Committee has overarching responsibility for clinical risk management, information governance and health & safety risks.
- The QIPP and Finance Committee continuously assesses financial and non-financial risks relating to the QIPP plans and ensure the CCG has in place measures and mitigation to manage risk.
- The Executive Committee monitors, in detail, risks to achieving individual corporate objectives including action plans with a particular focus on risks rated amber and red risks.

After every meeting, each committee reports its findings on risk management to the next Governing Body meeting; in this way the CCG is assured that risk is effectively controlled and that its governance statement is valid.

Review of Effectiveness

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 CCG 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 management letter and other reports.

The board assurance framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, the other committees of the Governing Body and internal audit. A plan to address weaknesses and ensure continuous improvement of the system is in place.

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

Based on the work undertaken in 2014/15, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses have been identified.

We have issued one RED rated report relating to Harrow Health Limited and small contracts.

Harrow Health Limited (HHL) and small contracts
There were cases where contracts were not in place or where they were not up to date and had not been in place since the formation of the CCG. This included HHL, which is a large supplier for the CCG. This was identified by management and further concerns were identified that the Commissioning Support Unit (CSU) had not been maintaining an effective small contracts register.

The CSU were tasked with investigating the small contracts database in order to reconcile the contracts held against ledger payments, identify whether contracts had been signed and if an annual contract review process was in place. The transition process also identified during August 2014 that the function had been understaffed and as part of the consultation process increased the establishment by two WTE. The audit committee is continuing to monitor progress in this area.

We have issued two AMBER - RED rated reports during the course of the year relating to the transfer of CSU functions back in house report and continuing care.

Transfer of CSU Functions Back in house
During our part 1 review in this area we noted that the transitional costs of the CSU transfer were forecast to exceed the budgeted costs as set out in the original business case. Management had identified action plans primarily aimed at reducing the numbers of interims in post with the aim of both reducing the recurrent costs and improving the quality of the services delivered. Monitoring of this has continued on a regular basis with the intention being to ensure that the main objectives of the business case are met. Our phase 2 review undertaken at the end of the financial year confirmed that the financial outcome as set out in the business case was on track to be achieved.

Continuing Care
Whilst good progress had been made in a number of areas since the review in 2013/14 was completed where we had given a RED opinion, there remained areas of concern still requiring and receiving management attention, In particular the issues were around the three month and annual reviews on patients being undertaken within the specified timelines and ensuring that there are contracts in place with providers for each of the patients.

All other reviews have been provided with either GREEN or AMBER/GREEN ratings.

Action plans to address the issues raised in the audits rated red and red/amber, have been developed and progress on implementation is being overseen by the Audit committee.

Data Quality

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. All data that is forwarded to the Governing Body has been discussed, and analysed at a minuted committee meeting prior to being submitted for discussion, noting or a formal decision at the Governing Body.

Business Critical Models

I am satisfied that all business critical models have been identified and that specialist staff are employed to develop, use and quality assure each. The senior responsible officer for each process ensures it is compliant and appropriate, that model risks, limitations and major assumptions are understood and the use of the model outputs is appropriate. In line with the recommendations in the Macpherson Report, the CCG has developed a framework to assure their quality and information about quality assurance processes for those models has been provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health.

Data Security

The CCG submitted a satisfactory level of compliance with the information governance toolkit assessment, meeting at least level 2 for all requirements. The requirements within the information governance toolkit that relate to data security seek assurances regarding the CCG's risk management framework, business continuity plans and the robustness of the network infrastructure as well as outlining the standards to be attained for the confidentiality, integrity and availability of physical and electronic data, and information assets. The toolkit submission and supporting action plan was routinely scrutinised by the CCG's Quality, Safety and Clinical Risk Committee, through regular updates and reports to the Committee. An action plan has been developed for 2015/16 to ensure that the CCG is able to maintain compliance with, and further embed information governance and data security into the culture of the organisation. In 2014/15, the CCG reported no serious untoward incidents to the Information Commissioner's Office.

Discharge of Statutory Functions

During establishment, arrangements were put in place by the CCG with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for membership body and Governing Body decision and the scheme of delegation. Since then the CCG has refined its arrangements and following the Harris Review, has re-examined 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 CCG 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.

Conclusion

There are no significant issues other than the underlying financial position as described under Review of Economy, Efficiency & Effectiveness of the Use of Resources.

Rob Larkman
Accountable Officer

Date: 28 May 2015

NHS
Harrow
Clinical Commissioning Group

Annual Accounts 2014/15

6 ANNUAL ACCOUNTS 2014/15

Data entered below will be used throughout the workbook:

Entity name:	NHS Harrow CCG
This year	2014-15
This year ended	31 March 2015
This year commencing:	1 April 2014

NHS Harrow CCG - Annual Accounts 2014-15

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NHS Harrow CCG - Annual Accounts 2014-15

Statement of Comprehensive Net Expenditure for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	4.1.1	4,557	2,552
Operating Expenses	5	267,745	251,990
Other operating revenue	2	(2,805)	(1,505)
Net operating expenditure before interest		**269,497**	**253,037**
Investment Revenue	8	-	-
Other (gains)/losses	9	-	-
Finance costs	10	-	3
Net operating expenditure for the financial year		**269,497**	**253,040**
Net (gain)/loss on transfers by absorption	11	-	-
Total Net Expenditure for the year		**269,497**	**253,040**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	2,761	1,685
Operating Expenses	5	2,827	4,048
Other operating revenue	2	(2)	(79)
Net administration costs before interest		**5,586**	**5,654**
Programme Income and Expenditure			
Employee benefits	4.1.1	1,796	867
Operating Expenses	5	264,918	247,942
Other operating revenue	2	(2,803)	(1,426)
Net programme expenditure before interest		**263,911**	**247,383**

Other Comprehensive Net Expenditure	2014-15 £000	2013-14 £000
Movements in other reserves	-	-
Net actuarial gain/(loss) on pension schemes	-	-
Reclassification Adjustments	-	-
Total comprehensive net expenditure for the year	**269,497**	**253,040**

The notes on pages 5 to 32 form part of this statement.

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	13	-	-
Intangible assets	14	-	-
Trade and other receivables	15	-	-
Total non-current assets		**-**	-
Current assets:			
Trade and other receivables	15	2,655	2,511
Cash and cash equivalents	16	15	27
Total current assets		**2,670**	2,538
Total assets		**2,670**	2,538
Current liabilities			
Trade and other payables	17	(36,848)	(26,646)
Provisions	18	(67)	-
Total current liabilities		**(36,915)**	(26,646)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(34,245)**	(24,108)
Non-current liabilities			
Trade and other payables	17	-	-
Provisions	18	-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(34,245)**	(24,108)
Financed by Taxpayers' Equity			
General fund		(34,245)	(24,108)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(34,245)**	(24,108)

The notes on pages 5 to 32 form part of this statement.

The financial statements on pages 1 to 32 were approved by the Governing Body on 26th May 2015 and signed on its behalf by:

Rob Larkman
Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2015

Changes in taxpayers' equity for 2014-15	General fund	Total reserves
	£000	£000
Balance at 1 April 2014	(24,108)	**(24,108)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	**-**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(24,108)**	**(24,108)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15		
Net operating expenditure for the financial year	(269,497)	(269,497)
Net actuarial gain (loss) on pensions	-	-
Movements in other reserves	-	-
Transfers between reserves	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-
Transfers by absorption to (from) other bodies	-	-
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(269,497)**	**(269,497)**
Net funding	259,360	259,360
Balance at 31 March 2015	**(34,245)**	**(34,245)**

Changes in taxpayers' equity for 2013-14	General fund	Total reserves
	£000	£000
Balance at 1 April 2013	**-**	**-**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**12**	**12**
Adjusted NHS Commissioning Board balance at 1 April 2013	**12**	**12**
Changes in NHS Commissioning Board taxpayers' equity for 2013-14		
Net operating costs for the financial year	(253,040)	(253,040)
Net actuarial gain (loss) on pensions	-	-
Movements in other reserves	-	-
Transfers between reserves	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-
Transfers by absorption to (from) other bodies	-	-
Net Recognised NHS Commissioning Board Expenditure for the Financial Year	**(253,028)**	**(253,028)**
Net funding	228,920	228,920
Balance at 31 March 2014	**(24,108)**	**(24,108)**

The notes on pages 5 to 32 form part of this statement.

NHS Harrow CCG - Annual Accounts 2014-15

Statement of Cash Flows for the year ended 31 March 2015

	Note	**2014-15 £000**	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(269,497)	(253,040)
Depreciation and amortisation	5	-	12
Interest paid		-	-
Other Gains & Losses		-	-
Finance Costs		-	-
Unwinding of Discounts		-	-
(Increase)/decrease in trade & other receivables	15	(144)	(2,511)
Increase/(decrease) in trade & other payables	17	10,202	26,646
Provisions utilised	18	-	-
Increase/(decrease) in provisions	18	67	-
Net Cash Inflow (Outflow) from Operating Activities		**(259,372)**	(228,893)
Cash Flows from Investing Activities			
Interest received		-	-
(Payments) for property, plant and equipment		-	-
(Payments) for intangible assets		-	-
Proceeds from disposal of assets held for sale: property, plant and equipment		-	-
Proceeds from disposal of assets held for sale: intangible assets		-	-
Rental revenue		-	-
Net Cash Inflow (Outflow) from Investing Activities		**-**	-
Net Cash Inflow (Outflow) before Financing		**(259,372)**	(228,893)
Cash Flows from Financing Activities			
Net Funding Received		259,360	228,920
Net Cash Inflow (Outflow) from Financing Activities		**259,360**	228,920
Net Increase (Decrease) in Cash & Cash Equivalents	16	**(12)**	27
Cash & Cash Equivalents at the Beginning of the Financial Year		**27**	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**15**	27

The notes on pages 5 to 32 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 Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in the Manual for Accounts 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis [despite the issue of a report to the Secretary of State for Health under Section 19 of the Audit Commission Act 1998 for the anticipated or actual breach of financial duties].
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a Clinical Commissioning Group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

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 Acquisitions & Discontinued Operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 Pooled Budgets

Where the Clinical Commissioning Group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 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.
If the Clinical Commissioning Group is in a “jointly controlled operation”, the Clinical Commissioning Group recognises:

- The assets the Clinical Commissioning Group controls;
- The liabilities the Clinical Commissioning Group incurs;
- The expenses the Clinical Commissioning Group incurs; and,

· The Clinical Commissioning Group's share of the income from the pooled budget activities.

If the Clinical Commissioning Group is involved in a "jointly controlled assets" arrangement, in addition to the above, the Clinical Commissioning Group recognises:

· The Clinical Commissioning Group's share of the jointly controlled assets (classified according to the nature of the assets);

· The Clinical Commissioning Group's share of any liabilities incurred jointly; and,

· The Clinical Commissioning Group's share of the expenses jointly incurred.

1.6 **Critical Accounting Judgements & Key Sources of Estimation Uncertainty**

In the application of the Clinical Commissioning Group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 **Critical Judgements in Applying Accounting Policies**

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Clinical Commissioning Group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

1.6.1.1 ***Brent CCG Federation Recharge to Harrow and Hillingdon***

Certain functions such as Quality and Safety are delivered across all three CCG's using a Federation model. All federation costs are initially paid by Brent CCG with an appropriate proportion recharged to the other CCG's on a net accounting basis. The split for the period 1st April 2014 to 31st March 2015 has been determined at 39% for Brent, 28% for Harrow and 33% for Hillingdon. This is based on constrained population and has been updated for a small change in constrained population sizes in 2014/15.

Monthly invoices are raised from Brent CCG to the other CCG's based on budgeted amounts and a quarterly reconciliation of actual costs is undertaken with adjustment invoices issued accordingly.

1.6.1.2 ***Accounting for in-housed Commissioning Support Services***

The eight CCGs in North West London ceased acquiring commissioning support services (CSS) from NWL Commissioning Support Unit (CSU) from 1st October 2014. From this date the eight CCGs brought commissioning support services in-house. The CCGs manage the CSS budget as a shared budget which each CCG both pays into and for which each CCG manages some costs. All CCGs are net contributors to costs that are managed by Brent CCG (with the exception of Central London CCG which also manages a significant element of the costs related to services to the CWHHE CCGs).

In the annual accounts, the CCGs each fully account (gross) for the element of the CSS shared budget that they hold. This is shown in the accounts as follows:

- All CCGs show gross staff costs i.e. the full costs of all CSS staff paid directly by them.
- Gross staff costs are adjusted for charges in and charges out.
- All CCGs show Gross expenditure costs on each of the appropriate lines within the expenditure note in the accounts.
- Brent CCG (and Central London CCG) show the income received from other CCGs in their operating revenue note in the accounts under the 'Non-patient care services to other bodies" line in respect of non pay charges and "recoveries in respect of employee benefits" line in respect of pay charges.
- Other CCGs show their expenditure with Brent CCG/Central London CCG in the operating expenses note in the accounts under 'Services from other CCGs and NHS England" line in respect of non pay charges and the "gross employee benefits" line in respect of pay charges.

1.6.1.3 ***NHS 111 Shared Commissioning Arrangement***

NHS Hounslow CCG Commissioned 111 service from Harmoni on behalf of NHS Brent CCG, NHS Harrow CCG and NHS Ealing CCG. This arrangement has been in place from 1 April 2013. The service cost is recharged out to CCGs based on the population size on a net accounting basis. This means that the costs are split in the following proportions: NHS Hounslow 23%, NHS Ealing CCG 29%, NHS Brent CCG 27%, NHS Harrow CCG 21%.

1.6.2 **Key Sources of Estimation Uncertainty**

The following are the key estimations that management has made in the process of applying the Clinical Commissioning Group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

1.6.2.1 ***Prescription Pricing Authority***

The Prescription Pricing Authority (PPA) currently provides us with details of the monthly expenditure incurred by Independent Contractors in respect of Pharmacy contract payments and drug costs. There is two month delay in notifying the CCG of its expenditure for a particular month. The CCG has therefore applied estimation techniques based on previous trends, expenditure profiles, forecasts from PPA and local knowledge from our Prescribing Advisors. This method was used for many years by Harrow PCT and last year by the CCG and in previous years has not led to any material differences being identified.
Cost data has been received up to the end of January for drugs.

1.6.2.2 ***Recognition of Expenditure***

The CCG has used various techniques to estimate the appropriate levels of income and expenditure to be included in the accounts. These include basing forecasts on actual expenditure incurred to date extrapolated to a full year, using internal databases (such as Continuing Care), local knowledge from managers and past experience has also been used to determine the appropriate levels of income and expenditure to be included. This method has been used for many years and in previous years has not led to any material differences being highlighted.

1.6.2.3 ***Flex & Freeze Data for Acute Contracts***

Flex data is now known as monthly reconciliation data and freeze data as monthly post reconciliation data. As the terms imply there is a monthly closedown of the data. Post reconciliation data gets rolled into the next monthly reconciliation data. Trusts use the monthly reconciliation data to inform their monthly SLA Monitoring (SLAM) reports. The latest available SLAM information, Month 11 SLAM data available at the beginning of April, has been used for year-end accruals. In addition the creditors and accruals have been informed by the year-end Agreement of Balances exercise.

1.7 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 scheme is accounted for as if it were a defined contribution scheme: the cost to the Clinical Commissioning Group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the Clinical Commissioning Group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.9 **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.

Expenses and liabilities in respect of grants are recognised when the Clinical Commissioning Group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

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 **Valuation**

All property, plant and equipment are 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. All assets are measured subsequently at fair value.

Land and buildings used for the Clinical Commissioning Group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

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. Fair values are determined as follows:

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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.

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.

Intangible assets acquired separately are initially recognised at fair value. 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**

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 fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

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 their estimated useful lives.
At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13 **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 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Clinical Commissioning Group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.13.2 **The Clinical Commissioning Group as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Clinical Commissioning Group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Clinical Commissioning Group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.14 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Clinical Commissioning Group's cash management.

1.15 **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:

- Timing of cash flows (0 to 5 years inclusive): Minus 1.50%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.05%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.30%

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.

The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in note 1.4 to these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 18 to these financial statements.

1.16 **Clinical Negligence Costs**

The NHS Litigation Authority operates a risk pooling scheme under which the Clinical Commissioning Group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the 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 Litigation Authority 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 **Continuing healthcare risk pooling**

In 2014-15 a risk pool scheme has been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme Clinical Commissioning Group contribute annually to a pooled fund, which is used to settle the claims.

1.19 **Carbon Reduction Commitment Scheme**

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the Clinical Commissioning Group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.20 **Contingencies**

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, contingencies are disclosed at their present value.

1.21 **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 fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.21.1 **Financial Assets at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Clinical Commissioning Group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.21.2 **Held to Maturity Assets**

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.21.3 **Available For Sale Financial Assets**

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.21.4 **Loans & Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.
The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.
At the end of the reporting period, the Clinical Commissioning Group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.
If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.22 **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.
Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.22.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.22.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Clinical Commissioning Group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.22.3 **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, 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.

1.23 **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.

1.24 **Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Clinical Commissioning Group has no beneficial interest in them.

1.25 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.26 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2014-15, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 13: Fair Value Measurement
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year.

2. Other Operating Revenue

	2014-15 Total	2014-15 Admin	2014-15 Programme	2013-14 Total
	£000	£000	£000	£000
Recoveries in respect of employee benefits	-	-	-	-
Patient transport services	-	-	-	-
Prescription fees and charges	-	-	-	-
Dental fees and charges	-	-	-	-
Education, training and research	92	-	92	1
Charitable and other contributions to revenue expenditure: NHS	-	-	-	-
Charitable and other contributions to revenue expenditure: non-NHS	29	-	29	-
Receipt of donations for capital acquisitions: NHS Charity	-	-	-	-
Receipt of Government grants for capital acquisitions	-	-	-	-
Non-patient care services to other bodies	1,223	-	1,223	56
Income generation	-	-	-	-
Rental revenue from finance leases	-	-	-	-
Rental revenue from operating leases	-	-	-	-
Other revenue	1,460	2	1,458	1,449
Total other operating revenue	**2,805**	**2**	**2,803**	**1,506**

Notes:

1) Admin Revenue
Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

2) Programme Revenue
Programme revenue is revenue received that is relating to the provision of healthcare or healthcare services.

3) Cash drawdown from NHS England
Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

3. Revenue

All the CCG revenue is from the rendering of services.

4. Employee benefits and staff numbers

4.1.1 Employee benefits 2014-15

	Total £000	Total Permanent Employees £000	Other £000	Total £000	Admin Permanent Employees £000	Other £000	Total £000	Programme Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	3,996	1,981	2,014	2,432	1,011	1,421	1,564	970	594
Social security costs	263	189	74	156	95	61	107	94	13
Employer Contributions to NHS Pension scheme	299	241	58	173	125	48	126	116	10
Other pension costs	-	-	-	-	-	-	-	-	-
Other post-employment benefits	-	-	-	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-	-	-	-
Termination benefits	-	-	-	-	-	-	-	-	-
Gross employee benefits expenditure	**4,557**	**2,411**	**2,146**	**2,761**	**1,231**	**1,530**	**1,796**	**1,179**	**617**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-	-	-	-	-	-	-
Total - Net admin employee benefits including capitalised costs	**4,557**	**2,411**	**2,146**	**2,761**	**1,231**	**1,530**	**1,796**	**1,179**	**617**
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-
Net employee benefits excluding capitalised costs	**4,557**	**2,411**	**2,146**	**2,761**	**1,231**	**1,530**	**1,796**	**1,179**	**617**

4.1.2 Recoveries in respect of employee benefits 2014-15

	Total £000	Permanent Employees £000	Other £000
Total recoveries in respect of employee benefits	**-**	**-**	**-**

4.2 Average number of people employed

	2014-15 Total Number	2014-15 Permanent employed Number	2014-15 Other Number	2013-14 Total Number
Total	**65**	**53**	**12**	39
Of the above:				
Number of whole time equivalent people engaged on capital projects	-	-	-	-

Included within the above whole time equivalent staff numbers are 17.74 relating to CSS In-housed Services.

4.3 Staff sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	81	14
Total Staff Years	25	19
Average working Days Lost	**3**	**1**

Staff sickness absence figures are provided by the department of Health and cover the calendar year.

There have been no retirements on the basis of ill health agreed by the Clinical Commissioning Group during 2014/15 (2013/14 : None).

4.4 Exit packages agreed in the financial year

The Clinical Commissioning Group has not agreed any exit packages during 2014/15 (2013/14 : None).

However, during the year there were 4 redundancies totalling £609k in respect of former NWL Commissioning Support Unit (CSU) staff employed by Brent CCG. These costs have been recharged out to the eight CCGs in North West London, and Harrow CCG's share included within its expenditure is £67k, which is shown in Note 5 - Employee benefits excluding governing body members.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

The NHS Pension Scheme is an unfunded, multi-employer defined benefit scheme. Individual NHS bodes are therefore unable to identify their share of the underlying scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the Clinical Commissioning Group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of Pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of Pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their Pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

The scheme was actuarially valued as at 31 March 2012 which determined contribution rates from 1 April 2015. As a result Employer contributions will increase from 14% to 14.3%. Details can be found on the pension scheme website http://www.nhsbsa.nhs.uk/Pensions.aspx.

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

The latest assessment of the liabilities of the Scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

4.5 Pension costs

4.5.3 Scheme Provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

• The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;

• With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as “pension commutation”;

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year;

• Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

• 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 the statement of comprehensive net expenditure at the time the Clinical Commissioning Group commits itself to the retirement, regardless of the method of payment; and,

• Members can purchase additional service in the Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

5. Operating expenses

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	4,264	2,540	1,724	2,268
Executive governing body members	293	221	72	284
Total gross employee benefits	**4,557**	**2,761**	**1,796**	**2,552**
Other costs				
Services from other CCGs and NHS England	2,822	1,739	1,084	2,974
Services from foundation trusts	54,795	-	54,795	46,669
Services from other NHS trusts	142,409	-	142,409	139,372
Purchase of healthcare from non-NHS bodies	28,997	-	28,997	28,525
Chair and Non Executive Members	512	490	22	418
Supplies and services – clinical	1,298	-	1,298	581
Supplies and services – general	389	82	307	157
Consultancy services	63	12	51	356
Establishment	141	117	24	179
Transport	1	1	0	1
Premises	1,627	214	1,412	1,173
Impairments and reversals of receivables	(85)	-	(85)	225
Depreciation	-	-	-	12
Audit fees	83	83	-	84
Other non statutory audit expenditure				
· Internal audit services	-	-	-	-
· Other services	1	1	-	-
Prescribing costs	30,154	-	30,154	29,457
GPMS/APMS and PCTMS	3,846	-	3,846	1,719
Other professional fees excl. audit	175	51	124	79
Clinical negligence	6	-	6	-
Education and training	101	7	94	9
Provisions	67	30	37	-
CHC Risk Pool contributions	344	-	344	-
Other expenditure	-	-	-	-
Total other costs	**267,745**	**2,827**	**264,918**	**251,990**
Total operating expenses	**272,302**	**5,588**	**266,714**	**254,542**

Notes:

1) Admin Expenditure

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

2) Programme Expenditure

Programme expenditure is revenue expenditure that is relating to the provision of healthcare or healthcare services.

3) CSS Expenditure

The eight CCGs in North West London ceased acquiring commissioning support services (CSS) from NWL Commissioning Support Unit (CSU) from 1st October 2014. From this date the eight CCGs brought commissioning support services in-house. The CCGs manage the CSS budget as a shared budget which each CCG both pays into and for which each CCG manages some costs. All CCGs are net contributors to costs that are managed by Brent CCG (with the exception of Central London CCG which also manages a significant element of the costs related to services to the CWHHE CCGs). In the annual accounts, the CCGs each fully account (gross) for the element of the CSS shared budget that they hold.

The total cost of the inhouse Commissioning Support Service for the 6 month period from 1 October 14 to 31 March 15 was £16.5m. Harrow CCG's share was £1.7m and £0.2m was incurred directly.

4) Mapping Changes as per the Department of Health Manual for Accounts

Internal Audit services provided by Baker Tilly during 2014/15 (£41k) are included within other professional fees excl. audit whereas in 2013/14 (£34k) they are included within Supplies and services - general.

6.1 Better Payment Practice Code

Measure of compliance	2014-15 Number	2014-15 £000	2013-14 Number	2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	7,648	34,386	7,150	25,860
Total Non-NHS Trade Invoices paid within target	7,268	31,932	6,849	24,408
Percentage of Non-NHS Trade invoices paid within target	**95.0%**	**92.9%**	**95.8%**	**94.4%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,358	198,698	2,097	178,788
Total NHS Trade Invoices Paid within target	3,258	197,635	1,961	173,623
Percentage of NHS Trade Invoices paid within target	**97.0%**	**99.5%**	**93.5%**	**97.1%**

The Better Payment Practice Code requires NHS Organisations to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	2014-15 £000	2013-14 £000
Amounts included in finance costs from claims made under this legislation	-	3
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**3**

7. Income Generation Activities

The Clinical Commissioning Group did not undertake any income generation activities whose full cost exceeded £1m or was otherwise material during 2014/15 (2013/14 : None).

8. Investment revenue

The Clinical Commissioning Group did not have any investment revenue during 2014/15 (2013/14 : None).

9. Other gains and losses

The Clinical Commissioning Group did not have any other gains or losses during 2014/15 (2013/14 : None).

10. Finance costs

	2014-15 £000	2013-14 £000
Interest		
Interest on late payment of commercial debt	-	3
Other interest expense	-	-
Total interest	**-**	**3**
Other finance costs	-	-
Provisions: unwinding of discount	-	-
Total finance costs	**-**	**3**

11. Net gain/(loss) on transfer by absorption

The Clinical Commissioning Group did not have any gains or losses on transfer by absorption during 2014/15 (2013/14 : None).

12. Operating Leases

12.1 As lessee

The Clinical Commissioning Group is charged for property owned and managed by NHS Property Services Ltd and Community Health Partnerships Ltd. For 2014/15 rent was charged on actual costs based on actual, subsidised and void occupancy. In 2013/14 a transitional rent based on annual property cost allocations was charged.

12.1.1 Payments recognised as an Expense

	Land	**Buildings**	**Other**	**2014-15 Total**	2013-14 Total
	£000	**£000**	**£000**	**£000**	£000
Payments recognised as an expense					
Minimum lease payments	-	1,618	-	**1,618**	1,173
Contingent rents	-	-	-	**-**	-
Sub-lease payments	-	-	-	**-**	-
Total	**-**	**1,618**	**-**	**1,618**	**1,173**

12.1.2 Future minimum lease payments

Whilst our arrangements with Community Health Partnership's Limited and NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for the arrangements only.

12.2 As lessor

The Clinical Commissioning Group did not own any property nor lease out any property during 2014/15 (2013/14 : None).

13. Property, plant and equipment

2014-15	Information technology £000	Total £000
Cost or valuation at 1 April 2014	12	12
Additions purchased	-	-
Reclassifications	-	-
Disposals other than by sale	(12)	(12)
Cost/Valuation At 31 March 2015	**-**	**-**
Depreciation 1 April 2014	12	12
Reclassifications	-	-
Disposals other than by sale	(12)	(12)
Charged during the year	-	-
Depreciation at 31 March 2015	**-**	**-**
Net Book Value at 31 March 2015	**-**	**-**
Purchased	-	-
Donated	-	-
Government Granted	-	-
Total at 31 March 2015	**-**	**-**
Asset financing:		
Owned	-	-
Held on finance lease	-	-
Total at 31 March 2015	**-**	**-**

13.2 Donated assets

The Clinical Commissioning Group did not have any donated assets as at 31 March 2015 (31 March 2014 : None).

13.3 Government granted assets

The Clinical Commissioning Group did not have any government granted assets as at 31 March 2015 (31 March 2014 : None).

13.3 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	-	-

14. Intangible non-current assets

The Clinical Commissioning Group held no intangible assets as at 31 March 2015 (31 March 2014 : None).

15. Trade and other receivables	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	1,457	-	1,606	-
NHS prepayments and accrued income	201	-	303	-
Non-NHS receivables: Revenue	1,100	-	773	-
Non-NHS prepayments and accrued income	23	-	-	-
Provision for the impairment of receivables	(139)	-	(225)	-
VAT	13	-	54	-
Interest receivables	-	-	-	-
Other receivables	0	-	-	-
Total Trade & other receivables	**2,655**	**-**	**2,511**	**-**
Total current and non current	**2,655**		**2,511**	
Included above:				
Prepaid pensions contributions	-		-	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to Clinical Commissioning Groups to commission services, no credit scoring of them is considered necessary.

15.1 Receivables past their due date but not impaired	2014-15 £000	2013-14 £000
By up to three months	50	-
By three to six months	-	-
By more than six months	-	-
Total	**50**	**-**

£Nil of the amount above has subsequently been recovered post the statement of financial position date.

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2015 (31 March 2014 : None).

15.2 Provision for impairment of receivables	2014-15 £000	2013-14 £000
Balance at 1 April 2014	(225)	-
Amounts written off during the year	-	-
Amounts recovered during the year	85	-
(Increase) decrease in receivables impaired	-	(225)
Transfer (to) from other public sector body	-	-
Balance at 31 March 2015	**(139)**	**(225)**

This is a provision for impairments based on a general provision at the following rates and specific provisions based on management's judgement on the likelihood of debts being settled.

General Provision	2014-15 %	2013-14 %
Receivables are provided against at the following rates:		
NHS debt	0%	0%
0-90 days	0%	0%
91-120 days	50%	50%
121-180 days	75%	75%
Over 180 days	100%	100%

16. Cash and cash equivalents

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	27	-
Net change in year	(12)	27
Balance at 31 March 2015	**15**	**27**
Made up of:		
Cash with the Government Banking Service	15	27
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**15**	**27**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2015	**15**	**27**
Patients' money held by the Clinical Commissioning Group, not included above	-	-

17. Trade and other payables

	Current 2014-15 £000	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	-	-	-	-
NHS payables: revenue	7,557	-	10,774	-
NHS accruals and deferred income	14,271	-	4,988	-
Non-NHS payables: revenue	2,812	-	1,750	-
Non-NHS accruals and deferred income	11,917	-	8,792	-
Social security costs	23	-	23	-
VAT	-	-	-	-
Tax	25	-	25	-
Other payables	244	-	294	-
Total Trade & Other Payables	**36,848**	**-**	**26,646**	**-**
Total current and non-current	**36,848**		**26,646**	

There are no liabilities included above due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £32k outstanding pension contributions at 31 March 2015 (31 March 2014 : £30k).

18. Provisions

	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Legal claims	30	-	-	-
Continuing care	37	-	-	-
Other	-	-	-	-
Total	**67**	**-**	**-**	**-**
Total current and non-current	**67**		**-**	

	Legal Claims £000s	Continuing Care £000s	Total £000s
Balance at 1 April 2014	**-**	**-**	**-**
Arising during the year	30	37	67
Utilised during the year	-	-	-
Reversed unused	-	-	-
Unwinding of discount	-	-	-
Change in discount rate	-	-	-
Transfer (to) from other public sector body	-	-	-
Balance at 31 March 2015	**30**	**37**	**67**
Expected timing of cash flows:			
Within one year	30	37	67
Between one and five years	-	-	-
After five years	-	-	-
Balance at 31 March 2015	**30**	**37**	**67**

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided by them.

The Clinical Commissioning Group had a provision of £67k with regards to one new continuing care claim and one legal claim as at 31 March 2015.

There are no provisions included in the provisions of the NHS Litigation Authority as at 31 March 2015 in respect of clinical negligence liabilities of the Clinical Commissioning Group (31 March 2014 : None).

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Clinical Commissioning Group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2015 is £9.12m (31 March 2014 : £9.54m).

19. Contingencies

The Clinical Commissioning Group did not have any contingent assets or liabilities as at 31 March 2015 (31 March 2014 : None).

20. Commitments

20.1 Capital commitments

The Clinical Commissioning Group had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2015 (31 March 2014 : None).

20.2 Other financial commitments

The Clinical Commissioning Group had no non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2015 (31 March 2014 : None).

21. Financial instruments

21.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Clinical Commissioning Group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Clinical Commissioning Group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Clinical Commissioning Group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Clinical Commissioning Group and

21.1.1 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

21.1.2 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.

21.1.3 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.

21.1.3 Liquidity risk

NHS Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

21. Financial instruments cont'd

21.2 Financial assets

2014-15	**At 'fair value through profit and loss'**	**Loans and Receivables**	**Available for Sale**	**Total**
	£000	**£000**	**£000**	**£000**
Embedded derivatives	-	-	-	-
Receivables:				
· NHS	-	1,457	-	1,457
· Non-NHS	-	1,100	-	1,100
Cash at bank and in hand	-	15	-	15
Other financial assets	-	0	-	0
Total at 31 March 2015	**-**	**2,572**	**-**	**2,572**

2013-14	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	£000	£000	£000	£000
Embedded derivatives	-	-	-	-
Receivables:				
· NHS	-	1,606	-	1,606
· Non-NHS	-	773	-	773
Cash at bank and in hand	-	27	-	27
Other financial assets	-	-	-	-
Total at 31 March 2014	**-**	**2,406**	**-**	**2,406**

21.3 Financial liabilities

2014-15	**At 'fair value through profit and loss'**	**Other**	**Total**
	£000	**£000**	**£000**
Embedded derivatives	-	-	-
Payables:			
· NHS	-	21,827	21,827
· Non-NHS	-	14,973	14,973
Private finance initiative, LIFT and finance lease obligations	-	-	-
Other borrowings	-	-	-
Other financial liabilities	-	-	-
Total at 31 March 2015	**-**	**36,800**	**36,800**

2013-14	At 'fair value through profit and loss'	Other	Total
	£000	£000	£000
Embedded derivatives	-	-	-
Payables:			
· NHS	-	15,762	15,762
· Non-NHS	-	10,542	10,542
Private finance initiative, LIFT and finance lease obligations	-	-	-
Other borrowings	-	-	-
Other financial liabilities	-	-	-
Total at 31 March 2014	**-**	**26,304**	**26,304**

22. Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Acute	170,520	0	**170,520**	0	0	**0**
Mental Health	20,407	0	**20,407**	0	0	**0**
Continuing Care	17,867	0	**17,867**	0	0	**0**
Community	20,352	0	**20,352**	0	0	**0**
Prescribing	29,896	0	**29,896**	0	0	**0**
Primary Care	5,157	0	**5,157**	0	0	**0**
Corporate & Estates / Other / Income	8,103	(2,805)	**5,298**	0	0	**0**
Unallocated	0	0	**0**	2,670	(36,915)	**(34,245)**
	0	0	**0**	0	0	**0**
Total	**272,302**	**(2,805)**	**269,497**	**2,670**	**(36,915)**	**(34,245)**

The Chief Operating Decision Maker (CODM) is considered to be the Governing Body, which evaluates performance of the organisation based on net expenditure of the segments. The statement of financial position, and cash flow statements are not reported on a segmental basis.

Reconciliation between Operating Segments and SoCNE

	31-Mar-15 £'000
Total net expenditure reported for operating segments	269,497
Total net expenditure per the Statement of Comprehensive Net Expenditure	269,497

Reconciliation between Operating Segments and SoFP

	31-Mar-15 £'000
Total assets reported for operating segments	2,670
Total assets per Statement of Financial Position	**2,670**

	31-Mar-15 £'000
Total liabilities reported for operating segments	(36,915)
Total liabilities per Statement of Financial Position	**(36,915)**

23. Pooled budgets

The clinical commissioining group were not party to any pooled budget arrangements during 2014/15 (2013/14 : None).

24. Intra-government and other balances

2014-15	Current Receivables £000	Non-current Receivables £000	Current Payables £000	Non-current Payables £000
Balances with:				
· Other Central Government bodies	11	-	486	-
· Local Authorities	913	-	442	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	1,014	-	359	-
· NHS Trusts and Foundation Trusts	644	-	21,468	-
Total of balances with NHS bodies:	**1,658**	**-**	**21,827**	**-**
· Public corporations and trading funds	-	-	-	-
· Bodies external to Government	73	-	14,093	-
Total balances at 31 March 2015	**2,655**	**-**	**36,848**	**-**

2013-14	Current Receivables £000	Non-current Receivables £000	Current Payables £000	Non-current Payables £000
Balances with:				
· Other Central Government bodies	53	-	89	-
· Local Authorities	500	-	56	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	431	-	262	-
· NHS Trusts and Foundation Trusts	1,478	-	15,500	-
Total of balances with NHS bodies:	**1,909**	**-**	**15,762**	**-**
· Public corporations and trading funds	-	-	-	-
· Bodies external to Government	49	-	10,739	-
Total balances at 31 March 2014	**2,511**	**-**	**26,646**	**-**

25. Related party transactions

During the year none of the Executive or lay members, or parties related to any of them, has undertaken any material transactions with the clinical commissioning group.

Details of related party transactions with GP members are as follows:

Payments shown below are in respect of payments in respect of services provided to the clinical commissioning group by the practice which the member is a partner rather than payments to members themselves.

GP Member	GP Practice	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£000	£000	£000	£000
Dr Amol Kelshiker & Dr Lawrence Gould	Pinn Medical Centre *	386	-	-	-
Dr Lawrence Gould	Stanmore Medical Centre	64	-	-	-
Dr Kaushik Karia	Aspri Medical Centre	38	-	-	-
Dr Dilip Patel	Civic Medical Centre	27	-	-	-
Dr Kanesh Rajani	Streatfield Health Centre	35	-	-	-
Dr Genevieve Small	Ridgeway Surgery *	436	-	2	-

*Both Pinn Medical Centre and Ridgeway Surgery host Walk in Centres during Out of Hours.

Dr K Rajani is a Director of Harrow Health Limited and Dr A Kelshiker, Dr L Gould, Dr K Karia, Dr D Patel and Dr G Small are shareholders in Harrow Health Limited . The CCG has received invoices from Harrow Health Ltd for 2014/15 amounting to £1.63m.

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:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
NHS England including CCG's;				
NHS England	344	1,065	-	223
North West London CSU	1,521	-	-	-
NHS Brent CCG	2,294	99	250	401
NHS Hillingdon CCG	47	210	9	186
NHS Ealing CCG	24	91	-	37
NHS Foundation Trusts;				
Central And North West London MH NHS Foundation Trust	22,200	-	1,518	1
Chelsea And Westminster Hospital NHS Foundation Trust	789	-	-	44
Frimley Health NHS Foundation Trust	106	-	21	-
Great Ormond Street Hospital for Children NHS Foundation Trust	471	-	4	-
Guys And St Thomas NHS Foundation Trust	867	-	-	57
King's College Hospital NHS Foundation Trust	242	-	2	-
Moorfields Eye Hospital NHS Foundation Trust	7,082	-	2,421	-
Royal Brompton And Harefield NHS Foundation Trust	1,905	-	106	-
Royal Free London NHS Foundation Trust	8,463	-	1,551	120
The Hillingdon Hospital NHS Foundation Trust	7,734	-	986	-
The Royal Marsden NHS Foundation Trust	114	-	-	54
University College London NHS Foundation Trust	2,892	-	96	-

25. Related party transactions (contd.)

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
NHS Trusts;				
Barnet and Chase Farm Hospitals NHS Trust	1,052	-	-	-
Barnet, Enfield & Haringey Mental Health NHS Trust	142	-	39	-
Barts Health NHS Trust	494	-	67	-
Central London Community Healthcare NHS Trust	621	-	37	-
Ealing Hospital NHS Trust	5,338	65	-	-
East And North Hertfordshire NHS Trust	808	-	-	128
Imperial College Healthcare NHS Trust	8,651	-	395	84
London Ambulance Service NHS Trust	6,264	-	74	-
London North West Healthcare NHS Trust	58,824	65	3,997	130
North Middlesex University Hospital NHS Trust	129	-	64	-
North West London Hospitals NHS Trust	45,916	-	-	-
St George's Healthcare NHS Trust	171	-	-	-
Sussex Community NHS Trust	115	-	11	-
Royal National Orthopaedic Hospital NHS Trust	3,788	-	128	-
The Whittington Hospital NHS Trust	239	-	63	2
West Hertfordshire Hospitals NHS Trust	3,183	-	-	21
West London Mental Health NHS Trust	111	-	3	-
West Middlesex University Hospital NHS Trust	140	-	4	1

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

Community Health Partnerships Ltd	768	-	185	-
London Borough of Harrow	700	885	442	885
NHS Property Services Ltd	946	-	203	-

26. Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the Clinical Commissioning Group.

27. Losses and special payments

The Clinical Commissioning Group had no losses or special payments during 2014/15 (2013/14 : None).

The Clinical Commissioning Group recovered £85k (1case) in respect of a bad and doubtful debt provision made last year see note 15.2.

28. Third party assets

The Clinical Commissioning Group held no third party assets as at 31 March 2015 (31 March 2014 : None).

29. 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:

	2014-15 Target £'000	**2014-15 Performance £'000**	2013-14 Target £'000	2013-14 Performance £'000
Expenditure not to exceed income	272,385	272,302	244,531	254,580
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	269,580	269,497	242,991	253,040
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	6,352	5,586	5,730	5,657

30. Impact of IFRS

Accounting under IFRS had no impact on the results of the Clinical Commissioning Group during the 2014/15 financial year (2013/14 : no impact).

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS HARROW CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Harrow Clinical Commissioning Group for the year ended 31 March 2015 under the Audit Commission Act 1998[1].The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes numbered 1 to 30. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- payments to past senior managers in section numbered 4.4.2
- the table of salaries and allowances of senior managers and related narrative notes in sections numbered 4.5 and 4.6;
- the table of pension benefits of senior managers and related narrative notes in sections numbered 4.7 to 4.7.2; and
- the table of pay multiples and related narrative notes in section numbered 4.8.

This report is made solely to the members of NHS Harrow Clinical Commissioning Group in accordance with Part II of the Audit Commission Act 1998 and for no other purpose. Our audit work has been undertaken so that we might state to the NHS Harrow Clinical Commissioning Group 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 NHS Harrow Clinical Commissioning Group, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's (APB's) Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Accountable Officer; and
- the overall presentation of the financial statements.

[1] References throughout this report to the Audit Commission Act 1998 are saved transitionally for the purposes of the 2014/15 audit of accounts.

In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Harrow Clinical Commissioning Group as at 31 March 2015 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the approval of the Secretary of State; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not comply with NHS England's guidance;

We have nothing to report in this respect.

Exception reports

We have a duty under the Audit Commission Act 1998 to refer the matter to the Secretary of State if we have a reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 27 May 2015 we referred a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 in relation to its initial deficit budget for 2015/16 which would lead to a breach of its duty under section 223I(3) of the NHS Act 2006 to stay within its revenue resource limit placed upon It by NHS England.

Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the CCG and auditor

The CCG is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014.

We report if significant matters have come to our attention which prevent us from concluding that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the CCG has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission determined these two criteria as those necessary for us to consider under its Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

In considering the Clinical Commissioning Group's arrangements for securing financial resilience, we identified that in the Clinical Commissioning Group's latest budget for 2015/16 approved by the Board, revenue expenditure is estimated to exceed the Clinical Commissioning Group's revenue resource limit by £5.2 million. We further note that the same budget assumes that the Clinical Commissioning Group will be in receipt of additional non-recurrent funding of £13.3 million from other Clinical Commissioning Groups within the North West London sector. This, in turn, is dependent on approval by NHS England, which has not yet been obtained. Development of the financial plan for 2016/17 is in progress.

Qualified conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that in all significant respects NHS Harrow Clinical Commissioning Group put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate
We certify that we have completed the audit of the accounts of NHS Harrow Clinical Commissioning Group in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Craig Wisdom FCA
For and on behalf of Deloitte LLP
Appointed Auditor

St Albans

28th May 2015