NHS
Harrow
Clinical Commissioning Group

NHS Harrow Clinical Commissioning Group

Annual Report and Accounts 2016/17

Performance Report

Staff from the Drug and Alcohol Service at a NHS Harrow CCG event

The Performance Report comprises of the:

- Performance Overview
- Performance Analysis

Rob Larkman
Accountable Officer
NHS Brent, Harrow and Hillingdon CCGs
Date: 24 May 2017

1 Performance Overview

1.1 Statement from the Chair and Accountable Officer

Welcome to the 2016/17 annual report for NHS Harrow Clinical Commissioning Group (CCG). This performance overview gives a summary of our achievements during the past 12 months, how we spent the money allocated to us and how we delivered our services.

It also sets out how we discharged our functions, our strategic vision, the key risks to achieving our objectives, our activities during the 2016/17 financial year and includes an outline of the overall health of the borough.

In the past year, the main focus of our work has been to work with neighbouring CCGs, the public, voluntary and third sector groups, NHS providers and the London Borough of Harrow to put together a five year plan for health and care in North West (NW) London.

The plan, called the North West London Sustainability and Transformation Plan (STP), is designed to maintain and improve the quality of care while making sure that services stay on an even financial keel.

You can read about the STP here. We've produced a second document which has more information about the specific plans for Harrow.

While much of the focus has been on the future, we have achieved a great deal this year too. You can read more in section 1.5 but some of the highlights include:

- Opening a third walk-in centre in the borough at Belmont Practice in East Harrow. Harrow residents now have access to 1,100 extra appointments a week at walk-in centres should they need to see a clinician urgently and they are unable to wait for a slot at their local GP practice,
- Launching the Health Help Now app – this is a portal for smart phones and tablets which delivers self-care tools and information with the details of local health services that are available.
- An integrated diabetes strategy is in place which includes acute, community, primary and social care services.

We're also committed to delivering extra investment for local health services. In December 2016, NHS Harrow CCG's Governing Body agreed to support a bid for over £500m of investment across North West London to improve NHS buildings and facilities in the next ten years. The bid will now be subject to approval by NHS England and central government.

For residents in Harrow, such an investment will bring many benefits including:

- improved GP practice buildings and facilities, making them accessible and enabling the delivery of many more services,
- a new out of hospital hub in Belmont/Kenmore (North East Harrow),

- developing more out of hospital services, creating out of hospital hubs at the Pinn Medical Centre and the Alexandra Avenue Health and Social Care Centre and
- improving buildings at Northwick Park Hospital and increasing the scope of post-surgery recovery and critical care beds.

You can find out more about the work we are prioritising for the future in section 1.6 and our Commissioning Intentions document , which sets out our plans for the next two years.

If you want to find out more about our work, please visit our website, where you can also find out dates, times and locations for our regular meetings of the Governing Body, which are held in public. We welcome the contributions of all our partners in planning and driving forward improvements in health and care services across Harrow.

Dr. Amol Kelshiker
Chair
NHS Harrow CCG

Rob Larkman
Accountable Officer
NHS Brent, Harrow and Hillingdon CCGs

1.2 Our vision and who we are

NHS Harrow CCG was established in April 2013 under Section 1H of the National Health Service Act 2006, as amended by Section 11 Health and Social Care Act 2012.

It is a GP-led organisation, responsible for planning, buying (commissioning) and designing many of the health services needed by the approximately 260,000 people registered with GPs in Harrow.

The CCG is one of more than 200 CCGs in the UK, whose collective challenge is to meet the demands of a population that is growing in size, getting older and living with increasingly complex conditions.

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

Our guiding principles are to deliver care that is personalised, localised, integrated (more joined up) and centralised, where it benefits patients.

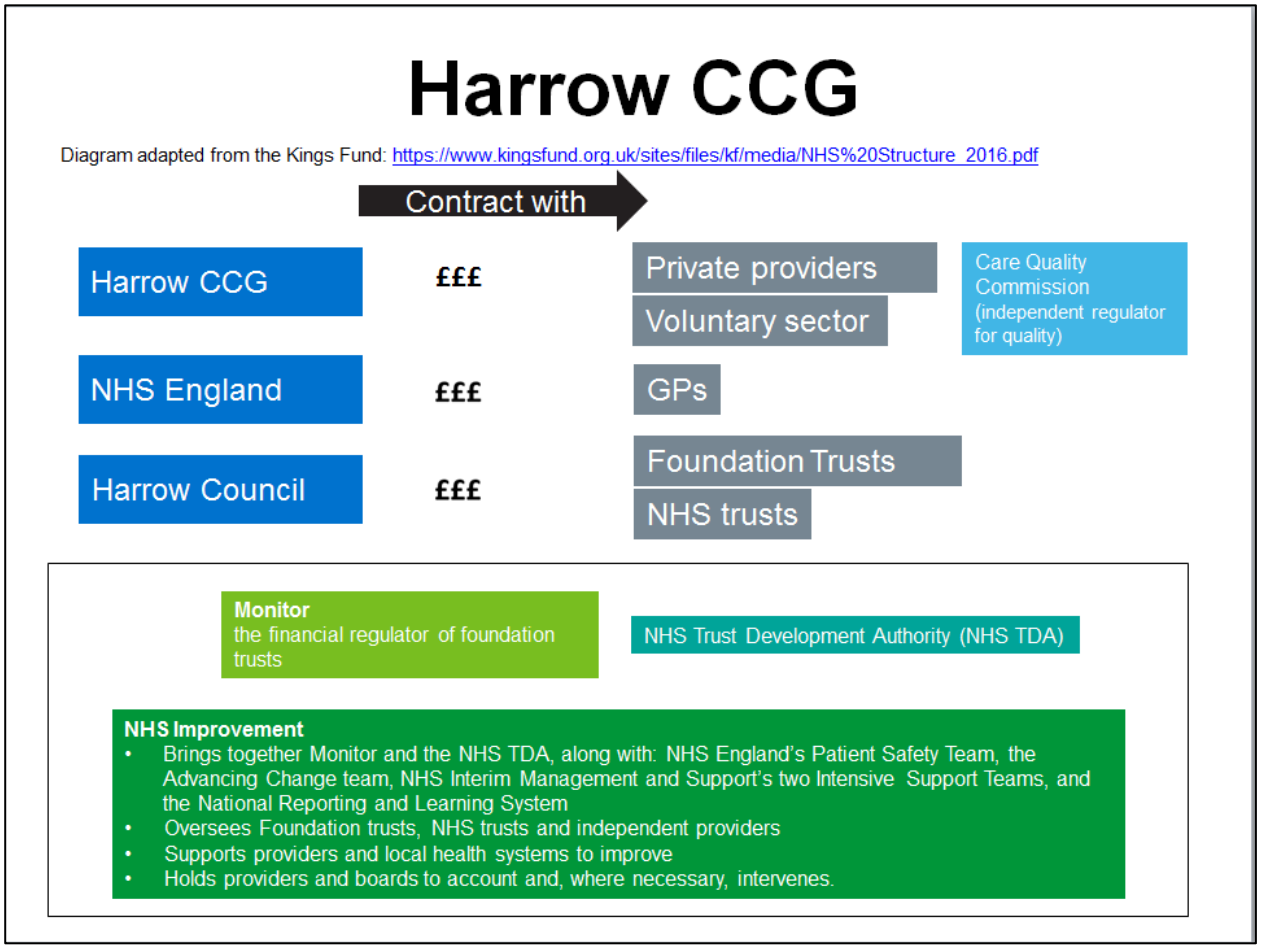



1.3 How the CCG works and its activities

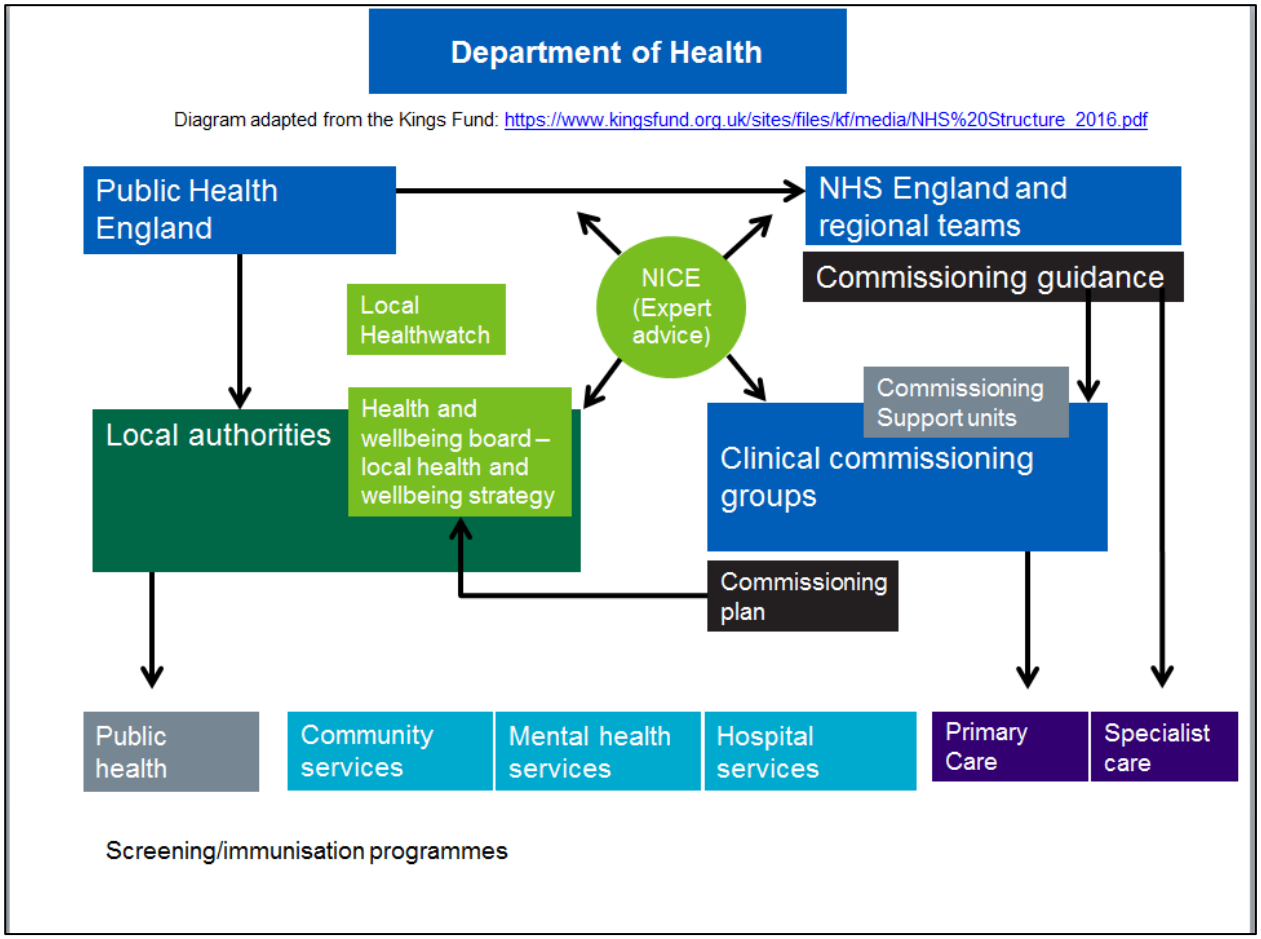
We are a membership organisation, made up of the 34 GP practices in the borough. Our vision is to work in partnership with our members to ensure that local residents receive high quality, modern, sustainable, needs-led and cost effective care within the financial budgets that are

available to us.

The diagrams below set out how NHS Harrow CCG works in the context of the roles of other health and social care providers. We also explain how public funding is used and the governance arrangements that are in place to ensure that public money is accounted for while maintaining priorities of delivering high quality care.



Harrow Healthwatch attends NHS Harrow CCG's Governing Body meetings.



- Primary care is commissioned jointly with NHSE who have the majority vote in decision making.
- Shared services operate in-house within North West London (NW London) CCGs, rather than through a separate Commissioning Support Unit (CSU).

Patients are always at the heart of everything we do. We make decisions about health services that take account of the feedback from patients, carers and local patient representative organisations to ensure services we purchase and re-design are those services that our residents need and are able to access.

The work of NHS Harrow CCG is overseen by its Governing Body, which ensures NHS Harrow CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically. We continue to work with other CCGs in NW London to improve healthcare services for Harrow's residents.

By working together with patients and the public and other partners, we want to ensure that Harrow's patients get better access to care around the clock. This means:

- being able to get appointments with a GP quickly and conveniently,
- making sure that more specialist doctors are available, no matter the day of the week,
- ensuring that mental health is considered at the same time as physical health,
- facilitating one single, coordinated approach being taken by health and voluntary sector organisations and
- where longer term care from different people is needed, it is joined up so that a patient does not need to keep repeating their history to a range of different people across a number of services.

We make sure that the public helps us to shape care, and we involved them from the early stages in designing our services. We continue to listen to their feedback along the way.

Please visit our website for more information about NHS Harrow CCG and the work it does, including our constitution.

1.3.1 Taking forward devolution in health and care for London

London faces significant population, health, organisational and financial challenges which must be addressed if we are to support Londoners to be as healthy as they can be and for services to be sustainable. London partners, including London CCGs, have committed to work more closely together to support those who live and work in London to lead healthier, independent lives, prevent ill-health, and to make the best use of health and care assets. London health and care leaders have worked closely together at local, sub-regional and regional level over a number of years to develop a clear vision for better health and care, built on the views of Londoners, and central government and national bodies backed this commitment through the 2015 London Health Devolution Agreement.

Throughout 2016, local, multi-borough and sub-regional (STP) areas in London have worked hard to plan rapid improvements to health and care within existing powers. Five London devolution 'pilots' have also explored how more local powers, resources and decision making could accelerate the improvements that Londoners want to see. Our devolution work has underscored the importance of working at different levels in London under the three themes of prevention, integration and estates. We are clear that transformation must be locally led and that many services can only be delivered at the borough or smaller locality level, whereas others are more appropriately aggregated across boroughs or London-wide.

The forthcoming London Health and Care Devolution Memorandum of Understanding (MoU) will express commitments by national bodies to enable these improvements to go further and faster, based on the different ambition and appetite of local areas. We have also been working to commence delivery of more collaborative health and care governance and delivery capability at London-level working within the London Health Board arrangements. This aims to complement and support local areas in their transformation ambitions. As an example, the London Estates board has started to meet in shadow form, looking at what projects need help at a London level to progress more speedily and how NHS buildings are best utilised. This work will help to deliver the modern buildings which London's health service needs, use them as intensively as possible and potentially free up the land for much needed new housing.

1.4 Health of the borough

A comprehensive picture of Harrow's health was captured in the Joint Strategic Needs Assessment (JSNA) document that was compiled by Harrow Council. What follows in this section is based on Harrow Council's 2015/2020 JSNA.

Health and wellbeing is not just about health services alone. The biggest impacts on an individual's health and wellbeing derive from the environments that people were born in, live or work in, their education, wealth and relationships with others.

Tackling the determinants of health is required across the full life cycle, using a life course approach (rather than an overview being considered at any single point in time). This uses the Marmot approach based on the Marmot Review published in 2010 which set out key areas that needed to be improved to make a significant impact in reducing health inequalities and addressing the health inequalities between the vulnerable and non-vulnerable populations. This approach helps to focus on people of all ages and stages of life.

The aim of Harrow's JSNA is to identify the inequalities in health and wellbeing and other associated factors in Harrow. Strategies and action plans are aimed at addressing such issues to improve the lives of people who live in the borough.

Around 260,268 people live in Harrow and just over half of this total population is female. 7% of the total population are under the age of 5 years and 7% of the population are people aged over 75 years. Compared to the average rates across London, the population of Harrow has a higher proportion of older people (those aged over 60 years) and a lower proportion of people that are in their 20s and 30s. The age structure of the population varies across the borough.

Ethnic diversity

Harrow is one of the most ethnically diverse boroughs in the country. In 2011, 43% of Harrow's population came from an Asian or Asian-British background. The percentage from a white ethnic background is almost equal at 42%.

A further 8% of the population comes from a Black/African/Caribbean or Black-British ethnic background. In the next 10 years, it is predicted that the local Black, Asian and minority ethnic (BAME) populations in Harrow will increase from 51% to 68% of the total population.

Every year, Harrow welcomes over 2,000 new British citizens in citizenship ceremonies. Demographics based on the age structure of the population and ethnic mix varies across Harrow. In Pinner and Pinner South wards, BAME groups make up around 40% of the total population, while in Queensbury, Kenton West and Kenton East, BAME groups make up over 70% of the population (this data was extracted from Census 2011). An increase in the BAME population will result in different patterns of health and illness than in previous years. For example, higher rates of diabetes and heart disease in BAME groups may require a different and culturally appropriate approach being taken when planning their prevention and treatment.

Religious diversity

Alongside ethnic diversity, Harrow has great religious diversity. Harrow is home to one of the largest Hindu communities in the country where 26% of the population are Hindu. There is also a greater proportion of people from Muslim and Jewish faiths than is the national average for England.

Gender/Sexual orientation

Although gender and sexual orientation is a protected characteristic under equalities legislation, robust data does not exist on numbers of people that classify themselves as lesbian, gay, bisexual or transgender.

On sexual orientation, data from the National Survey of Sexual Attitudes and Lifestyle, the Treasury and Stonewall (a UK charity supporting the rights of Lesbian, Gay, Bisexual and Transgender – LGBT – people) broadly agrees that approximately 5-7% of the population in Harrow classify themselves as lesbian, gay or bisexual.

It is also worth noting that, between December 2005 (when the Civil Partnership Act came into force) and the end of 2013, there have been 71 civil partnerships in Harrow. Since 29 March 2014, same sex marriages were permitted, but no local data is yet available to provide statistics.

Deprivation

Deprivation is most commonly measured by using the Index of Multiple Deprivation (IMD). This

index incorporates a number of factors and includes varied dimensions such as housing, employment and income to deliver a single deprivation score. Harrow is ranked 203 out of 354 districts in England where the first score relates to the most deprived district. Most deprivation can be found in the center of the borough, with some pockets of deprivation located in the south and east. Harrow's least deprived areas are likely to be found to the west of the borough. Not all disadvantaged people live in deprived areas and conversely, not everyone who lives in a deprived area could be classified as disadvantaged.

Vulnerable groups

In terms of children and young people, Harrow is home to 55,800 children aged between 0 to 17. About 3,100 children were in need of a social care service between April 2013 and the end of March 2014. This includes the 'Children Looked After' (CLA) categories, those supported in their families or independently, and children that were the subject of a child protection plan (CPP).

Key issues and challenges

Nearly two-thirds of Harrow's under 18 Children in Need (CiN) populations are from BAME groups. The proportion of children in need from Asian or Asian British origins was over one quarter (higher than the figures for our statistical neighbours). Harrow has a rate of 19.8%, the average figure for London is 13.1% and the average figure for England is 6.2%. As at 31 March 2014, approximately 54.8% of those in the CiN category were male children compared to 43.7% female children in Harrow. This percentage is consistent with London, England and Harrow's statistical neighbours.

The number and rate of CiN referrals per 10,000 children in Harrow has historically been low compared to the national averages, but 2013/14 saw a rise in these proportions, due to revised thresholds and changing demographics. There were 2,305 referrals made to children's social care services in 2013/14 compared to 1,529 in the previous year. Nationally, there has been a rise in referrals of approximately 11%.

- **Children with learning disabilities**
  The estimated prevalence of special educational needs in Harrow has remained consistent over time at 2.6%. This is lower than the average for London, at 2.7% and England's average of 2.8%. The number per 1,000 of children with moderate learning disabilities in Harrow is lower than London's average but is higher for children with severe learning disabilities.

- **Children with sensory impairments**
  For sensory impairments, approximately 180 children are reported to be deaf in Harrow and we have achieved a rate of 99% of regular hearing aid checks for these groups of children.

1.5 Achievements

Some of the achievements by NHS Harrow CCG are listed below:

- Opening a third walk-in centre in the borough at Belmont Practice in East Harrow. Harrow residents now have access to 1,100 extra appointments a week at walk-in centres should they need to see a clinician urgently and they are unable to wait for a slot at their local GP practice.
- With Harrow Council, setting up a new service targeting Children and Young Peoples' Emotional Health and Wellbeing Service. The service works with children having special

educational needs, disabilities and various disorders along the autism spectrum, CLA groups, young carers, and children or young people displaying challenging behaviours (and/or those who are experiencing life events from bereavement, self-harm, school exclusions and obsessive compulsive disorders or OCD).

- Launching the Health Help Now app – this is a portal for smart phones and tablets which delivers self-care tools and details of local health services that are available,
- Putting an integrated diabetes strategy in place which includes acute, community, primary and social care services.
- Working collaboratively with Harrow Council to improve the Children Looked After (CLA) service. The new service is in place following a successful two year pilot. It has become an integral and valued resource in Harrow and has been recognised as an example of good practice by NHSE, Ofsted and neighbouring CCGs.

Changes to maternity and childrens' services across North West London

In maternity services, we improved care and ensured the delivery of many new standards that were set out in the National Maternity Review 'Better Births' released in 2016. These improvements included:

- Meeting London's standard for the numbers of midwifes to births (100 new midwives were recruited).
- More consultants are available day and night.
- There is better continuity in care available through post-natal and ante-natal care in the same hospital.

We tested a range of new ways of working to transform maternity services. These improvements were recognised nationally.

Changes to children's services in NW London improved care

- Better access was made available day and night, seven days a week to more senior children's doctors in five hospitals across NW London.
- More inpatient and paediatric assessment beds were provided at West Middlesex, Hillingdon, Northwick Park hospitals.
- Four new paediatric assessment units provide same day care in a purpose-built environment for patients needing treatment, but where they do not need to be in A&E or be admitted to hospital. This reduces the average length of stay in hospital by 12 hours.
- An extra 48 paediatric nurses and 10 paediatric consultants have been introduced.

Mental Health in NW London

In 2016/17 new mental health services were launched including:

- a new 24/7, year round service providing support, advice and information for those who experience mental health illness, their carers and professionals which has helped reduce A&E attendances for people in mental health crisis by 300-400 a year,
- a new specialist assessment, treatment and support service for pregnant women or women who have given birth within the past year and
- a new service for children and young people affected by eating disorders which accepts self-referrals from young people and children, parents, as well as GPs, health and other professionals, including teachers. It aims to reduce 200 crisis visits per year.

1.6 Priorities

NHS Harrow CCG has a clear organisational vision to work in partnership to ensure that Harrow residents receive high quality, modern, sustainable, needs-led and cost-effective care within the financial budgets available.

CCG Chair Dr. Kelshiker reviewing how the Health Help Now app works

Priority 1 – Personalised services

- We are working with patients and other key stakeholders to ensure that we meet the diverse needs of Harrow residents.
- We will promote self-care and better healthcare education. By focusing on prevention, we will develop better patient pathways for diabetes and services that are related to musculo-skeletal conditions (MSK).

Priority 2 – Localised services

- We aim to reduce hospital attendance by commissioning more elective procedures outside hospitals, by investing more in building community and primary care capacity across the borough.
- We will work with GP Practices to increase the access to primary care services and provide more services out of hours.

Priority 3 – Integrated services

- We will transform services to deliver whole-systems community based care. This is focused on providing joined-up support for people who are at risk of hospital admissions or those who have Long-Term Conditions (LTCs).
- We will leverage the benefits of technology to provide more timely, joined up services

and better, more consistent treatments that make optimum use of resources.
- We will work with our partners in NW London to improve urgent care and out-of-hours care pathways to ensure that more responsive care and reduced pressures on A&E and the London Ambulance Services (LAS) are achieved.
- We will partner with other service commissioners and providers to develop better and more integrated mental health and children's services.

Priority 4 – Centralised services

- Where appropriate, people can get better care when services are centralised so all the specialist care they might need is in one place.
- At the same time, we want to reduce the amount of time patients spend in hospital by increasing the availability of community beds. We are also developing better, efficient care pathways for out-of-hospital care within community settings.

1.7 Health and Wellbeing Strategy

Under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007, CCGs must, in exercising their functions, have regard to the most recent joint health and wellbeing strategy prepared by the local council.

Our vision of the local Harrow Health and Wellbeing Strategy is to help each other to start, live, work and age well. This is explained below:

- Starting well: we want children from the womb to adulthood to be safe, happy and able to receive every opportunity to reach their full potential.
- Living well: we want high quality, easily accessible health and care services when and where needed, sufficient and good quality housing, green spaces and spaces for activity, healthy high streets and neighbourhoods.
- Work well: we want to help people to be financially secure through finding good jobs and staying in work in organisations that will promote their overall health and wellbeing.
- Age well: we want to enable older people to remain well and connected to others while being able to live independently in their own homes for longer. We want to enable more dignified deaths.

The key priorities are to:

- use every opportunity to promote mental well-being,
- empower the community and voluntary sector to collaborate to deliver alternate delivery models and funding solutions and
- provide integrated health and care services.

The Health and Wellbeing partners in Harrow will focus on how they can contribute towards making Harrow a better place to live and reduce differences in life expectancy and healthy life expectancies between local communities.

Measuring Progress in 2016/17

For the purposes of this report, the primary means by which the CCG and the Council monitor the strategy is via the Health and Wellbeing Board Executive and a review of progress and contributions across the borough – one of many regular reviews through the year – took place in March 2017.

We also measured progress against the delivery of our Commissioning Intentions in 2016/17 through:

- presenting a review of progress against each of the ten key priorities at each meeting of NHS Harrow CCG's Governing Body and Harrow's Health and Wellbeing Board,
- engaging with GP Practices through Peer Group Meetings and the GP Forum on the progress with implementing our Commissioning Intentions on a quarterly basis,
- facilitating a patient and stakeholder Commissioning Intentions 'stock-take' event in March 2016,
- working with Harrow Healthwatch and the Harrow Patient Participation Network and other affiliate groups to review progress updates – helping us to focus on particular priority areas – and
- engaging with NHS England on the progress regarding delivery of our Commissioning Intentions and the Sustainability Transformation Plan (STP) through building in an on-going assurance process.

1.8 Key issues and risks

1.8.1 Issues

Governance

Following the outcome of an in-depth governance review, the CCG recognised the need to improve governance effectiveness to support improved organisational agility, better use of resources and delivery capability. This warranted establishing committees in common, having proactive risk escalation processes, establishing a shared secretariat function across Brent, Harrow and Hillingdon (BHH) CGGs and revising constitutions and standing orders.

To enact the above, we developed a BHH CCGs governance improvement plan. Implementation of the plan started in the third quarter of the financial year. The full tangible benefits will be manifested in the 2017/18 financial year.

In October 2016, NHS Harrow CCG adopted an initial Improvement Plan to address known and perceived weaknesses in its governance and decision-making. This incorporated the outcomes of the in-depth governance review, work from Smarter Working Awaydays and themes identified by the recently-appointed Interim Director of Compliance. This plan has been regularly reviewed, extended and refined. Assurance on its delivery is being obtained through the Audit Committee.

The majority of the items have been achieved, and there is good progress on all the others. However, there is still work to do in continuing to strengthen the CCG's governance and decision-making, building on the groundwork done so far. A new plan has been drawn up for continuing improvement in the next stage of the CCG's development, reflecting particularly its emphasis on recovery.

Organisational Development

We developed a shared strategic direction for organisational development (OD) across the eight CCGs in NW London (NWL) which was published in the NW London People Strategy. This strategy sets out our ambition to develop a more collaborative, integrated and innovative workforce.

Over the past year, the central Organisational Develoment (OD) team has supported the CCGs, including NHS Harrow CCG, in the following programmes of work:

- delivering our Learning and Development programme,
- staff engagement and surveys,
- promoting health and wellbeing,
- improving our organisational culture and behaviours,
- developing our leadership development offer,
- delivery of a corporate induction programme and
- development of a coaching and mentoring programme.

1.8.2 Risks

Financial Position

The key risk for the CCG has been its in-year deficit and underlying deficit position. The CCG finished the financial year with a £1.3m in-year deficit. The underlying position, which takes into account all non-recurrent items of expenditure, is a deficit of £9.9 million. See section 5.9.1 for more information.

Quality, Innovation, Productivity and Prevention (QIPP) Schemes

Delays in realising efficiency savings, leading to a forecast under-delivery of QIPP savings in 2016/17 with the risk of an escalating burden on future years, remained the primary risk to NHS Harrow CCG's objectives - namely, managing resources effectively to ensure best value and the delivery of financial targets.

The outcome of contract negotiations and reduction in the planned level of financial support from the NW London strategy increased the required QIPP savings to be found in the year. Following on from a review of the position, budget adjustments were actioned in the month to close the majority of the gaps.

However, there has been a deterioration in the reported position, predominately around acute performance, prescribing and continuing care, which increased the QIPP 'stretch requirement'. Control arrangements and assurances around QIPP delivery have been closely examined by the Governing Body.

1.9 Going Concern

The CCG accounts have been prepared on a going concern basis.

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

1.10 Performance summary

The CCG's full annual accounts have been prepared under a direction as issued by NHS England (NHSE), under the National Health Service Act 2006 (as amended). NHSE directed that the financial statements of CCGs shall meet the accounting requirements of the Manual for Accounts that was 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.

From 1 April 2013, NHS Harrow CCG has been responsible for commissioning (planning and

purchasing) of local health services - excluding primary care and specialised services that are commissioned by NHSE. Previously primary care trusts (PCTs) had the responsibility for the full range of services.

Financial position

The CCG financial position was a deficit of £1.3m in 2016/17 and an underlying deficit (after taking into account non-recurrent items) of £9.9m.

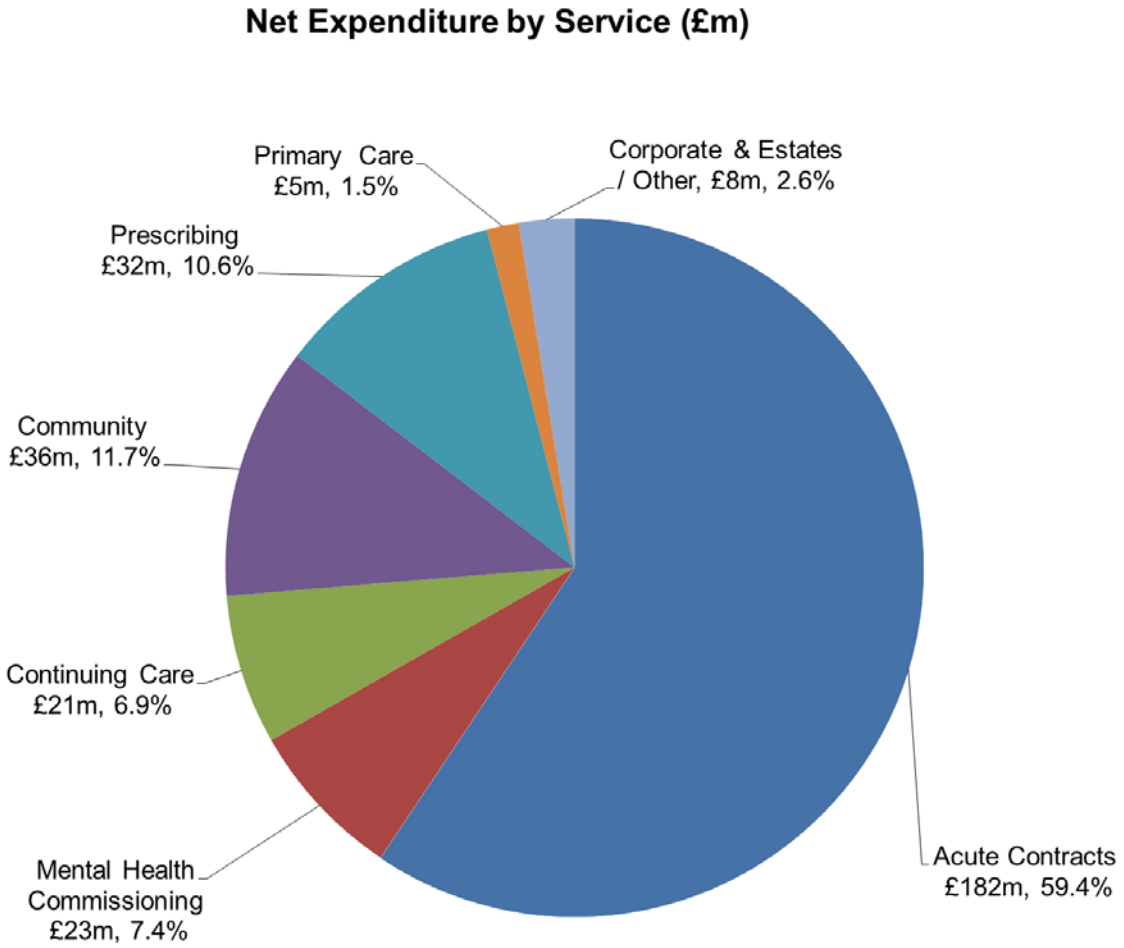
Uncommitted reserve requirement

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1% reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Harrow CCG has released its uncommitted reserve to the bottom line, resulting in a reduction to the in year deficit of £1.1m. This has been offset against other cost pressures from the current financial year.

1.11 How we spent your money

The chart below gives a breakdown by service of the CCG's total net expenditure of £303.4m.



2 Performance Analysis

2.1 How the CCG measures performance

NHS 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 from 2014/15 to 2018/19 (Operating Framework) and the NHS Mandated Outcomes Framework.

Performance of the CCG is monitored by the senior management team, and is regularly reviewed at key system and operational meetings with providers and other commissioners. Performance of the CCG is also routinely (and as requested) reported to NHSE as part of the quarterly assurance cycle.

As part of the Improvement and Assessment Framework CCGs work under, you can keep up to date with the performance of the CCG and the wider local NHS by typing your postcode into the new My NHS website.

2.2 Development and performance during the year

Although there have been areas of improvement in NHS Harrow CCG's performance in 2016/17, there remain areas where NHS Harrow CCG needs to improve performance in collaboration with providers.

A summary of performance across the range of NHS Constitution Standards is provided in the subsequent paragraphs.

2.2.1 Financial targets (see note 18 of the Financial Statements)

CCGs have a number of financial duties under the National Health Service Act 2006 (as amended) regarding the use of its resources. For 2016/17, NHS Harrow CCG's performance against each is summarised below:

- **Expenditure not to exceed its income**
  For 2016/17 NHS Harrow CCG had an overall target of £306m and actual performance of £307.3m and so achieved a deficit of £1.3m
- **Capital resource use not to exceed the amount specified in directions**
  For 2016/17 NHS Harrow CCG did not have a capital allocation
- **Revenue resource use not to exceed the amount specified in directions**
  For 2016/17 NHS Harrow CCG net revenue expenditure totalled £303.7m against a revenue resource allocation of £302.4m.

In addition, NHSE has placed the following additional controls on clinical commissioning groups' use of resources:

- **Capital resource use on specified matters not to exceed the amount specified in directions**
  For 2016/17 Harrow CCG did not have a capital allocation
- **Revenue resource use on specified matters not to exceed the amount specified in directions**
  For 2016/17 Harrow CCG did not have any resources allocated with specific directions
- **Revenue administration resource use not to exceed the amount specified in directions**
  For 2016/17 Harrow CCG had a target of £5.2m and actual performance of £4.5m an so achieved a surplus of £0.7m (running costs).

A deficit on programme of £2m and a surplus on running costs of £0.7m together equal Harrow CCG's deficit of £1.3m.

2.2.2 Funding allocations

NHS England published CCG allocations for three years with indicative allocations for the following two years in January 2016.

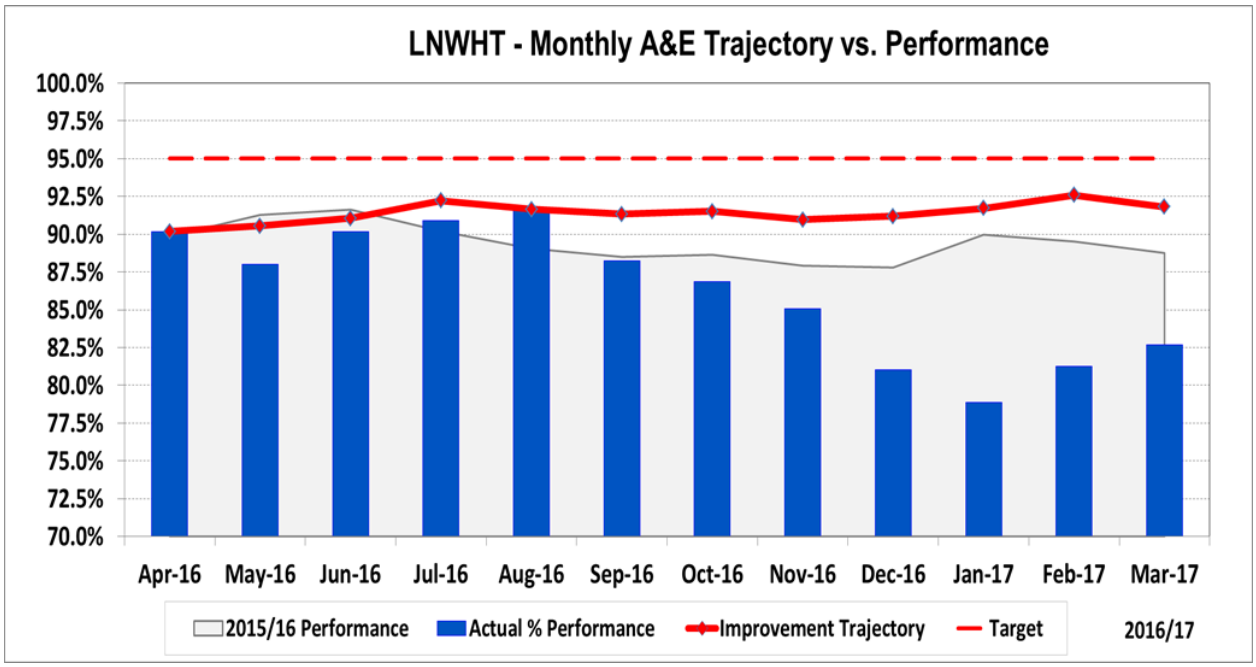
For 2016/17, the CCG received an increase in allocation of 6.0% on the funding received in 2015/16, equivalent to £15.9m.

In 2017/18, the CCG receives an increase in allocation of 2.9% on the funding received in 2016/17, equivalent to £8.0m. In 2018/19, the CCG will receive an allocation increase of 2.9%, equivalent to £8.3m. By the end of 2018/19, the CCG is calculated to be 2.2% below its funding capitation target.

In 2017/18, the CCG takes on delegated responsibility for commissioning primary care medical services. The additional allocation received for commissioning these services will be £30.8m. In 2018/19 the allocation for primary medical services will increase by 3.5%, equivalent to £1.1m. By the end of 2018/19, the allocation received by the CCG for primary medical services is calculated to be 4.4% below its funding capitation target.

2.2.3 Accident and Emergency (A&E) department

Achievement of the A&E 4-hour wait target continues to be challenging for NHS Harrow CCG with the year end position at 86.2%. Work has been on-going throughout the year with London North West Healthcare Trust (LNWHT) to improve patient flow and reduce delayed transfers of care.

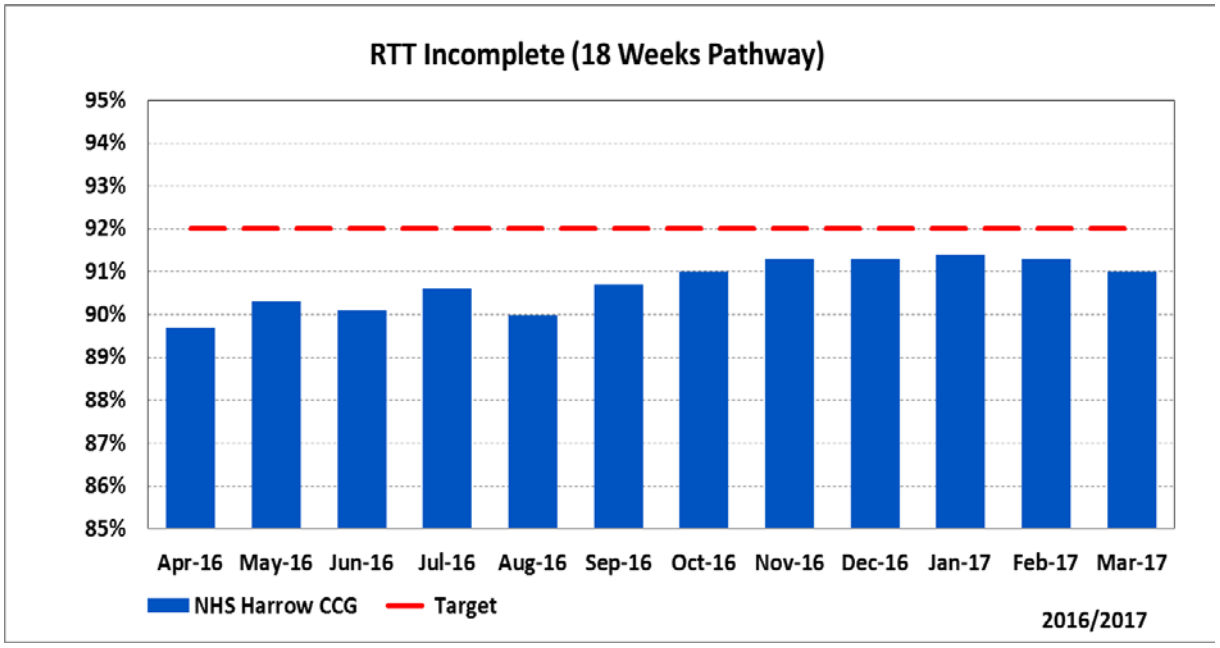


The trajectory represents the path agreed by the CCG, the Trust and our partners to support consistent achievement of the A&E target.

2.2.4 Referral to Treatment (RTT)

The Referral to Treatment incomplete target (percentage of incomplete patients seen within 18 weeks) is the main national access performance indicator.

NHS Harrow CCG year end performance is 90.7%. Performance against the standard was not achieved this year due to the need to prioritise non-elective admissions and cancer procedures. NHS Harrow CCG performance has also been impacted by Imperial College Healthcare Trust and the CCG is working closely with the Trust to ensure sufficient capacity within specialties with high demand. In October 2016, LNWHT met the 92% RTT Incomplete pathway national standard and, along with a sustainability plan, measures are in place to sustain performance.

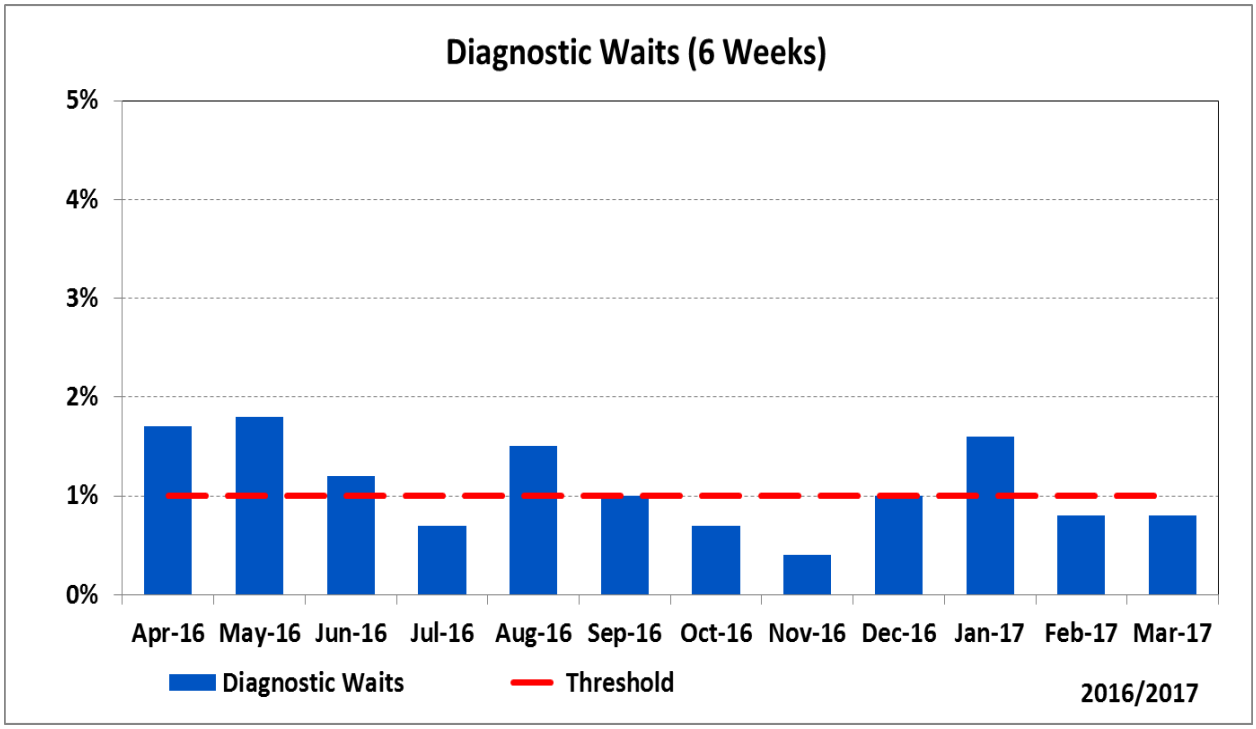


2.2.5 Diagnostic waiting times

The diagnostic waiting times target (for 15 key diagnostic tests and procedures) states that 99% of all patients should wait no more than 6 weeks for their diagnostic test.

Year end performance is 98.9% which is slightly below the 99% target. Overall performance has remained stable and NHS Harrow CCG is working with LNWHT to monitor compliance against this standard.

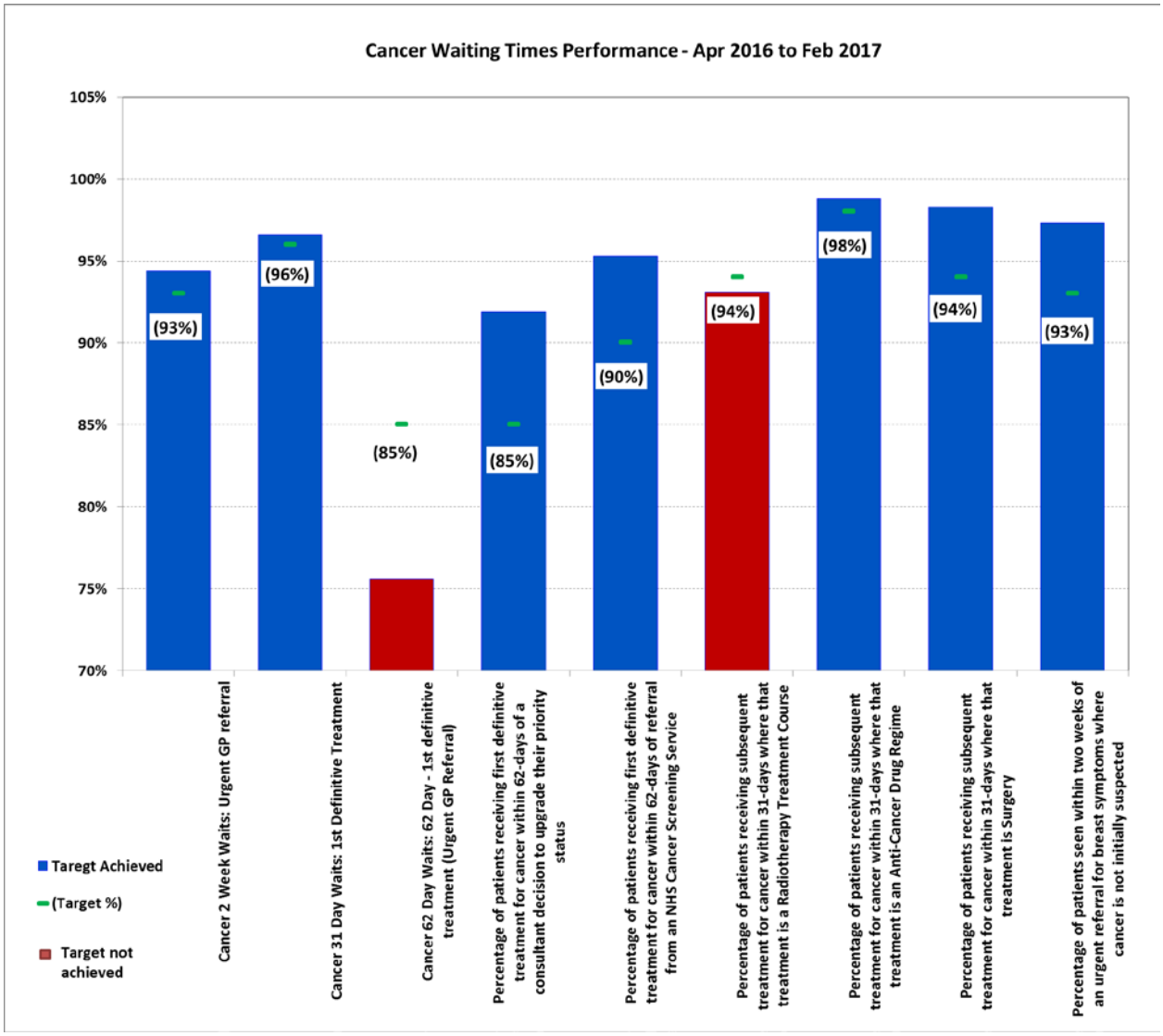
The graph below measures the percentage of patients waiting longer than 6 weeks so the target line is therefore set at 1%.



2.2.6 Cancer waiting times

NHS Harrow CCG is currently achieving seven of the nine cancer waiting time standards on a year end basis. Performance has been stable through 2016/17 with the exception of the 62 day waits for first definitive treatment standard which is currently at 75.6% for year end performance. Further improvements are being supported thought the NHSE Cancer Taskforce.

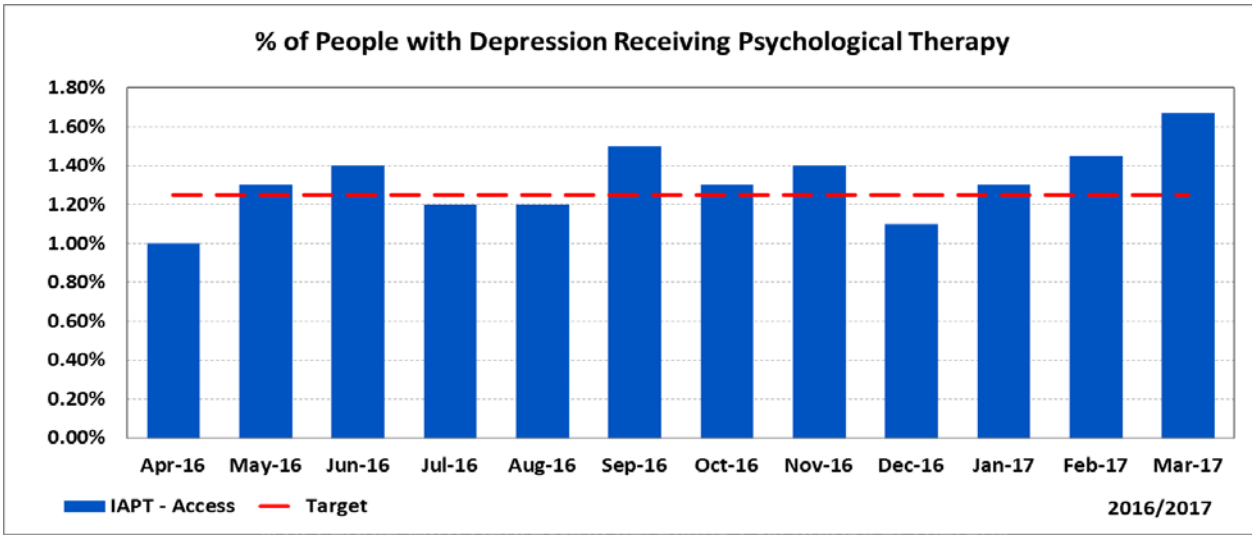
Initiatives to improve performance include the implementation of surveillance lists to reduce backlog numbers, weekly patient list review and capacity analysis across high demand specialties.

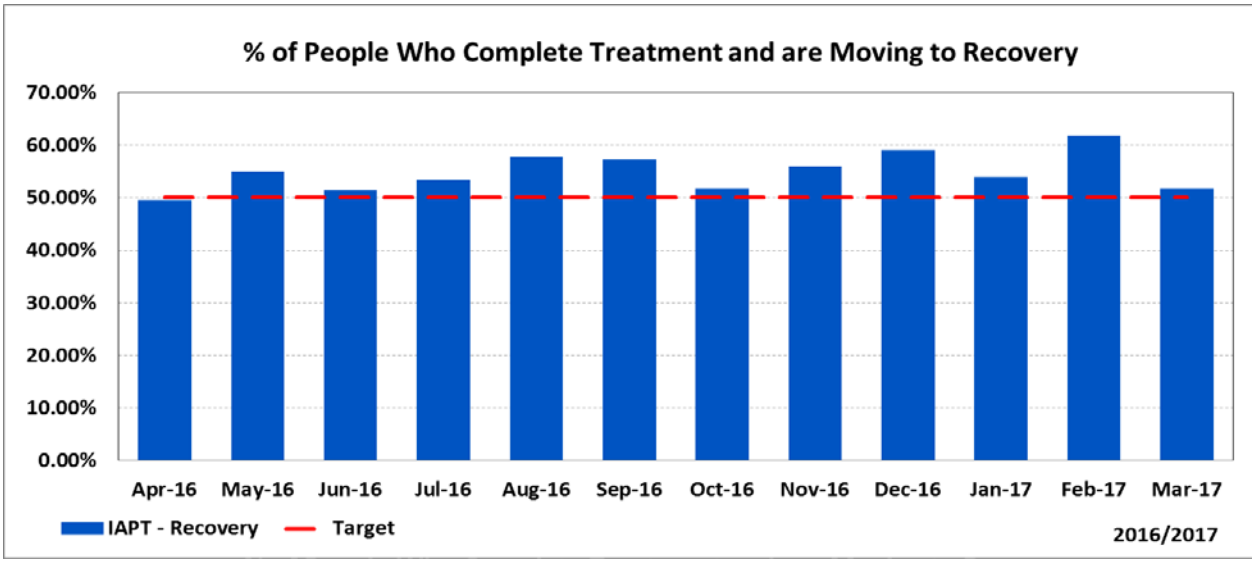


2.2.7 Improved Access to Psychological Therapies (IAPT)

NHS Harrow CCG has seen an increase in access and recovery rates throughout 2016/17. The year end positions for both IAPT Access and Recovery have met the national standards at 1.32% and 54.9% respectively.

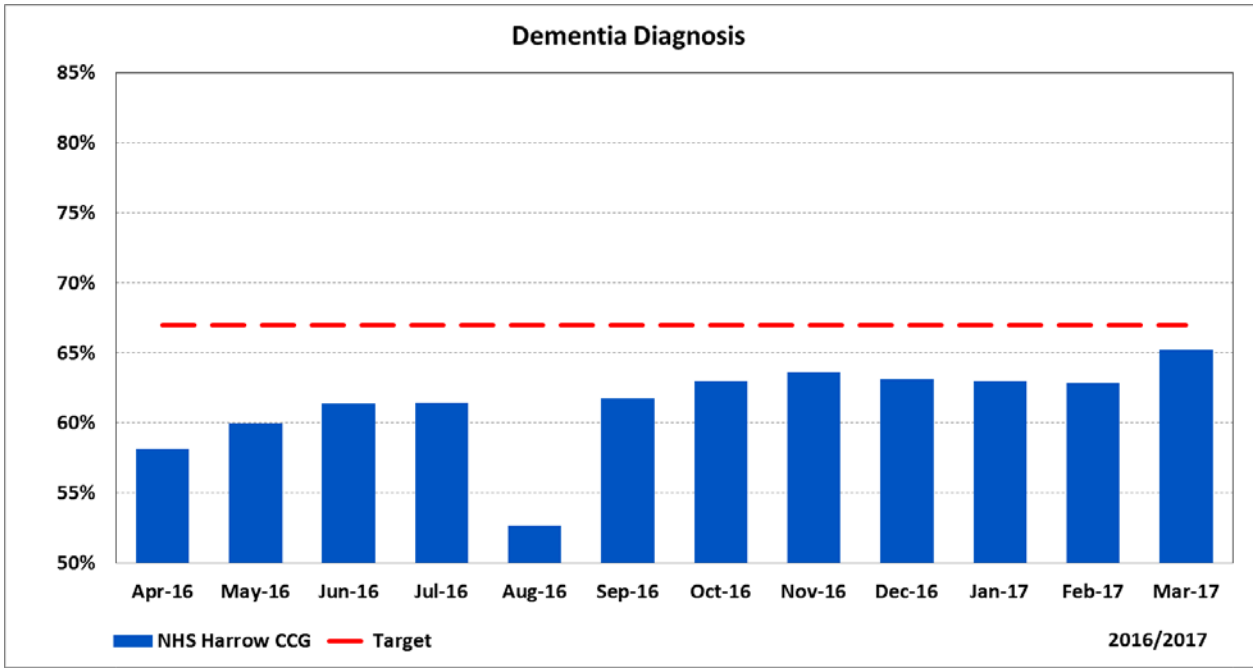
Providers have worked closely with primary care to improve GP referrals. In addition, the service has improved community outreach by partnering with local voluntary sector organisations. There is also a programme in place to increase numbers of self-referrals which is expected to improve recovery. These efforts have enabled the CCG to deliver above its access targets for 2016/17.





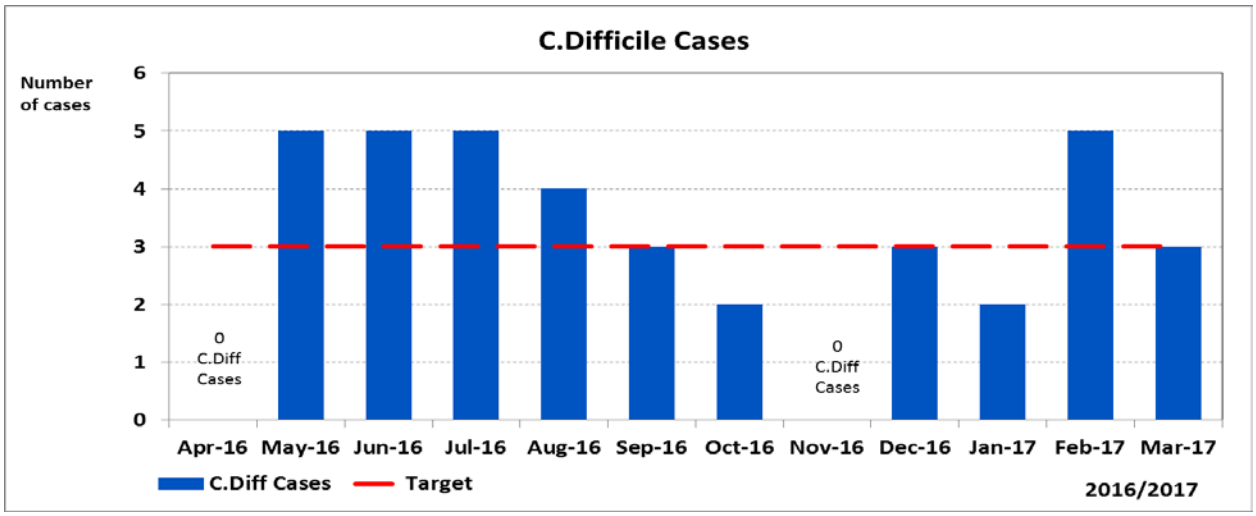
2.2.8 Dementia diagnosis

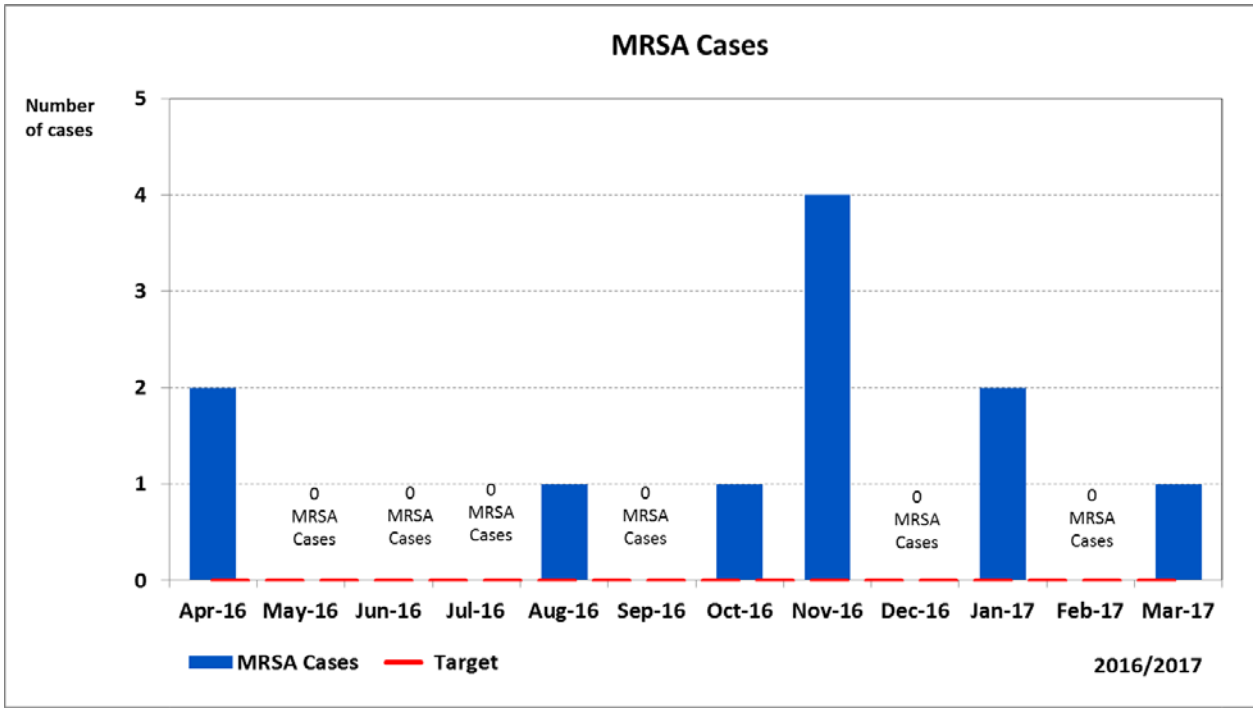
The numbers of patients aged 65 and over who have been diagnosed with dementia has increased significantly during 2016/17. However, the CCG remains under the national target of 66.7%. Actions include increased local engagement and encouragement with GPs and practice managers through peer group meetings and realignment of current resources to deliver a Dementia Intensive Support Team.



2.2.9 Health Care Associated Infections (HCAIs) such as MRSA and C.difficile

Both C.difficile and MRSA targets are not being met by NHS Harrow CCG. The CCG quality team is undertaking a review of HCAI cases across providers including a full post infection review specifically for MRSA cases. A revised assessment form has also been developed to help support the identification of areas of improvement in C. difficile lapses of care.





2.3 Sustainable Development

As an NHS organisation, utilising public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services.

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets, we can improve health in the immediate and long term, even in the context of the rising cost of natural resources.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our carbon footprint.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline).

The majority of the environmental and social impacts are through the services we commission. We work with our providers through the contracting process to make sure sustainability is factored into the services they offer local people.

2.4 Improve quality

NHS Harrow CCG has a statutory duty under Section 14R of the National Health Service Act 2006 (as amended) to report on the performance of a number of services defined nationally within the NHS Constitution, Everyone Counts Guidance for 2015/16 to 2018/19 (Operating Framework) and the NHS Mandated Outcomes Framework.

The Quality and Safety Team works across BHH CCGs to enable effective sharing of resources to focus in on the quality challenges across the three boroughs as well as within the individual CCG area.

Throughout 2016/17, the Quality and Safety Team has provided monthly and quarterly quality

reports to the Quality and Safety and Integrated Governance Committees. These have fed into the Governing Bodies to ensure that CCGs have sufficient information to gain assurance regarding the services they commission. The reports provide an overview of Quality and Safety for the CCGs focusing on the main health providers across BHH CCGs, highlighting good practice and areas for improvement.

The CCGs commit to commissioning quality health services for their patient population. To achieve this, the CCGs hold providers to account through contractual monitoring. To gain assurance regarding the quality of services, the Quality and Safety Team monitor the work of the providers through the Clinical Quality Review Groups (CQRGs) which focus on clinical effectiveness, patient safety, patient experience and leadership.

BHH CCGs work with the other CCGs in NW London with each taking a lead commissioning role for the main contracts. The table below illustrates the current structure for lead and associate commissioning arrangements.

Trust/Provider	Abbreviation	Lead CCG	Used by CCG
Central London Community Health	CLHC	Harrow	Harrow
Central and North West London Mental Health Foundation Trust (Mental Health)	CNWL	Harrow	Brent Harrow Hillingdon
Central and North West London Mental Health Foundation Trust (Community)	CNWL	Hillingdon	Hillingdon
Imperial College Healthcare NHS Trust	ICHT	Hammersmith and Fulham	Brent
London Ambulance Service	LAS	Brent	All of London
London North West Healthcare NHS Trust (Acute)	LNWHT or LNWH	Brent	Brent Harrow
London North West Healthcare NHS Trust Community Services	LNWHT or LNWH	Ealing	Brent Harrow
Royal Brompton Hospitals NHS Foundation Trust	RBHT	NHSE (80%) Hillingdon (20%)	All of England
The Hillingdon Hospitals NHS Foundation Trust	THHFT or THH	Hillingdon	Hillingdon
Urgent Care – Greenbrook at Northwick Park Hospital	N/A	Harrow	Harrow Brent
Urgent Care – Greenbrook at The Hillingdon Hospital	N/A	Hillingdon	Hillingdon
Urgent Care – Care UK at Central Middlesex Hospital	N/A	Brent	Brent
111 – Care UK	N/A	Hounslow	Brent Harrow
111 – Care UK	N/A	Hillingdon	Hillingdon

In addition, there are contracts with other acute Trusts and a number of smaller contracts providing a range of health care including:

- Walk-In Centre service,
- end of life care,
- mental health services,

- dementia support,
- carer support,
- bereavement and counseling,
- interpreting services,
- dermatology,
- termination of pregnancy,
- wheelchairs and
- various community services.

These contracts are managed by the Central Contracts Team for the whole of NW London. To strengthen the monitoring of the quality of these services, BHH CCGs, in 2016, established a substantive quality leadership role for central contracts, working as part of the wider BHH Quality and Safety Team.

This has enabled the development and implementation of a quality monitoring system that satisfies the high expectations BHH CCGs have in gaining quality assurance of all providers they commission services from. This has included regular contract meetings to, among other tasks, review the quality indicators set out in the North West London Core Quality Requirements document (which all providers are expected to adhere to) alongside quality assurance visits, so that concerns or issues regarding quality can be identified at an early stage and dealt with appropriately, in order to mitigate any potential risk to patients.

A summary of performance across the range of NHS Constitution standards is provided in the subsequent paragraphs.

2.4.1 Continuing HealthCare (CHC)

CHC sits in the Quality and Safety Directorate. The service ensures that the BHH CCGs adhered to their statutory responsibilities and that they are discharged in accordance with relevant standing rules and guidance, including the National Framework. The care for those patients eligible for CHC or Children's Continuing Care (CCC) is assessed in collaboration with the patient and their representatives and is deemed appropriate to meet all of the individual's health and associated social care needs. The care commissioned is provided either within or outside the person's home, as appropriate to their assessed needs with regular reviews to ensure that the care package continues to meet their needs.

In 2016/17 the CCG continued to ensure that patients eligible for Continuing Healthcare and Children's Continuing Care have had the right to have a Personal Health Budget. We also started to plan for Personal Health Budgets to be offered more widely, where evidence has indicated an individual could benefit.

2.4.2 Quality and safety monitoring and assurance

The BHH Quality and Safety Team uses four domains to monitor the services commissioned by the CCGs:

- Clinical effectiveness.
- Patient safety.
- Patient experience.
- Leadership and responsiveness.

These domains are aligned to the Care Quality Commission's (CQC's) Key Lines of Enquiry, i.e. Safe, Caring, Responsive, Effective and Well-Led. This enables the team to support providers in measuring themselves against the CQC requirements.

2.4.3 Clinical effectiveness

During 2016/17, the team continued to work with providers to encourage an open and transparent culture. The main providers have shared their Quality Accounts with the CCGs to identify areas for improvement.

The providers submit data on a monthly or quarterly basis to the CCGs which is monitored via a quality dashboard by the Quality and Safety and Clinical Risk/Integrated Governance Committees.

The team has developed a quality alert system to provide an early warning system of themes arising across the health services commissioned by the CCGs. During 2016/17, this system has been implemented in NHS Harrow CCG. This has enabled the team to prompt discussions with providers to ensure improvements are made.

The team has worked with other CCGs across North West London to develop core requirements for quality as well as specific indicators relating to the type of service being provided. These indicators are tracked through the use of a quality and performance dashboard, provider led audits and thematic reviews. These are reviewed by the Clinical Review Quality Groups (CQRGs) which also receive regular reports for clinical audit and assurance of compliance with NICE Guidance by the providers.

2.4.4 Quality assurance visits

The Quality Team has developed a programme of quality assurance visits to services serving the BHH CCGs' patient population across NW London. This has not only enabled concerns to be raised with providers early, but also to enhance the relationship between commissioner and provider, ensuring that patients receive a constantly improving service. The intelligence gained from these visits is triangulated with Serious Incidents (SIs) and complaints and the data and information provided through the CQRGs with the providers.

Visits include:

- **London Ambulance Service (LAS) –** The team has conducted three assurance visits to LAS to review medicines management, operational systems and distribution. These have been documented as part of the CCG assurance reporting programme. The next assurance visits will be shadowing the operational teams and crews and a new pilot for handover breaches in Emergency Departments (EDs).
- **Care Homes –** There are regular visits by the Continuing Health Care Team to homes supporting CCG-funded patients to ensure that our patients are receiving safe, good care. There have also been ad hoc visits to providers by the Quality Team to gain a broader perspective of the quality of care.
- **Main Trusts –** During 2016/17, the BHH Quality Team has undertaken quality visits to a variety of services to gain assurance regarding the quality and safety of the care being delivered by our main commissioned services. This has informed commissioners about the quality of care and enabled the team to work with providers to identify and support service improvement areas.

2.4.5 Mortality

During 2016/17, the BHH Quality and Safety Team has been working with our lead mental health and learning disability trust (CNWL) to strengthen the approach taken to review the deaths of service users with learning disabilities or mental health problems. This has been effective in improving practice for monitoring the physical health of service users with mental health problems. This will be developed in line with the CQC requirements.

Following the CQC publication of its review in December 2016, Learning, Candor and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England, NHS Improvement set out the governance framework that is required for all NHS Trusts to improve how they collect data and publish information on deaths.

The BHH Quality and Safety Team will monitor the development of the framework in each of the Trusts and support the sharing of the learning across NW London.

2.4.6 Patient safety

The Quality and Safety Team manages the SI process for BHH CCGs' main providers. Investigations of SIs are undertaken to ensure that weaknesses in a system and/or process are identified and analysed to understand what went wrong, how it went wrong and what can be done to prevent similar incidents occurring again. The quality of SIs reports from our providers has been under continual scrutiny and assurances have been provided in respect of training of staff in Root Cause Analysis (RCA) investigations.

Investigations of SIs include Never Events, which are key indicators that there have been failures to put in place the required systemic barriers to error. Their occurrence can tell commissioners something fundamental about the quality, care and safety processes in an organisation.

During 2016/17, the team has been able to build and implement an improved system for monitoring the compliance of providers to meet the timescales for reporting of SIs and submission of the investigative reports, as well as enabling the team to draw better intelligence regarding the themes arising from the incidents and measure the impact of the learning of the providers from SIs. This approach has resulted in improved reporting and improved compliance with the National Framework.

2.4.7 Pressure ulcers

A significant aspect of patient safety continues to be in relation to pressure ulcers. A NW London Pressure Ulcer Clinical Network has been revitalised to engage all of the main acute and community NHS Trusts in NW London to work with the CCGs to share good practice and initiatives to reduce the risk of pressure ulcers. It takes a collaborative approach between acute and community providers to implement education and practice improvements across NW London.

2.4.8 Safeguarding

NHS Harrow CCG continues to ensure that all services commissioned for the population of Harrow safeguard children, young people and adults at risk. It has a responsibility to commission services that can support children, young people and adults at risk of harm or neglect, ensuring access is a priority for those most in need. NHS Harrow CCG has policies for Safeguarding Children, Safeguarding Adults and Prevent in place and the commissioning team ensures they are embedded in all contracts with service providers.

The CCG has a dedicated team for safeguarding children and adults and it remains a high priority across all aspects of CCG work. The Safeguarding Team works closely with the Quality Team to ensure the quality of services is good. A Quality Outcomes Framework for Safeguarding Children and Adults has been included in all contracts since April 2016 and this ensures a reporting matrix of Key Performance Indicators (KPI's). KPIs set the standard for safeguarding children and adults within a service and enable the Designated Professionals to review the information and be assured service provision safeguards vulnerable service users.

Through the KPIs, all commissioned services are monitored for their compliance and commitment to safeguarding those at risk and this will include monitoring of training levels in accordance with the Inter-collegiate Document for both children and adults at risk. Use of these documents ensures all health staff working with children or adults at risk are trained to recognise and respond to abuse or neglect at the appropriate level for their role.

KPIs also provide assurance that appropriate safeguarding professionals are in post, as well as help tackle national priorities such as child sexual exploitation, domestic abuse, female genital mutilation, modern slavery and preventing and reducing the incidence of pressure ulcers. The Designated Nurse from the CCG lead commissioner will attend the monthly Clinical Quality Group (CQG) meetings to review the information submitted by the provider. The safeguarding professionals also perform inspections with the quality leads where there have been concerns about safeguarding, safety and quality standards. These visits allow for improved scrutiny while also supporting the provider to make the necessary improvements to the service.

The Designated Professionals support the CCG with service specifications to ensure all commissioned services have safeguarding embedded in service provision. They provide a source of expertise where there are issues about the safeguarding of patients. The Designated Professionals also support and attend the contract monitoring meetings with Harrow Public Health who commission health visiting, school nursing, sexual health services and drug and alcohol services. They also provide advice and support with safeguarding concerns.

The Designated Professionals for safeguarding children and adults provide training for all CCG staff and support training with the Named GPs for GP practices in Harrow. They are also a source of information and support to the GP practices. The Designated Professionals work closely with the Named Professionals/Leads from the provider services and provide supervision on a regular basis.

The Designated Professionals for Safeguarding Children also support the Child Death Overview Panel (CDOP) and cover the rapid response when a child dies unexpectedly. Safeguarding issues are always considered, shared when appropriate with the Local Safeguarding Children Board (LSCB) or NHS Harrow CCG.

NHS Harrow CCG is committed to supporting and working with both the LSCB and the Safeguarding Adult Board (SAB), with representation from the Designated Professionals for Safeguarding, Clinical Leads for Safeguarding and the Assistant Chief Operating Officer Leads for Safeguarding. Annual Reports are produced for both Safeguarding Children and Safeguarding Adults. These reports are reviewed and agreed at the Quality Safety and Clinical Risk Committee and then presented at the Governing Body.

2.4.9 Infection control

Cases of Methicillin Resistant Staphylococcus Aureus (MRSA) Blood Stream Infections (BSIs) are reported and reviewed in line with the national reporting requirements.

All 23 cases across the BHH CCGs – of which seven were in Harrow – were subject to a Post Infection Review (PIR). Outcomes of the PIR are aimed at attributing responsibility for the learning actions and are shared across the health economy. Not all cases have a clear source and set of learning actions for prevention and as such are attributed to a third party. Below is the table of 2016/17 MRSA BSIs.

Methicillin Sensitive Staphylococcus Aureus (MSSA) BSI

While MRSA has been the principle S.aureus of concern, nationally it is recognised that MSSA is on the increase and is now reported on. Although there are no national targets for MSSA BSIs, cases identified in acute settings are reviewed while there are no investigations undertaken for community-acquired cases.

Escherichia coli (E.coli) BSIs

E Coli BSIs have also been on the increase nationally. Currently, there are no investigations undertaken for these cases in the community. Since a significant number of cases are linked to urinary sepsis, action plans are in place to reduce risks of urinary tract infections.

Clostridium difficile Infections (CDIs)

BHH CCGs continue to make progress in reducing the number of CDIs.

Cases in acute settings are subject to a Root Cause Analysis (RCA) to try and identify lapses in care. Any such lapse is followed up with individual remedial actions aimed at preventing similar cases. CDI cases are classified as avoidable or unavoidable.

CCG	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Harrow	0	5	5	5	4	3	2	4	3	2	5

2.4.10 Patient experience

Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS.

NHS Harrow CCG uses a number of measures to monitor patient experience and these are set out below.

Complaints and principles for remedy

BHH CCGs work together to manage complaints and concerns, recognising that complaints, expressions of concern and compliments from the users of health services provide insight into the performance and efficiency of the services they commission. The CCGs use this valuable first-hand intelligence concerning the services they commission to ensure quality, patient-focused services are at the heart of their work. Every person's experience counts.

The CCGs aim to be compliant with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

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

- Openness, transparency and candor throughout the system.
- Importance of narrative as well as numbers within the data.
- Visibility of themes at board level and evidence of response to both individuals and themes.

BHH CCGs aim to ensure 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 and its Principles of Good Complaints Handling 2009.

The aim is to ensure a consistent approach is taken concerning the management and investigation of complaints, regardless of issues raised. 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.

Friends and Family

The Team monitors the compliance of the main providers to the Friends and Family framework at the Clinical Quality Review Groups (CQRGs). This enables the CCGs to gain an understanding of the level of confidence that patients and relatives have in commissioned services. Where insufficient responses are gained, the Quality Team discuss with the provider what other methods of gaining patient engagement are being undertaken to ensure that there is a commitment to constantly improve patient experience.

Quality Impact Assessments

During 2016/17, a quality impact assessment framework has been developed to support the CCGs in evaluating the impact of any changes to the commissioning of services. This will be used, in addition to equality impact assessments, to ensure that there is full consideration of the impact of CCG decisions regarding the commissioning, or decommissioning, of services on patient experience.

2.4.11 Leadership/Responsiveness (Well-Led)

The Quality and Safety Team monitor the quality of the leadership and responsiveness of providers to engage with CCGs and partners to constantly improve services for patients.

A significant way the team gathers this intelligence is from the CQC to monitor the progress of improvements of services and respond to clinical risks that could impact on the safety of patients.

In the year, the CCG was assessed by NHS England under its Improvement and Assurance Framework. The CCG was rated as “Requires Improvement”. Following this, the CCG has put in place a number of measures to improve governance and leadership for 2017/18.

CQC Assurance

Each provider has undergone a CQC inspection under the commission’s new regulatory regime. All providers are supported by their respective BHH Associate Directors for Quality and Safety in the assurance and oversight of CQC action plans. These CQC action plans are captured locally and managed via the individual provider CQRG process. In addition, action plans are shared as part of local quality and safety monitoring.

2.5 Patient and public involvement

This section explains how the CCG has discharged its duty under Section 14Z2 of The NHS Act 2006 (as amended) to involve the public in commissioning (planning, decision-making and proposals for change that will impact on individual or groups and how health services are provided to them).

NHS Harrow CCG is committed to involving, consulting and listening to patients, carers, members of the public and other stakeholders to help us understand the needs, preferences and experiences of our residents so that health services meet their needs.

The CCG's Equality and Engagement Committee oversees and provides assurance of its engagement work. It includes representatives from Healthwatch Harrow and the voluntary sector and is chaired by the governing body lay member for public and patient involvement.

Engagement takes place through a number of approaches that include targeted outreach to stakeholder groups, public events, partnership working with our voluntary sector, and the use of social media so patients and members of the public can have their say about the design and development of local services.

As a result, the CCG provided a range of opportunities for involvement by the public, clinicians and community organisations, with this demonstrated through its engagement with them on the following:

Obtaining views on the CCG's health plans and services

The CCG's 'Healthcare in Harrow' public event in April 2016 provided an update to 94 participants on its health plans and obtained their views on local healthcare services. This included obtaining feedback on BHH CCG's vision and plans for a 24/7 integrated urgent care access, treatment and clinical advice service.

Sustainability Transformation Plan priorities and the CCG's plans to deliver them through its Commissioning Intentions for 2017/18

Members of the public, community organisations and stakeholders such as Public Health, Young Harrow, and Healthwatch, provided feedback on the CCG's STP and Commissioning Intentions at a public event in October 2016.

Further engagement on the STP and Commissioning Intentions took place through an online survey, and with target stakeholder groups – carers, Health and Social Care Voluntary Sector Group, Inter-faith Network, MIND user group and Harrow Patients' Participation Network.

Developing new service models through co-design and empowerment

150 children and young people and over 130 parents and professionals were engaged through workshops and discussions with the CCG to identify and design a user-led model for a health and well-being service for 0 – 18 year olds (up to 25 for young people with additional needs). The engagement work undertaken has informed the CCG and its partners to shape the specification for this service and provide an input into the procurement process.

Helping people to access the right care for them and to self-manage

The CCG engaged with members of the Gorkha, Somali and Middle Eastern communities to provide information on how to access the right NHS services and to improve their understanding of services available.

The Gorkhas were supported to engage with Diabetes UK to help them understand the condition better and how they can help themselves through diet and exercise.

Harrow Health Help Now App provides advice and information, and directs people to the nearest available service. Available on smartphones and PCs, the App was promoted through outreach to community groups, via Harrow Patients' Participation Network and health fairs to patients, at stalls located in public settings and through the CCG's social media channels. Over 5,000 downloads of the App by Harrow residents were completed.

Improving healthcare pathways and quality of services

The Right Care programme initiative involved service users, carers, Harrow Council, providers and clinicians coming together with the CCG at a number of workshops covering dementia, MSK, cancer and respiratory disease. These focused on developing together patient-centred approaches to achieve better outcomes for those affected by the aforementioned, which have been used to develop project proposals.

Understanding the benefits and challenges of delegated commissioning of primary care in Harrow

Engagement activities have been part of an on-going programme of work to ensure that not only Members (GP practices) are kept informed on what's entailed in the move to delegated commissioning, but also patient groups through Harrow Patients Participation Network (HPPN), and the public through the CCG's website.

Patients' preferences on engagement to improve local NHS building and facilities

As part of the NW London-wide information gathering survey to develop a better understanding of how patients want to be engaged on the development of hubs and GP practices, the CCG engaged with the Somali and Afghani community to obtain their input.

Obtaining perspectives on the CCG's engagement and communications

Discussions with a variety of community organisations and representatives helped to obtain a range of perspectives to inform the CCG's approach to engagement and its current communications, including from migrant community, young people, Somali women and Voluntary Action Harrow. These will be used to develop the CCG's Engagement and Communications Strategy for 2017 to 2020 to further strengthen public and stakeholder involvement in its work.

Developing the patients' voice

The CCG worked with HPPN, which it funds, to develop the patients' voice through Patients Participation Groups (PPGs) comprising the network. This included joint HPPN and CCG meetings to provide information and develop dialogue on areas of work, such as proposed health plans and delegated commissioning.

2.6 Reducing health inequality

This section explains how the CCG discharged its duty under Section 14T of the National Health Service Act (as amended), having regard to the need to reduce inequalities.

The CCG also publishes a Public Sector Equality Duty Report annually which can be found on our website.

The Equality Act 2010 provides a framework for NHS Harrow CCG to work towards eliminating discrimination and reducing inequalities in the heath of local people. The Act sets out the 'personal nine' characteristics protected by legislation. This effectively ensures that everyone is protected from discrimination as one or more characteristic will apply to all as they include age, race and ethnicity, pregnancy and maternity, marriage and civil partnership, disability, gender re-assignment, religion or belief, gender and sexual orientation.

NHS Harrow CCG is committed to meeting its equality and diversity duties across all its work,

policies and functions. Each year it provides a performance update on our progress, working towards reducing inequalities.

Equality objectives

The CCG collaborated with Healthwatch Harrow, Public Health, Mencap and Shaping a Healthier Future (SaHF) programme staff to take a partnership approach towards establishing a number of equality objectives that focus on driving improvements in the local community's health. The objectives are aligned to the four overarching themes of the NHS equalities framework (Equalities Delivery System 2), and are delivered through a range of activities including commissioning, workforce development, provider contracts monitoring, engagement and communications within Harrow's communities. We will be working with our stakeholders in the next year to review and revise our current equality objectives and to develop new ones for 2017 to 2021.

Equality Delivery System (EDS2)

The NHS' equalities reporting framework helped us to identify what we are doing well, what we need to improve on and the equality gaps and risks that we will need to address. The CCG's approach to date has been to self-assess its progress against the EDS2 framework, which highlighted gaps in our work. We are addressing this by working towards developing a partnership approach to improving and assessing our performance.

NHS Workforce Race Equality Standard (WRES)

The WRES helps NHS organisations to address race equality issues in a range of staffing areas and report on this against nine indicators. The CCG workforce is too small for the WRES indicators to be applied properly, so it collaborated with its neighbouring CCGs (Brent and Hillingdon) to submit a jointly co-ordinated WRES report in May 2016. Some of the key data on workforce race equality indicators is highlighted below.

- BME workforce representation increased, including in Agenda for Change bands 8-9 and Very Senior Management posts
- White staff are 1.28 times relatively more likely to be appointed from shortlisting across all posts compared to the rate of 2.48 times greater, which was the case in the previous year and
- Access to non-mandatory training and CPD is 1.89 times relatively greater for BME staff, compared to 0 times previously.

Equality Analysis

As part of ensuring that the CCG gives 'due regard' to equalities in its commissioning plans, policy development and any proposed service changes, Equality Impact Assessments (EIAs) are undertaken. These help to ensure that there is no negative or disproportionate effect on any particular protected group, and that all measures to eliminate or minimise any such effect have been considered.

EIAs were reported to the Equality and Engagement Committee for scrutiny, with these including on the QiPP schemes and Future in Mind Business Case.

To ensure that EIAs are embedded as integral to the CCG delivering service improvements, guidance on undertaking EIAs has been developed for implementation in 2017 onwards.

Partnership working

A key part of the CCG's work on tackling health inequalities has been to collaborate with its partners on the Health and Wellbeing Board to agree priorities to address key health challenges in the borough, as detailed in Harrow's Health and Well-being Strategy 2016/20.

As a commissioner of healthcare, the CCG has a duty to ensure that NHS providers are meeting their statutory duties under the Public Sector Equality Duty. The CCG regularly monitors the providers' performance, patient experience and service access, as well as work with them to gauge their progress on meeting their equality duties, including on implementation of the Accessible Information Standard. Our providers publish their equality compliance reports annually on their websites.

Workforce training

One of the key ways the CCG can foster inclusion and reduce health inequalities is through training of its staff to be 'equality-aware' in their work. All staff and governing body members were mandated to either complete or refresh their knowledge on diversity through in-house training. Training on reflecting social value in procurement processes was provided to commissioners, which will help the CCG to consider and address some of the social determinants of poor health through its procurement of services.

Communications

The CCG significantly grew its digital presence to reach diverse audiences by extending its communications channels across key social media platforms – website, Twitter, Facebook, YouTube and Instagram. The CCG continued to fine-tune its website for accessibility, and increased its twitter following with this being the largest across North West London CCGs. It actively used social media to communicate health messages in an appropriate, accessible way to local people – most importantly via the Harrow Health Help Now App.

Accountability Report

Cllr. Shah (Harrow's Mayoress) cuts the ribbon at the opening of a new Walk-in-Centre

The Accountability Report comprises of the:

- Corporate Governance Report
- Remuneration and Staff Report
- Parliamentary Accountability and Audit Report

Rob Larkman
Accountable Officer
NHS Brent, Harrow and Hillingdon CCGs
Date: 24 May 2017

Corporate Governance Report

The Corporate Governance Report outlines the composition and organisation of the CCG governance structures and how they support the achievement of the CCG's objectives.

This report comprises of the:

- Members' Report
- Statement of the Accountable Officer's Responsibillities
- Governance Statement

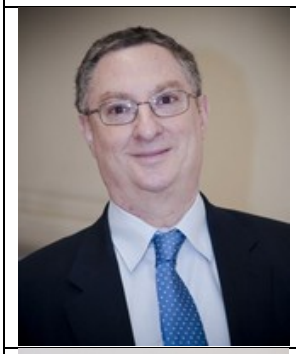
3 Members' Report

NHS Harrow CCG is responsible for planning and commissioning health services for the people of the London Borough of Harrow. Set up in 2013, the CCG operates in accordance with its Constitution with a governing body made up of lay members, clinicians and executive directors.

3.1 Member profiles

		Biography
	**Dr Amol Kelshiker** Chair and Clinical Director	Amol works at The Pinn Medical Centre and has a special interest in diabetes and cardiology. A Harrow resident for more than 40 years, Amol has worked in the borough as a GP for more than half of that time and passionately believes in reducing dependence on hospitals, allowing more patients to be treated in their GP practice and ensuring continuity of care.
	**Dr Kaushik Karia** Vice Chair and Clinical Director	Kaushik is a GP with a special interest in gynaecology, working at the Aspri Medical Centre. He has worked in the area for more than 20 years. Kaushik would like to see the delivery of quality clinical care to our patients closer to their homes and believes that access to the health care system in Harrow needs to improve, something that can be done by enhancing resources in primary care.
	**Dr Dilip Patel** Clinical Director Resigned 31 March 2017	Dilip has been involved with the local health system for 30 years as a clinician and a member of various health related committees. Based at the Civic Medical Centre, he's a GP with a diverse range of interests including diabetes, ischemic heart disease and urology.

	**Dr Genevieve Small** Clinical Director	Genevieve is the Named GP for Safeguarding Children for NHS Harrow. She was brought up in Harrow and has worked in the borough for more than ten years. She is currently at The Ridgeway Surgery and is passionate about strong community services enabling patients to access services that are more responsive to their day-to-day needs.
	**Dr Shahla Ahmad** Clinical Director Appointed 20 June 2016	Shahla has been a dedicated partner for over 16 years at the GP Direct practice in Harrow. She has a specialist interest in mental health, paediatrics and prevention. Shahla is dedicated to making robust and efficient pathway changes to improve experiences for all patients in Harrow. She has lived in Harrow for most of her life and would like to see the best possible provision of Harrow services for her patients.
	**Dr Shaheen Jinah** Clinical Director Appointed 6 June 2016	Shaheen is currently a sessional GP at Roxbourne Medical Centre and The Pinn Medical Centre where she has worked since 2003. She grew up in Harrow and completed her medical degree at University College London (UCL) and GP training in Reading as part of the South Oxfordshire GP training scheme. Shaheen has a special interest in mental health, gynaecology and reproductive healthcare. In June 2013, she moved to Alberta, Canada for two years where she worked as a Rural Physician, helping to set up maternity and teenage health clinics.
	**Dr Sharanjit Takher** Clinical Director Appointed 1 September 2015	Sharanjit is a GP with a special interest in paediatrics, working at the Enderley Road Medical Centre. He worked at the practice as a trainee doctor and was inspired to become a GP by his time there. Among his many clinical interests and roles, Sharanjit is involved in the care of residents at a nursing home for neuro-disability, performs minor surgery and joint injections and teaches local medical students.

	**Dr Sandy Gupta** Secondary Care Consultant	Sandy is the Consultant Cardiologist at Whipps Cross and St Bartholomew's Hospitals since 1999. He has a keen interest in research concerning inflammation and heart disease and was awarded a British Heart Foundation (BHF) research fellowship.
	**Ian Holder** BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees Appointed 21 July 2016	Ian previously held roles as a Non-Executive Director (NED) and Deputy Chair for an NHS Foundation Trust providing mental health and community services where he also went on to chair the Audit Committee. He is a chartered accountant with extensive experience as a director of multinational companies and formerly a mentor for the Institute of Chartered Accountants (ICAEW) Financial Leaders of the Future Programme. Ian's specialities include being an organisational consultant, executive coach and senior accredited BACP registered counselling psychotherapist.
	**Gerald Zeidman** Deputy Chair and Lay Member Contract completed 31 March 2017	Gerald is a pharmacist and a Fellow of the Royal Pharmaceutical Society. Gerald has been a Non-Executive Director of a number of former NHS health authorities. Currently Gerald is Chief Officer of Bedfordshire Local Pharmaceutical Committee.
	**Richard Smith** Lay Member Appointed 18 July 2016	Richard has spent his career helping organisations to get the best from the people who work for them and where people give their best to their organisations. Specialising in leadership development, managing change, and the effectiveness of senior teams, he held senior posts in retail, manufacturing, IT and banking industries. Richard now leads an international consulting practice, and is an author on change management. He has been a Harrow resident for over 30 years.

	**Sanjay Dighe** Lay Member	Sanjay is responsible for Patient and Public Engagement. He is also the principal of a company specialising in financial risk management. He is an honorary director of Third Sector Potential, a social enterprise supporting the voluntary sector. Sanjay is the Chair of the BBC Trust's London Audience Panel.
	**Rob Larkman** Accountable Officer	Rob Larkman has been an NHS Chief Executive for over 20 years in both provider and commissioning organisations. He has a background in financial management and has worked in advertising and management consultancy before joining the NHS in 1993. He was Chief Executive of NHS Camden between 2002 and 2009 and, more recently, was the Chief Executive of the Whittington Hospital before moving to North West London.
	**Paul Jenkins** Interim Chief Operating Officer Appointed 11 January 2017	In a career in the NHS spanning 28 years, Paul is an experienced health and social care system commissioner. He has held a range of board-level management positions in NHS commissioning and hospital provider roles. Throughout his career Paul has led major programmes of service redesign across primary, secondary care and mental health and has experience of commissioning in all dimensions of health care and primary care contracting. Paul also has held director portfolios covering information management and technology and performance improvement. He joined NHS Harrow CCG in January 2017, but has worked previously in NW London as deputy chief executive at Westminster Primary Care Trust and managing director with NW London's acute commissioning partnership. Paul has held a number of trustee appointments with charitable not-for-profit organisations focused on health promotion, HIV and sexual health, and supporting people with and alcohol and drug addictions.

	**Javina Sehgal** Chief Operating Officer Seconded out from 23 January 2017	Javina has been chief operating officer for NHS Harrow CCG since April 2013. Previous to this she has been the acting borough director and borough director of NHS Harrow PCT, as well as the deputy borough director. Previous to this she had senior roles in the social services departments of Brent, Hammersmith and Fulham councils.
	**Neil Ferrelly** Chief Finance Officer	Neil has worked in NHS Finance for more than 35 years and has experience from both acute trusts and in NHS commissioning roles. Before coming to NW London CCGs, Neil was the director of finance at North West Surrey CCG. Before that, he was Primary Care Trust (PCT) Director of Finance at Harrow, West Sussex and Kingston and the Joint Chief Finance Officer of both NHS Richmond CCG and NHS Kingston CCG. Neil has a vital role supporting clinical commissioners to ensure that the CCGs' resources are used to provide the best health outcomes for people in Brent, Harrow and Hillingdon.
	**Alex Faulkes** Director of Delivery and Performance Appointed 1 April 2016	Alex has over 16 years of experience working in the NHS, spanning acute hospitals, mental health trusts and specialist providers. He joined BHH CCGs from Croydon Health Services NHS Trust, where he was Associate Director of Performance, Contracting and Planning. Before that he headed up the performance and planning team at Great Ormond Street Hospital and has also held a general management role at King's College Hospital. His portfolio includes performance monitoring and management across the three BHH CCGs as well the London Ambulance Service on behalf of CCGs across London.

	**Diane Jones** Director of Quality and Safety Appointed 1 March 2017	Diane has worked in the NHS for over 25 years and is a trained midwife. She joined BHH CCGs from NHS Greenwich CCG where she was the Director of Integrated Governance, and took up her new role in March 2017. Diane has significant leadership experience, having worked at senior management level for the past 10 years. Prior to her role at NHS Greenwich CCG, Diane was Deputy Nurse Director with NHS Redbridge CCG.
	**Andrew Howe** Director of Public Health, Harrow Council	Andrew is the jointly appointed Director of Public Health for Barnet and Harrow Councils. He moved to Harrow in 2008 and previously worked as the Director of Public Health for NHS Blackpool and Blackpool Council.
	**Mina Kakaiya** Representative, Healthwatch Harrow	Mina has over twenty years of working in the health and social care sector, especially within the NHS mental health field, and has a proven track record of working in social work and community development. Mina was part of a team that helped guide the improvement of East London NHS Foundation Trust's translation services and in developing culturally responsive wellbeing services in Hackney.

3.2 Member practices

Our population is served by 34 GP practices that make up NHS Harrow CCG's membership.

NHS Harrow CCG member practices	
Aspri Medical Centre	Kenton Clinic
Bacon Lane Surgery	Kings Road Surgery
Belmont Health Centre	Northwick Surgery
Circle Practice	Pinn Medical Centre
Civic Medical Centre	Pinner Road Surgery
Elliott Hall Medical Centre	Pinner View Medical Centre
Enderley Medical Centre	Ridgeway Surgery
Enterprise Practice	Roxbourne Medical Centre
First Choice Medical Care	Savita Medical Centre
GP Direct	Shaftesbury Medical Centre
Mollison Way Surgery	Simpson House
Hatch End Medical Centre	St Peters Medical Centre
Headstone Lane Medical Centre	Stanmore Medical Centre

Headstone Road Surgery Honeypot Medical Centre Kenton Bridge Medical Centre (Dr Golden) Kenton Bridge Medical Centre (Dr Raja)	Stanmore Surgery Streatfield Health Centre Streatfield Medical Centre Zain Medical Centre

3.3 Composition of Governing Body

The main function of the Governing Body is to ensure that the CCG has appropriate arrangements in place to ensure it exercises its functions effectively, efficiently and economically, and in accordance with any generally accepted principles of good governance that are relevant to it.

The Governing Body leads on setting the vision and strategy, approves commissioning plans, monitors performance against plan, and provides assurance of strategic risks.

Governing Body members		
Name	**Title**	**Voting/ non-voting**
Dr Amol Kelshiker	Chair and Clinical Director	voting
Dr Kaushik Karia	Vice Chair and Clinical Director	voting
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	voting
Dr Genevieve Small	Clinical Director	voting
Dr Shahla Ahmad Appointed 20 June 2016	Clinical Director	voting
Dr Shaheen Jinah Appointed 6 June 2016	Clinical Director	voting
Dr Sharanjit Takher	Clinical Director	voting
Dr Sandy Gupta	Secondary Care Consultant	voting
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	voting
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	voting
Gerald Zeidman Contract completed 31 March 2017	Deputy Chair and Lay Member	voting
Richard Smith Appointed 18 July 2016	Lay Member	voting
Sanjay Dighe	Lay Member	voting
Rob Larkman	Accountable Officer	voting
Paul Jenkins Appointed 11 January 2017	Interim Chief Operating Officer	non-voting
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	non-voting
Neil Ferrelly	Chief Finance Officer	voting
Alex Faulkes Appointed 1 April 2016	Director of Delivery and Performance	non-voting
Diane Jones Appointed 1 March 2017	Director of Quality and Safety	voting
Ann Jackson Appointed 1 January 2017 Resigned 28 February 2017	Interim Director of Quality and Safety	voting

Jan Norman Resigned 31 December 2016	Director of Quality and Safety	voting
Andrew Howe	Director of Public Health, Harrow Council	non-voting
Mina Kakaiya	Representative, Healthwatch Harrow	non-voting

More information on the Governing Body members can be found in the Governance Statement.

3.4 Committees, including Audit Committee

3.4.1 Audit Committee

NHS Harrow CCG holds meetings in common with Brent and Hillingdon CCGs. The main purpose of the Audit Committee is to scrutinise the governance, risk management and internal control arrangements put in place to ensure the achievement of organisational objectives. It also ensures the adoption of best practice in the conduct of public business and stewardship of public funds.

Its membership comprises:

Audit Committee members	
Name	**Title**
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees
Dr Dilip Patel Resigned 31 March 2017	Clinical Director
Gerald Zeidman Contract completed 31 March 2017	Lay Member

3.4.2 Executive Committee

The purpose of the CCG Executive Committee is to ensure the strategic and operational arrangements of the CCG are effective and enable the CCG to achieve the objectives and performance.

The Executive Committee is authorised through the scheme of delegation and standing financial instructions, among others, to undertake a range of duties.

These include ensuring the strategic and operational arrangements of the CCG and enabling 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.

Executive Committee members		
Name	**Title**	**Voting/ non-voting**
Dr Amol Kelshiker	Chair and Clinical Director	voting
Dr Kaushik Karia	Vice Chair and Clinical Director	voting
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	voting
Dr Genevieve Small	Clinical Director	voting
Dr Shahla Ahmad Appointed 20 June 2016	Clinical Director	voting

Dr Shaheen Jinah Appointed 6 June 2016	Clinical Director	voting
Dr Sharanjit Takher	Clinical Director	voting
Rob Larkman	Accountable Officer	voting
Paul Jenkins Appointed 11 January 2017	Interim Chief Operating Officer	non-voting
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	non-voting
Neil Ferrelly	Chief Finance Officer	voting
Alex Faulkes Appointed 1 April 2016	Director of Delivery and Performance	non-voting
Diane Jones Appointed 1 March 2017	Director of Quality and Safety	voting
Ann Jackson Appointed 1 January 2017 Resigned 28 February 2017	Interim Director of Quality and Safety	voting
Jan Norman Resigned 31 December 2016	Director of Quality and Safety	voting
Gilbert George	Interim Head of Governance	non-voting

3.5 Register of Interests

NHS Harrow CCG maintains a register of interests that details names of individuals and details of their interest. Individuals will declare any interest they have, which may lead to a conflict with the interests of the CCG in relation to any decision to be made by the CCG.

The CCG has developed proactive mechanisms for managing conflicts of interest, and potential conflicts of interest, in such a way as to ensure that they do not, and do not appear to, affect the integrity of the CCG decision-making.

The Register of Interests and our Conflicts of Interest Policy is available on the CCG website.

3.6 Raising concerns – whistleblowing arrangements

The CCG has a policy and procedure in place for staff and external parties to raise concerns without fear of reprisal or victimization which demonstrates the CCG's commitment and support to those who may need to come forward.

Concerns may relate to unlawful conduct, financial malpractice or malpractice related to patients, employees, the public or the environment.

Where concerns have been raised, the CCG has carried out an investigation following the due process outlined in our Raising Concerns (Whistleblowing) Policy and reported the outcomes as appropriate.

3.7 Personal data related incidents

In 2016/17, NHS Harrow CCG reported no personal data related incidents to the Information Commissioner's Office.

3.8 Statement of disclosure to Auditors

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

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

3.9 Modern Slavery Act

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

4 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 (NHSE). NHSE has appointed the Accountable Officer of NHS Harrow CCG.

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

- the propriety and regularity of the public finances for which the Accountable Officer is answerable,
- for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction).
- for safeguarding the CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities). The relevant responsibilities of accounting officers under Managing Public Money.
- ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)).
- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHSE 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 Group Accounting Manual issued by the Department of Health and in particular to:

- observe the Accounts Direction issued by NHSE, 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 Group Accounting Manual 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 under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter, except that the CCG did not meet the following statutory financial duties:

- For expenditure not to exceed income: as expenditure exceeded income by £1.3million
- For revenue resource use not to exceed the amount specified in Directions: as the amount was exceeded by £1.3million

I also confirm that:

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

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

5 Governance Statement

5.1 Introduction and context

NHS Harrow CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended). The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended).

The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

NHS England is supported by legislation in exercising formal powers of direction if it is satisfied that a CCG is (a) failing or (b) is at risk of failing to discharge its functions. Formal intervention action would be proposed, as laid out in section 14Z21 of the NHS Act 2006 (as amended).

As of 1 April 2016, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006. A full list of formal powers of direction can be viewed on the NHSE website.

5.2 Scope of responsibility

The Accountable Officer has responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which he is personally responsible, in accordance with the responsibilities assigned to him in Managing Public Money. He also acknowledges his responsibilities as set out under the National Health Service Act 2006 (as amended) and in his Clinical Commissioning Group Accountable Officer Appointment Letter.

The Accountable Officer is responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. He also has responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

5.3 Governance arrangements and effectiveness

5.3.1 CCG Constitution and structure

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

The above is set out in The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b).

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

- Determination of the arrangements by which the members of the CCG approve those decisions that are reserved for the membership.

- Consideration and approval of applications to NHSE on any matter concerning changes to the CCG's constitution, including terms of reference for the CCG'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.
- Approval of the arrangements for identifying practice members to represent practices in matters concerning the work of the CCG and appointing clinical leaders to represent the CCG's membership on the CCG's Governing Body, for example through election (if desired).
- Approval of 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 (incorporating gifts, hospitality and sponsorship) Policy, Anti-Bribery Policy, and a Conflicts of Interest Policy.

In addition, jointly with NHS Brent and Hillingdon 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 NHSE 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.

5.3.2 Governing Body

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

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 of any CCG (e.g. unregistered)
- Commissioning emergency care for anyone present in London Borough of Harrow.
- Paying its employees' remuneration, fees and allowances in accordance with the determinations made by 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 via the Joint Remuneration Committee.

The main areas of work undertaken during 2016/17 included oversight of the work of the committees that report to the Governing Body, establishing CCG objectives for 2016/17. Other areas include:

- Oversight of the work of the committees that report to the Governing Body and supporting a review of the governance structures and member participation,
- Governing Body members led a number of the CCG's events this year and presented at local community groups. These events gave local residents an opportunity to learn about key health initiatives and to give them a chance to feedback on local services.
- Further refined risk registers and closely monitored of strategic risks facing the CCG through the Board Assurance Framework (BAF).

- Governing Body members took part in a dedicated procurement workshop refreshing knowledge on procurement panel processes, the overall procurement process, flexibility and exceptionality and transparency work.
- Reviewed and approved of various business cases to shape service pathways/delivery and improve patient outcomes.
- Directly supported the development of the CCG's Commissioning Intentions.

Performance of the Governing Body

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.

Governing Body committees will follow a similar process from 2017/18 with the outcomes considered by the Governing Body as part of a wider annual review of performance. In addition, with the assistance of an external consultant, the CCG has conducted organisational development seminars.

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

[Note: For voting/non-voting status, refer to table in section 3.3]

Governing Body Members			
Name	**Title**	**Present/ deputy**	**Absent**
Dr Amol Kelshiker	Chair and Clinical Director	6	0
Dr Kaushik Karia	Vice Chair and Clinical Director	6	0
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	6	0
Dr Genevieve Small	Clinical Director	4	2
Dr Shahla Ahmad Appointed 20 June 2016	Clinical Director	5	1
Dr Shaheen Jinah Appointed 6 June 2016	Clinical Director	5	1
Dr Sharanjit Takher	Clinical Director	4	2
Dr Sandy Gupta	Secondary Care Consultant	5	1
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	2	4
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	0	0
Gerald Zeidman Contract completed 31 March 2017	Deputy Chair and Lay Member	6	0
Richard Smith Appointed 18 July 2016	Lay Member	4	2
Sanjay Dighe	Lay Member	5	1
Rob Larkman	Accountable Officer	1	5
Paul Jenkins Appointed 11 January 2017	Interim Chief Operating Officer	2	4
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	4	2

Neil Ferrelly	Chief Finance Officer	5	1
Alex Faulkes Appointed 1 April 2016	Director of Delivery and Performance	3	3
Diane Jones Appointed 1 March 2017	Director of Quality and Safety	1	0
Ann Jackson Appointed 10 January 2017 Resigned 28 February 2017	Interim Director of Quality and Safety	0	1
Jan Norman Resigned 31 December 2016	Director of Quality and Safety	3	3
Andrew Howe	Director of Public Health, Harrow Council	6	0
Mina Kakaiya	Representative, Healthwatch Harrow	4	2

5.3.3 Audit Committee

The Committee reviews the establishment and maintenance of effective systems of integrated governance, risk management and internal control across the whole of NHS Harrow CCG's activities, designed to support the achievement of the CCG's objectives. Its work dovetails with that of NHS Harrow CCG's Integrated Governance and Finance, QIPP and Performance committees, which it has established to seek assurance that robust clinical quality is in place.

The Audit Committee reviews the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any appropriate independent assurances, prior to endorsement by NHS Harrow CCG's Governing Body,
- the underlying assurance processes that indicate the degree of achievement of each of NHS Harrow CCG's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements,
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification and
- the policies and procedures for all work related to fraud, bribery and corruption as set out in the NHS Protect Standards for Commissioners and as required by NHS Protect.

In carrying out this work, the Audit Committee primarily uses the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It also seeks reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This is evidenced through the Audit Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

In discharging these responsibilities, the Audit Committee has focused 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 the financial control environment assessments, closely monitoring the contracting database developments, monitoring the refinement of risk management and overseeing the extension of internal audit and counter fraud contracts.

The Committee was appointed as the Audit Panel (approved by BHH CCGs Governing Bodies) to oversee the procurement, and recommend appointment of, external auditors to undertake external audit services across the eight NWL CCGs, from 1 April 2017.

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 recognised that conflicts of interest perceived or real, posed a particular challenge for NHS Harrow CCG. To ensure that all dealings were beyond reproach, it oversaw the ongoing development of the conflicts of interest policy, specific arrangements to oversee the co-commissioning of primary care services with NHSE and transparency in the management of conflicts of interest. In so doing, the Committee met on six occasions with attendance as follows:

Audit Committee Members			
Name	**Title**	**Present/ (deputy)**	**Absent**
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	3	1
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	2	0
Gerald Zeidman Contract completed 31 March 2017	Deputy Chair and Lay Member	5	1
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	1	5

5.3.4 Executive Committee

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

- ensures the CCG has arrangements in place to comply with the processes to review and measure performance set out in the mandate,
- works in partnership with its local authority to develop joint strategic needs assessments and joint health and well-being strategies,
- ensures that health services are provided in a way that promotes awareness of, and has regard to, the NHS Constitution
- acts with a view to securing continuous improvement to the quality of services,
- assists and supports NHSE in relation to its duty to improve the quality of primary medical services,
- promotes the involvement of patients, their carers and representatives in decisions about their healthcare,
- secures continuous improvement to the quality of services,
- promotes innovation, research and the use of research and
- acts 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 CCG
- considers that this would improve the quality of services or reduce inequalities.

Areas reviewed by the Committee included:

- draft Annual Governance Statement,
- QIPP governance processes,

- GP practice budget setting,
- operating plan activity and narrative,
- managing the conflict of interest process for the Chairs and Clinical Director election process,
- access to phlebotomy services in Harrow,
- improving access to primary care through walk-in centres,
- primary care co-commissioning model,
- improving early diagnosis of dementia,
- improving Access to Psychological Therapies (IAPT),
- Board Assurance Framework (BAF) summary reports,
- Harrow quality strategy and work plan,
- Healthy London Partnership,
- LNWHT Recovery Plan,
- primary care ICT and interoperability,
- terms of reference of the BHH CCGs Education Forum,
- Harrow Better Care Fund – BCF plan,
- NWL STP – Strategic Transformation Plan and
- Tier 3 primary care delegation application to NHSE.

To discharge these duties, it has met on 10 occasions during the year with attendance as follows:

Executive Committee Members			
Name	**Title**	**Present/ (deputy)**	**Absent**
Dr Amol Kelshiker	Chair and Clinical Director	10	0
Dr Kaushik Karia	Vice Chair and Clinical Director	9	1
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	8	2
Dr Genevieve Small	Clinical Director	10	0
Dr Shahla Ahmad Appointed 20 June 2016	Clinical Director	7	3
Dr Shaheen Jinah Appointed 6 June 2016	Clinical Director	3	5
Dr Sharanjit Takher	Clinical Director	9	1
Rob Larkman	Accountable Officer	6	4
Paul Jenkins Appointed from 11 January 2017	Interim Chief Operating Officer	2	0
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	8	2
Neil Ferrelly	Chief Finance Officer	10	0
Alex Faulkes Appointed 1 April 2016	Director of Delivery and Performance	3 (2)	5
Diane Jones Appointed 1 March 2017	Director of Quality and Safety	1	0
Ann Jackson Appointed 10 January 2017 Resigned 28 February 2017	Interim Director of Quality and Safety	0	0
Jan Norman Resigned 31 December 2016	Director of Quality and Safety	7	0
Gilbert George	Interim Head of Governance	10	0

5.3.5 Procurement Panel

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

- 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 propose single tender sourcing.
- Oversee the sourcing and implementation of 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 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 10 occasions. In these meetings, items for discussion included:

- phlebotomy,
- cardiology,
- Walk-in centres,
- Harrow Health Limited contract,
- care management LIS (Local Improvement Scheme) and
- medicines optimisation support

Procurement Panel members			
Name	**Title**	**Present/ (deputy)**	**Absent**
Gerald Zeidman Contract completed 31 March 2017	Lay Member	10	0
Sanjay Dighe	Lay Member	7	3
Mukesh Panchal	Associate Lay Member	6	4
Dr Sandy Gupta	Secondary Care Consultant	8	2
Rob Larkman	Accountable Officer	2	8
Paul Jenkins Appointed from 11 January 2017	Interim Chief Operating Officer	3	0
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	6	2
Neil Ferrelly	Chief Finance Officer	(7)	3
Alex Faulkes Appointed 1 April 2016	Director of Delivery and Performance	0	10
Diane Jones Appointed 1 March 2017	Director of Quality and Safety	0	1
Ann Jackson Appointed 10 January 2017 Resigned 28 February 2017	Interim Director of Quality and Safety	0	0
Jan Norman Resigned 31 December 2016	Director of Quality and Safety	5	0

Gilbert George	Interim Head of Governance	2	8

5.3.6 Other Governing Body committees

Finance, Research and Quality, Innovation, Prevention and Productivity (QIPP) Committee

The purpose of the Finance, Research and Quality, Innovation, Prevention and Productivity (QIPP) 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 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 and
- receive and review business cases and procurement procedures as required.

Over the year, items for discussion included:

- 2016/17 initial budgets and financial plan
- Performance reports
- Finance reports
- QIPP Project Management Office reports
- Draft NWL financial strategy
- Interim community beds procurement
- End of life single point of access.

To discharge these responsibilities, the Committee met on 12 occasions during the year.

Quality Safety and Risk Committee

The Quality, Safety and Clinical Risk Committee works to provide assurance that the CCG and its committees and subcommittees have in place the proper process for monitoring quality, safety, risk and driving improvement.

The general areas of responsibility for the committee are to:

- seek assurance that the Commissioning Plan and strategy for the CCG fully reflects all elements of quality (patient experience, effectiveness and patient safety), keeping in mind that the strategy and response may need to adapt and change,
- 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),
- provide oversight and assurance of the process and compliance issues concerning SIs,
- receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans,
- ensure a clear escalation process, including appropriate trigger points, 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 and
- have responsibility for CCG information governance compliance and monitoring provider information governance compliance.

During 2016/17 the committee has:

- monitored the quality and safety risks of commissioned services,
- reviewed monthly integrated performance and quality reports, focusing on the exceptions regarding quality risks and mitigating actions,
- embedded quarterly reports which have provided the committee with an overview of quality and safety risks and priorities,
- considered key areas in more depth including themes and learning from SIs, pressure ulcers,
- received annual reports in relation to both adults and children's safeguarding,
- monitored and discussed the challenges faced by the CCG in relation to continuing and complex care,
- examined the Quality Account for CNWL, the mental health trust, as the lead commissioner, to enable the CCG to submit a statement on behalf of NW London CCGs,
- reviewed the priorities within the Quality Accounts of those providers for which the CCG is an associate commissioner or those out of area to ensure that the CCG is sighted on the quality of their commissioned services and
- scrutinised the quality impact of changes to commissioning of services such as medicines management.

To discharge these responsibilities, the Committee met on 12 occasions during the year.

Equality and Engagement Committee

The purpose of the Equality and Engagement Committee is to meet the public sector equality duty. It does this by:

- providing oversight and assurance that the CCG is eliminating unlawful discrimination harassment, victimisation and 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,
- making 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 CCG and
- promote the involvement of patients, their carers and representatives in decisions about their healthcare.

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

During 2016/17 the Committee focused on:

- assuring that the CCG is responsive to the needs of deaf people or those with hearing impairments through the services it commissions,
- ensuring the public and patients are engaged on proposed service development, procurement and commissioning, with feedback acted upon,
- improving representation by the voluntary sector on the Committee, with this extended to the Voluntary Sector Forum and
- making sure the Equality Impact Assessment process is applied through screening, with a full assessment undertaken where required, and the outcomes of either reported to the Committee

5.3.7 Joint committees with delegated decision making authority

Local Primary care co-commissioning and eight Joint Committees in North West London

The CCG has entered into joint arrangements known as primary care co-commissioning with NHSE which are designed to enable the CCG to better influence the development of local primary care. Primary care co-commissioning will enable the CCG to ensure that primary care acts as a driver for ambitious plans to transform the local health and care economy, both locally and across NW London.

The local Primary Care Co-Commissioning Committee meets monthly. A meeting in common of the eight joint committees in North West London takes place quarterly (NHS Brent, Harrow, Hillingdon, Central London, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs).

The shared vision for primary care co-commissioning places GPs at the centre of organising and coordinating care for people, seven days a week, through both individual practices and practice networks. By aligning this work with transformation work across NW London, co-commissioning is designed to achieve the following:

- Services that are joined up, coordinated, and easily navigated, with more services available closer to people's homes,
- High quality out-of-hospital care and improved access to services,
- Improved health outcomes, equity of access, reduced inequalities, and better patient experiences
- Enhanced local patient and public involvement in developing services, with a greater focus on prevention, staying healthy, and patient empowerment.

The meetings held in common have focused on devising a coordinated NW London approach to key strategic issues, such as the implementation of the Strategic Commissioning Framework and strategic approaches to estates development and the Personal Medical Services (PMS) review.

Harrow's local joint committee has focused on formulating CCG-specific Commissioning Intentions for the reinvestment of the local PMS premiums, the development of local estates strategies, and the deployment of funds through the Primary Care Transformation Fund. It has also considered the commissioning of APMS contracts. The private sections of the local meetings have considered confidential practice issues, including contract performance issues and have had oversight of action plans to address these.

The joint committees have also worked hard to engage local stakeholders (including Healthwatch Harrow and the Health and Wellbeing Boards) in co-commissioning. Through

the NW London primary care transformation team, the joint committees have also supported lay member co-commissioning education sessions, including on the local primary care landscape, primary care finance, and the methodologies of the PMS review.

In December 2016, NHS Harrow CCG applied to become a level three delegated CCG taking full responsibility for the commissioning of primary medical services, subject to members agreement. On 15 February 2015, members of the CCG voted in favour of level three delegation, there was a turnout of 88% of practices. 78% of practices voted in favour.

NHS Harrow CCG will take on responsibility for commissioning primary care medical services from 1 April 2017. NHS Harrow CCG will establish a committee of the Governing Body in order to carry out these functions. The final terms of reference will be adopted into the CCG's constitution and these will have effect from 1 April 2017. With full delegation, NHS Harrow CCG expects to be able to commission services in a more integrated way, be more responsive to patients and to general practitioners.

5.3.8 Other Joint Committees

North West London (NWL) CCGs' collaboration board (a non-statutory joint committee for consultation and for decision making in limited areas)

This committee brings together eight CCG chairs, two Accountable Officers and shared directors, together with lay members and Healthwatch Harrow representation, to discuss joint strategic objectives and proposals. This allows the NW London CCGs to seek a consensus view, taking into account the needs of local health populations, before proposals and recommendations are discussed in each CCG.

The board serves to guide the CCGs' overall approach to the annual contracts rounds and to develop a business intelligence and informatics strategy. In limited areas, the board has delegated authority from the CCGs in which it can take joint decisions. For instance, it takes decisions in response to the recommendations of NWL CCGs' Policy Development Group on Individual Funding Requests (IFRs) and Planned Procedures with a Threshold (PPwTs). In all cases regarding financial investment, the CCGs' Standing Financial Instructions are adhered to and the local decision making routes are followed.

North West London (NWL) CCGs' collaboration board (a non-statutory joint committee for consultation and for decision making in limited areas)

The collaboration board serves to guide the CCGs' approach to developing joint strategy, including business intelligence and informatics strategy, and also spends time at the beginning of the contracts round providing feedback on the approach to be taken, led by the NW London CCGs' director of contracting, performance and procurement. In limited areas, the board has delegated authority from the CCGs in which it can take joint decisions. For instance, it takes decisions in response to the recommendations of NWL CCGs' Policy Development Group on Individual Funding Requests (IFRs) and Planned Procedures with a Threshold (PPwTs) as to what healthcare treatment may be funded in the boroughs and against which criteria. In all other cases regarding financial investment, the CCGs' respective local Standing Financial Instructions are adhered to and the local decision making routes are followed.

A key focus of collaboration during 2016/17 was to accelerate and deepen the development of the NW London STP, with a large contingent of the board's membership also meeting regularly together with a range of stakeholders via the Strategic Planning Group for NW London. Since the publication of the STP, the board's strategy meetings have been re-orientated to ensure that health commissioners explore in depth the progress within and across the five 'delivery areas' and three 'enablers' of the STP, and provide rigorous challenge to the executive arm of the sector.

5.3.9 Clinical Board

The Clinical Board provides clinical advice for the Shaping a Healthier Future (SaHF) re-configuration programme, ensuring that the approach to implementation across primary and secondary care is clinically sound and that clinical safety and quality are protected during the implementation period.

Its responsibilities include:

- Monitor and manage clinical risk to patients and the clinical delivery of services across NWL during reconfiguration implementation, agreeing collective action to address any issues.
- Lead clinical implementation planning, in particular advising on safe sequencing of change and readiness for change.
- Provide expert clinical advice on other programme deliverables if needed, including local workstream deliverables.
- Seek advice, where necessary, from:
  - the NW London Clinical Senate (once established),
  - the Governing Body and
  - the Clinical Networks – expert advisory groups of clinicians in the key areas of maternity, paediatrics and emergency and urgent care.
- Commission the Clinical Networks/Clinical Implementation Groups to provide advice on any specialty-specific implementation issues.

5.3.10 Shaping a Healthier Future (SaHF) Implementation Programme Board

The Implementation Programme Board oversees the implementation of the Shaping a Healthier Future reconfiguration programme in line with decisions taken by the NW London Joint Committee of Primary Care Trusts (NW London JCPCT, formed in 2012 and then comprised the eight NW London PCTs and three neighbouring PCTs – Camden, Richmond, Wandsworth).

The Programme Board has responsibilities to:

- bring together local commissioners and local providers to jointly manage reconfiguration implementation,
- plan, manage progress, resolve issues and manage risks and interdependencies,
- receive and discuss progress reports from workstream leads,
- track system-wide delivery of QIPP and Cost Improvement Plans and enabling projects as they pertain to the delivery of Shaping a Healthier Future reconfiguration by, for example, delivery of admissions avoidance and reductions in length of stay,
- receive and discuss key programme deliverables, in particular:
  - system-wide deliverables such as common modelling assumptions,
  - Outline Business Case (OBC) and Final Business Cases (FBCs) for capital expenditure,
- ensure the different parts of the programme maintain sufficient focus on issues relating to clinical risk, workforce, travel and access, equalities and carers and that appropriate patient engagement continues,
- ensure appropriate links are made with other strategic programmes and organisations outside NW London and
- ensure the CCG complies with information governance requirements to new and emerging priorities and risks.

5.4 UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Corporate Governance Code.

However, the CCG draws on best practice from the code in the areas of:

- Leadership – members having collective responsibility for the long term planning of the CCG
- Effectiveness – committee members having the appropriate balance of skills, experience, independence and knowledge to enable them to discharge their respective duties and responsibilities effectively.
- Accountability – members determining the nature and extent of the significant risks they are willing to take to achieve the CCG strategic objectives

5.5 Discharge of statutory functions

In light of recommendations of the 1983 Harris Review, the Clinical Commissioning Group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, the Accountable Officer can confirm that the Clinical Commissioning Group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

5.6 Risk management arrangements and effectiveness

5.6.1 Risk management strategy

The Risk Management and Assurance Strategy published in 2015 outlines NHS Harrow CCG's approach to risk management and its vision in relation to assurance systems. NHS Harrow CCG has a responsibility to ensure that it is effectively governed in accordance with best practice across corporate, clinical and financial governance.

Every activity that NHS Harrow CCG 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 organisation achieving its objectives.

Risk management aims to draw attention to actual or potential problems and to encourage the appropriate response to them. Risks are managed by the people who have the greatest ability to control them.

Successful risk management involves:

- identifying and assessing risks,
- taking action to anticipate or manage them,
- monitoring them and reviewing progress in order to establish whether further action is necessary or not and
- ensuring effective contingency plans are in place.

Through the management of risk, NHS Harrow CCG seeks to minimise, though not necessarily eliminate, threats and maximise opportunities. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Governing Body and management is not surprised by risks that could, and should, have been foreseen.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk.

Considered risk taking is encouraged, together with innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety and reduce our financial, operational and reputational risks through awareness, competence and management.

NHS Harrow CCG risk management processes ensure that risks are identified, assessed, controlled, and when necessary, escalated. These main stages are carried out through:

- clarifying objectives,
- identifying threats to the objectives,
- defining and recording risks,
- completion of the risk register and identifying actions and
- escalation of risks.

The risks NHS Harrow CCG is specifically exposed to 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 – HM Coroner reports, media, national reports, new legislation, surveys, reports from assessments/inspections by external bodies (e.g. CQC), reviews of partnership working, horizon scanning.
- Liaison – through practice visits, locality meetings, GP Forums, patient engagement forums, practice feedback forms and practice manager meetings.

The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level. For example, from a directorate (workstream) risk register to the corporate register, or from the team risk register to the directorate risk register. Risks are reviewed according to assigned domains by the appropriate CCG committee.

The Governing Body is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. By articulating its appetite for risk taking, the Governing Body makes clear that:

- some element of risk taking is necessary to allow the CCG to seize important opportunities,
- risk taking is more acceptable in some areas than in others and
- there is a point at which the management of a risk should be immediately escalated to the direct oversight of the Senior Management Team.

A formal risk appetite statement sets a clear process for the management of risk and enhances the reporting of any instances where the appetite and specific risk thresholds are reached.

The Governing Body will review its risk appetite on an annual basis or during times of increased uncertainty or adverse changes. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the Governing Body to determine the organisational capacity to control risk.

The Governing Body has a risk appetite matrix, which uses specific risk domains, it scores each risk against the national risk scoring matrix, determining a category of low, moderate, high or significant.

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.

Embedding risk management

Our processes for embedding risk management include:

Raising awareness

Staff will have an awareness and understanding of the risks that affect patients, visitors, and staff.

- Risk identification – line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.
- Accountability – staff will be identified to own the actions to tackle risks.
- Communication – there will be active and frequent communication between staff, stakeholders and partners.

Competence

Staff will be competent at managing risk.

- Training – staff will have access to comprehensive risk guidance and advice. Those who are identified as requiring more specialist training to enable them to fulfil their responsibilities relevant to their roles will have this provided internally
- Behaviour and culture – senior management will lead change by example, ensuring risks are identified, assessed and managed. All staff are encouraged to identify risks.

Management

Activities will be controlled using the risk management process and staff are empowered to tackle risks.

- Risk assessment and management – risks will be assessed and acted upon to prevent, control, or reduce them to an acceptable level. Staff will have the freedom and authority, within defined parameters, needed to take action to tackle risks, escalating them where necessary. Contingency plans will be put in place where required.
- Process – the process for managing risk will be reviewed to continually improve. This will be integrated with our processes for providing assurance, and the processes of our stakeholders and any relevant third parties.
- Measuring performance – exposure to risk will be measured with the aim of reducing this over time. The culture of risk management will also be measured and improved during the lifetime of this strategy.

Public stakeholder engagement

NHS Harrow CCG actively promotes patient and public involvement via partnership working and effective external and internal communication, website and intranet. The process for managing risk will be reviewed to continually improve. This will be integrated with our processes for providing assurance, and the processes of our stakeholders and any relevant third parties.

Control mechanism

There are different operational levels of risk governance in the CCG:

- Governing Bodies,
- Audit Committee,
- Finance and Performance Committee,
- Quality Safety and Clinical Risk Committee,
- Equality and Engagement Committee,
- Procurement Panel,
- The Executive (management) and
- workstream forums.

Risk management by the Governing Body is underpinned by a number of interlocking systems of control:

- Board Assurance Framework (BAF) sets out the strategic objectives, identifies risks inrelation to each strategic objective along with the controls in place and assurances available on their operation
- Corporate Risk Register (informed by Team, Work Stream Directorate risks) is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly, it demonstrates that an effective risk management approach is in operation within the organisation
- Audit and other committees exist to provide scrutiny and assurance of the robustness of risk processes and to support the Governing Body.

Prevention of risk

Best practice says each work-stream, team and directorate will have a forum where risk is discussed, including the risk register, actions, and any required escalation.

The CCG has both formal and informal mechanisms for identifying risks to achieving its objectives. One element of pro-active risk management is prevention. Prevention is embedded within the operation of the CCG through:

- an 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 and
- the impact assessment of all policies, practices, procedures and decisions to ensure equality and diversity compliance.

Horizon scanning can identify positive areas for NHS Harrow CCG to develop its business and services, taking opportunities where these arise. NHS Harrow CCG will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scan, NHS Harrow CCG is better able to respond to changes or emerging issues in a planned structured coordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach, it should consider on-going risks to commissioned services.

NHS Harrow CCG’s Governing Body has the responsibility to horizon scan and formally communicates matters in the appropriate forum relating to their areas of accountability.

Deterrent to risks arising

Although internal controls are in place, reliance on external organisations to perform key functions exposes NHS Harrow CCG to some risk of fraud and bribery. Measures to mitigate these risks are included in the Anti-Fraud and Anti-Bribery Policy and addressed as part of the Local Counter Fraud Specialist Work-plan 2016/17.

Operational risks are recorded and managed through the corporate risk register or through the BAF if it is deemed that 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.

5.6.2 Capacity to handle risk

The Accountable Officer has overall responsibility for risk management and discharges 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 and
- 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 controls and assurances in respect of each risk. 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 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 and Clinical Risk Committee has overarching responsibility for clinical risk management, information governance and health and safety risks.
- The Finance, Research and Quality, Innovation, Prevention and Productivity Committee (QIPP) Committee continuously assesses financial and non-financial risks relating to the QIPP plans and ensures the CCG has in place measures and mitigations 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.

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.

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 member of the Governing Body.

It is overseen by the Director of Quality and 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.

To ensure continued progress in the implementation of effective risk management, as outlined in the risk management and assurance strategy, the CCG has developed a risk training programme plan for different levels of risk management responsibilities and accountabilities:

- Operational.
- Management.
- Executive.

Review of effectiveness

The 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. This draws on performance information available. The review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.

The CCG has been advised on the implications of the result of the review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, Finance and Performance Committee and Quality Safety and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

5.6.3 Risk assessment

Using the risk and control framework, risk assessment is conducted in a systematic manner across all aspects of the CCG's strategic and operational goals.

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 and is fully mitigated, it may direct that the risk be removed from the assurance framework.

Risks to governance, compliance, management and internal control

As part of the approved internal audit plan for 2016/17, internal auditors were asked to undertake an audit of the CCG's BAF and risk management and information governance.

The internal auditors concluded that the CCG has adequate and effective framework for risk management, governance, internal control and information governance. They have identified further enhancements to the framework of risk management, governance, internal control and information governance to ensure that it remains adequate and effective.

The BHH CCGs have detailed a governance improvement plan informed by the findings and recommendations of a jointly commissioned independent review.

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.

Ref	Strategic Objectives	Summary Descriptor
1a	Improve the health and wellbeing of people in Harrow by commissioning high quality and safe services	Failure to deliver the Harrow Health and Wellbeing Strategy
2a	Involve and empower the people of Harrow in shaping of local services	Failure to actively engage public in an effective manner to support the shaping of local services
3a	Manage resources effectively ensuring best value and deliver financial balance	There is a risk that financial pressures lead to the CCG not achieving the financial plan, causing the statutory duty not to be met and an inability to improve services for the local population
3b	Manage resources effectively ensuring best value and deliver financial balance	There is a risk that unplanned provider activity results in the CCG not achieving the required efficiency savings while improving service quality which would lead to increased financial pressure in future years
4a	Implement our Local Services Strategy – primary care driving development and delivery of integrated care	There is a risk that delayed moves of services into the community will cause local QIPP programmes not to be achieved, reducing delivery against commissioning outcomes
5a	Develop robust and collaborative commissioning arrangements	There is a risk that silo working on individual organisations' priorities lead to the CCG and its partners not innovating to jointly commission services
5b	Develop robust and collaborative commissioning arrangements	Providers may fail to deliver services to the required standard within contracts without the CCG being aware or able to take timely action which could lead to avoidable harm to patients and the CCG not meeting its statutory responsibilities
6a	Improving performance in line with the NHS Constitution	There is a risk that pressures on provider services impacts on their ability to achieve national standards while maintaining patient care
7a	Empowering people of Harrow to keep well and have a positive experience of care when they require it	There is a risk that the CCG does not communicate sufficient information and clarity (with recognition of inequalities) to facilitate understanding, enabling people to make the right choices

Principal risks to compliance

The principal risks to compliance with NHS Harrow CCG's continued authorisation 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?
- Are CCGs commissioning services within their financial allocations?

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 authorisation is obtained from the NHSE self-assessment process and regular review meetings with NHSE.

Governing Body oversight

The main function of the Governing Body is to ensure that the CCG has arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant.

The Governing Body has responsibility for:

- assurance, including audit and remuneration,
- assuring the decision-making arrangements,
- oversight of arrangements for dealing with conflict of interest,
- agreeing the vision and strategy,
- formal approval of commissioning plans on behalf of the CCG,
- oversight of performance and
- providing assurance of strategic risks.

The Governing Body is responsible for the strategic direction of the CCG and for assuring the achievement of key health, wellbeing, financial, performance and service targets. It is directly accountable to the public, GP member practices of the CCG and NHSE.

5.7 Other sources of assurance

5.7.1 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.

5.7.2 Annual audit of conflicts of interest management

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

2016.

An internal audit on conflicts of interest management was conducted in line with the scope and approach contained within the NHSE framework. The internal audit review covered the five domain areas totalling 27 controls.

- Governance arrangements.
- Declarations of interests and gifts and hospitality.
- Registers of interests, gifts and hospitality and procurement decisions.
- Decision making processes and contract monitoring.
- Reporting concerns and identifying and managing breaches/ non-compliance.

The internal audit concluded with a Reasonable Assurance on compliance. The CCG was fully compliant on 70% of the 27 standards whilst the remaining 30% were either partially or non-compliant and management is agreeing actions to improve compliance in these areas.

5.7.3 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.

5.7.4 Information Governance

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

The CCG submitted level two satisfactory compliance on their annual Information Governance Toolkit. As part of the compliance process, a cyber-security and information governance internal audit was completed. The governance audit concentrated on the process of the Registration Authority, information governance training and the information governance framework. The cyber security audit focused on network security, malware prevention and system configurations.

As a result of this work, the CCG is undertaking a range of actions in 2017/18. This includes updating its cyber security policy.

The CCG’s continuing commitment is as follows:

- We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information.
- We have established an information governance management framework and have developed information governance processes and procedures in line with the information Governance Toolkit.
- We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.
- There are processes in place for incident reporting and investigation of SIs. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

The Director of Informatics has given assurance that the IT operating model, which includes backup and disaster recovery mechanisms, is in place and embedded in the operations of the informatics team. The model is supported by the terms of the service level agreements that underpin the service.

5.7.5 Business critical models

The CCG has an appropriate framework and environment in place to provide quality assurance of business critical models, in line with the recommendations in the Macpherson Report.

All business critical models have been identified and that information about quality assurance processes for those models has been provided to the Shaping a Healthier Future (SaHF) Implementation Programme Board.

5.7.6 Third party assurances

The CCG requests service auditor's reports from its third party providers for those providers it engages with directly. Where contracts are managed nationally by NHS England the Service Auditor's Reports are made available to CCGs via the NHS England SharePoint site. The Service Auditor's Reports are also made available to the CCGs external auditors as part of the year end audit.

5.7.7 Health and safety

The CCG recognises its responsibility to ensure that reasonable precautions are taken to provide a safe working environment and to prevent or minimise the causes of fires or other health and safety issues, in compliance with relevant statutes and codes of practice.

During the year, improvements were implemented following risk assessments with respect to the working environment, the systems in place including fire precautions and response arrangements and the information and training provided to staff.

NHS Brent, Harrow and Hillingdon CCGs have received professional health and safety and fire safety support to fulfil the role of the Competent Person throughout 2016/17 (i.e. an individual with the appropriate skills and training). Advice, support and training is available for all staff, including those volunteering for specific roles in the event of an emergency. A health and safety working group examines and coordinates the CCG's health and safety arrangements, described in a framework, and the response to incidents and near misses. A training needs analysis was undertaken with the HR department and specified health and safety training is mandatory, the completion of which is monitored by the working group and included in reports received by Governing Body's committees.

The CCGs have a work-plan for the Health and Safety group's activities through 2017/18 and priorities include the implementation of policy arrangements in identified risk areas, ensuring expert advice arrangements and ensuring appropriate training to staff.

5.7.8 Complaints

NHS 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 and its Principles of Good Complaints Handling 2009.

The aim is to ensure that a consistent approach is taken concerning the management and investigation of complaints, regardless of issues raised. 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 2016 to 31 March 2017, the CCG received a total of 24 complaints:

13 of these related to commissioning decisions taken by the CCG, of these, three related to the individual funding request process and five concerned NHS Funded healthcare. All were investigated and responded to under the NHS complaints procedure.

One complaint concerned primary care contractors and was forwarded to NHSE for investigation and response.

10 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.

Complaints referred to Parliamentary and Health Service Ombudsman

During the 2016/17 financial year, the CCG received two requests by the Parliamentary and Health Service Ombudsman (PHSO) for independent review.

The first matter related to CHC and the recovery of costs following a retrospective review. This was partly upheld by the PHSO.

The second matter related to the treatment of a patient received in a care home and is still subject to PHSO review.

The CCG acted on recommendations made by the PHSO and implemented actions within the requested timelines.

As a matter of policy, PHSO reports are shared with the relevant CCG staff in order to ensure that the relevant procedures and processes are embedded.

5.7.9 Freedom of Information (FOI)

The CCG, as statutory body for the purposes of the FOI Act, is required to respond to requests for information within 20 working days. It must either confirm that it does not hold the information or provide the information requested. The Act allows the CCG to exempt disclosure of some types of information where it is correct to do so and that it is in the public interest. The requester can refer the case to the Information Commissioner's Office (ICO) which has the regulatory duty to ensure public authorities comply with the Act and can investigate the CCG's decision and handling of requests.

In 2016/17, NHS Harrow CCG received 305 requests. This is a 16% increase on the 2015/2016 volume.

The CCG responded to 83% of requests within 20 working days. This is compared to 80% achieved in the previous year. The ICO has set an expectation for public authorities to aspire to 85% of all requests to be responded to in 20 working days.

5.7.10 Emergency planning preparedness and resilience

Emergency preparedness, resilience and response is defined by a series of statutory responsibilities under the Civil Contingencies Act 2004 and the 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 this legislation, NHS Harrow CCG collaborates with NHS Brent and Hillingdon CCGs to develop incident response and threat-specific plans (e.g. cold weather and severe weather plans) to ensure we continue to deliver our 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.

BHH CCGs are committed to collaboratively implementing an integrated and dynamic business continuity management system which is aligned to ISO 22301, and an emergency preparedness and response capability to ensure the continued delivery of safe and effective healthcare commissioning and management across outer North West London.

NHS Harrow CCG has incident response plans and procedures in place, which are fully compliant with NHS England's, Emergency Preparedness 2015 Guidance. The CCG regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing and exercising this plan, the results of which are reported to the Governing Body.

5.8 Control issues

Control issues – specifically the in-year deficit position, underlying financial position and mitigating actions – are set out in more detail in section 5.9.1.

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

The role of the Governing Body

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance.

The Governing Body receives regular reports summarising the financial performance of the CCG. In addition, its committees, including the Audit Committee, have important roles to play in assuring the Governing Body on the arrangements in place to secure economic, efficient and effective use of resources.

The Audit Committee provides the CCG's Governing Body with an independent and objective view of the CCG's efficiency and effectiveness, use of resources financial and control systems, financial and business information.

Jointly with NHS 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 of high quality care,
- the CCG to tackle cross borough issues,
- maximum influence in negotiating and managing contracts with key providers,
- shaping of the provider landscape in NW London and
- economies of scale.

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

- the NW London STP,
- primary care co-commissioning with NHS and
- a common financial strategy to deliver Shaping a Healthier Future.

Quality of leadership indicator

NHSE carry out an assessment based on four key lines of enquiry to determine how robustly the leaders of a CCG are performing their role. The indicator is based on four key lines of enquiry, concerning:

- robust culture and leadership sustainability,
- quality,
- governance, including financial governance and
- engagement and involvement.

Evidence-based assessments are made by NHS England local teams and moderated regionally and nationally in a process overseen by regional directors and the director of NHS operations and delivery.

There are four levels of assessment - Green Star (highest), Green, Amber, Red (lowest).

Harrow were rated Amber (based on latest assessment 2016/17 Q2). An action plan is now in place to address these issues.

5.9.1 In-year and underlying financial position

In-year financial position

The CCG's planned surplus in 2016/17 was £0.1m (0.03% of recurrent Revenue Resource Limit). The outturn position for 2016/17 is a deficit of £1.3m. The deficit was the result of overspends on acute contracts, continuing care and prescribing costs. These were partly off-set by underspends on community and primary care budgets as well as additional in-year support from the risk share arrangement across NHS Brent, Hillingdon and Harrow CCGs.

Underlying financial position

The CCG had an underlying deficit of £9.9m at the end of 2016/17. The difference between the in-year deficit of £1.3m and the underlying position of is accounted for by a combination of additional in-year allocations and other non-recurrent underspends.

Financial plans going forward

In 2017/18, the CCG's resource allocation has increased by £38.6m. £30.6m relates to the CCG taking on responsibility for commissioning primary medical services. The remaining £8.0m increase relates to growth applied to the CCG core allocation. The CCG is planning for an in-year deficit of £21.2m (£6.5% of recurrent Revenue Resource Limit) and an underlying deficit of £9.1m (2.8% of recurrent Revenue Resource Limit).

A two year recovery programme of work is in place to ensure that the CCG is financially sustainable going forward.

5.9.2 Delegation of functions

The CCG has not delegated any of its functions (no delegated chains) during the 2016/17 financial year.

5.9.3 Counter fraud arrangements

NHS 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.

NHS Harrow CCG 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.

NHS Harrow CCG will take all necessary steps to counter fraud and bribery in accordance with this policy, the NHS Protect Standards for Commissioners, the policy statement, Applying Appropriate Sanctions Consistently, published by NHS Protect and any other relevant guidance or advice issued by NHS Protect. NHS Harrow CCG also has a Standards of Business Conduct (gifts, hospitality and commercial sponsorship) Policy.

RSM Risk Assurance Services LLP provides the counter fraud provision on behalf of the CCG and appoints an Accredited Local Counter Fraud Specialist to undertake the counter fraud work proportionate to identified risks.

The CCG Audit Committee receives a report against each of the Standards for Commissioners on an annual basis demonstrating executive support and direction for a proportionate proactive work plan to address identified risks.

5.10 Head of Internal Audit Opinion

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:

> In accordance with the Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance statement. Our list of opinions is provided in Appendix A.

The head of internal audit opinion

For the 12 months ended 31 March 2017, the head of internal audit opinion for NHS Harrow Clinical Commissioning Group is as follows:

Head of internal audit opinion 2016/2017
The organisation has an adequate and effective framework for risk management, governance and internal control. **However our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.**

Factors and findings which have informed our opinion

The **Cyber Security** review was given a PARTIAL ASSURANCE opinion. It confirmed the CCG's known risks and the need for Security Improvement Projects (SIP) that will bring enhanced technologies to manage cyber threats. A number of control deficiencies were found across various cyber security themes including Firewalls and Internet Gateways; Secure Configuration; User Access Control; Malware Protection and Patch Management. Management has agreed an action plan and is in the process of implementing the agreed actions.

The **Continuing Healthcare** review was given a PARTIAL ASSURANCE opinion. An increase in demand, particularly around high cost cases such as fast track palliative care, meant that the duration of care was longer than expected. This strong demand for Continuing Healthcare had resulted in increased and substantial overspends against planned budgets. Additional work by the Value Care Organisation recently brought in to conduct some analysis on demand and patient activity should help the CCGs to assess demand more accurately moving forwards, which in turn will inform the budget setting process.

Following on from our work in 2015/16 on a complaint to NHS England regarding a procurement exercise conducted by the CCG we undertook a follow up exercise to review the implementation of actions. We found that overall the quality of the procurement processes examined as part of this review was considerably stronger than those which we had previously reviewed and there was a clearer process which added considerable rigour and transparency to the procurement process.

We have issued SUBSTANTIAL ASSURANCE opinions on the following reports:

- Budget Setting, Budgetary Control and Financial Reporting
- Financial Feeder Systems
- Primary Care Co – Commissioning
- Payroll Feeder Systems

We have issued REASONABLE ASSURANCE opinions on the following reports:

- Clinical Governance
- Procurement and Conflicts of Interest
- Quality, Innovation, Productivity and Prevention (QIPP)
- Conflicts of Interest

We have also issued one ADVISORY report relating to the Board Assurance Framework Review – Deep Dive Review.

Agreed action plans are in place for the above reports and we will follow up on the implementation of actions and provide updates to the Audit Committee as part of our Progress Report.

Further issues relevant to this opinion

We have also reviewed the Service Auditor Report from the internal auditors of NHS Shared Business Services, who via a contract with NHS England, provide services to the CCG. The Service Auditor Report did not raise any significant control issues which impacted on this opinion.

Issues judged relevant to the preparation of the annual governance statement

Based on the work we have undertaken on the CCG's system on internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS). However, the CCG may wish to consider whether any other issues have arisen, including the results of any external reviews which it might want to consider for inclusion in the Annual Governance Statement.

Scope of the opinion

The opinion does not imply that internal audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. As such, the assurance framework is one component that the board takes into account in making its annual governance statement (AGS).

As a practising member firm of the Institute of Chartered Accountants in England and Wales (ICAEW), we are subject to its ethical and other professional requirements which are detailed at http://www.icaew.com/en/members/regulations-standards-and-guidance.

The matters raised in this report are only those which came to our attention during the course of our review and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made.

Recommendations for improvements should be assessed by you for their full impact before they are implemented.

This report, or our work, should not be taken as a substitute for management's responsibilities for the application of sound commercial practices. We emphasise that the responsibility for a sound system of internal controls rests with management and our work should not be relied upon to identify all strengths and weaknesses that may exist. Neither should our work be relied upon to identify all circumstances of fraud and irregularity should there be any.

This report is supplied on the understanding that it is solely for the use of the persons to whom it is addressed and for the purposes set out herein. Our work has been undertaken solely to prepare this report and state those matters that we have agreed to state to them.

This report should not therefore be regarded as suitable to be used or relied on by any other party wishing to acquire any rights from RSM Risk Assurance Services LLP for any purpose or in any context. Any party other than the Board which obtains access to this report or a copy and chooses to rely on this report (or any part of it) will do so at its own risk. To the

fullest extent permitted by law, RSM Risk Assurance Services LLP will accept no responsibility or liability in respect of this report to any other party and shall not be liable for any loss, damage or expense of whatsoever nature which is caused by any person's reliance on representations in this report.

This report is released to you on the basis that it shall not be copied, referred to or disclosed, in whole or in part (save as otherwise permitted by agreed written terms), without our prior written consent.

We have no responsibility to update this report for events and circumstances occurring after the date of this report.

RSM Risk Assurance Services LLP is a limited liability partnership registered in England and Wales no. OC389499 at 6th floor, 25 Farringdon Street, London EC4A 4AB.

APPENDIX A: ANNUAL OPINIONS

The following shows the full range of opinions available to us within our internal audit methodology to provide you with context regarding your internal audit opinion.

Annual opinions

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

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

- There are weaknesses in the framework of governance, risk management and control such that it could be, or could become, inadequate and ineffective.

- The organisation does not have an adequate framework of risk management, governance or internal control

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

This review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. It draws on the performance information available. It is also informed by comments made by the external auditors in their annual audit letter and other reports.

The assurance framework provides evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed.

The Accountable Officer has been advised on the implications of the result of this review by:

* the Governing Body,
* the Audit Committee,
* if relevant, the Risk/Clinical Governance/Quality Committee,
* internal audit and
* other explicit review/assurance mechanisms.

5.12 Conclusion

The role and conclusions of each of the above was that the CCG had adequate and effective framework for risk management, governance and internal control.

However, as stated in section 1.8.1, the CCG recognises it has had weaknesses in its governance and decision-making. It has implemented an action plan to address these weaknesses which is monitored by the Audit Committee on behalf of the Governing Body.

An updated plan is being drawn up for 2017/18 to help the CCG build on the range of work undertaken so far.

Remuneration and Staff Report

6 Remuneration Report

6.1 Remuneration committee

The remuneration committee meets in common across BHH CCGs. Membership comprises the Chair of each CCG and a lay member from each CCG. The committee met once during 2016/17 with attendance as follows:

Member	Title	Present	Absent
Dr Amol Kelshiker	Chair and Clinical Director	1	0
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	0	0
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	0	0
Gerald Zeidman Contract completed 31 March 2017	Deputy Chair and Lay Member	1	0
Sanjay Dighe	Lay Member	1	0

The committee advises the Governing Body on appropriate remuneration and terms of service for the Accountable 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 Accountable Officer and senior managers.

6.2 Policy on the remuneration of senior managers

This remuneration policy includes clinicians, Lay Members and Executive Directors.

6.2.1 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:

Name	Title	Contract start date	Contract end date
Dr Amol Kelshiker	Chair and Clinical Director	1 April 2013	1 August 2018
Dr Kaushik Karia	Vice Chair and Clinical Director	1 October 2013	1 August 2018
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	1 October 2013	1 August 2018
Dr Genevieve Small	Clinical Director	1 October 2013	1 August 2018
Dr Shahla Ahmad	Clinical Director	20 June 2016	31 August 2018
Dr Shaheen Jinah	Clinical Director	6 June 2016	4 August 2018
Dr Sharanjit Takher	Clinical Director	1 September 2015	31 August 2018
Dr Sandy Gupta	Secondary Care Consultant	1 October 2013	4 August 2018

6.2.2 Lay Members

The Lay Members listed below 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.

Name	Title	Contract start date	Contract end date
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	21 July 2016	20 July 2018
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	1 July 2014	31 May 2016
Sanjay Dighe	Lay Member	1 April 2013	31 May 2019
Gerald Zeidman Contract completed 31 March 2017	Deputy Chair and Lay Member	1 August 2013	31 March 2017
Richard Smith Appointed 18 July 2016	Lay Member	18 July 2016	17 July 2019
Joanna Brown Appointed 1 August 2016	Associate Lay Member	1 August 2016	31 July 2018
Mukesh Panchal	Associate Lay Member	1 August 2014	31 July 2018
Hilary Ruth Barnes Resigned 29 July 2016	Associate Lay Member	1 August 2014	31 July 2016

6.2.3 Executive Directors

Executive Directors 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.

Details of the substantive Executive Directors are stated below.

Name	Title	Contract start date
Rob Larkman	Accountable Officer	1 April 2013
Neil Ferrelly	Chief Finance Officer	1 March 2016
Alex Faulkes	Director of Performance and Delivery	1 April 2016
Diane Jones	Director of Quality and Safety	1 March 2017
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	1 April 2013
Jan Norman Resigned 31 December 2016	Director of Quality and Safety	19 August 2015

6.2.4 Executive Directors performance related pay

The performance of all CCG staff, including directors and senior managers, is reviewed between April and March of each year in accordance with the CCG's annual performance review process.

The CCG established a process for a consolidated pay increase, as well as a mechanism for a non-consolidated performance related pay bonus for employees on the senior managers pay framework. The non-consolidated element of the performance related pay has been replaced and the revised Senior Manager Pay and Reward Policy came into effect from 1 April 2016.

All pay progression payments for directors and senior managers employed on the Senior Manager Pay framework are linked to annual appraisal of performance and the CCG achieving its strategic objectives in line with the Senior Manager Pay and Reward Policy. Performance awards for 2016/17 will be determined in the first quarter of 2017/18.

The performance of the Chief Operating Officer is appraised by the Accountable Officer and the Accountable Officer is appraised by the Chair. The performance of CCG directors is appraised by the Accountable Officer.

6.3 Remuneration of very senior managers

The Accountable Officer of NHS Harrow CCG is paid in excess of £142,500 per annum. However it should be noted that this remuneration is for services provided across the three CCGs – NHS Brent, Harrow and Hillingdon CCGs.

The Remuneration Committee advises the Governing Body of an appropriate remuneration for the Accountable Officer based on services provided to the three CCGs. In addition, the CCG Chair, who is part time, would be paid in excess of £142,500 per annum on a pro rata basis and this remuneration has been advised by the Remuneration Committee to the Governing Body who remain accountable for taking decisions on the remuneration and terms of service for senior managers.

6.4 Senior Managers remuneration (salary and pension entitlements)

6.4.1 Senior Managers definition

The Department of Health Group Manual for Accounts 2016/17 defines Senior Managers as:

> "Those persons in senior positions having authority or responsibility for directing or controlling the majority activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

6.4.2 Senior Managers: salaries and allowances (has been subject to audit)

Name	Title	Dates	Note	2016/17					2015/16			
				Salary & Fees (bands of £5,000) £000	Expense Payments (taxable) (nearest £100) £00	Performance Pay and Bonuses (bands of £5,000) £000	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) (nearest £00) £00	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Dr Amol Kelshiker	Chair and Clinical Director			80 - 85	-	-	12.5 - 15	95 - 100	80 - 85	-	7.5 - 10	90 - 95
Dr Kaushik Karia	Vice Chair and Clinical Director			40 - 45	-	-	-	40 - 45	45 - 50	-	-	45 - 50
Dr Dilip Patel	Clinical Director	Resigned 31.03.2017		35 - 40	-	-	7.5 - 10	45 - 50	40 - 45	-	10 - 12.5	55 - 60
Dr Genevieve Small	Clinical Director		1	70 - 75	-	-	12.5 - 15	85 - 90	80 - 85	-	7.5 - 10	90 - 95
Dr Kanesh Rajani	Clinical Director	Resigned 31.03.16		-	-	-	-	-	40 - 45	-	0 - 2.5	45 - 50
Dr Lawrence Gould	Clinical Director	Resigned 31.08.2015		-	-	-	-	-	20 - 25	-	-	20 - 25
Dr Shahla Ahmad	Clinical Director	Appointed 20.06.2016		30 - 35	-	-	157.5 - 160*	185 - 190	-	-	-	-
Dr Shaheen Jinah	Clinical Director	Appointed 6.06.2016		30 - 35	-	-	137.5 - 140*	170 - 175	-	-	-	-
Dr Sharanjit Takher	Clinical Director	Appointed 1.09.2015		35 - 40	-	-	75 - 77.5	115 - 120	20 - 25	-	297.5-300*	320 - 325*
Dr Sandy Gupta	Secondary Care Consultant			0 - 5	1	-	47.5 - 50	50 - 55	0 - 5	-	-	0 - 5
Ian Holder	BHH Lay Member (Governance), Chair of BHH Audit & Remuneration Committees	Appointed 21.07.2016	2	0 - 5	-	-	-	0 - 5	-	-	-	-
Tom Challenor	BHH Lay Member (Governance), Chair of BHH Audit & Remuneration Committees	Resigned 31.05.2016	2	0 - 5	-	-	-	0 - 5	5 - 10	-	-	5 - 10
Gerald Zeidman	Deputy Chair and Lay Member	Resigned 31.03.2017		15 - 20	-	-	-	15 - 20	10 - 15	-	-	10 - 15
Richard Smith	Lay Member	Appointed 18.07.2016		5 - 10	-	-	-	5 - 10	-	-	-	-
Sanjay Dighe	Lay Member			10 - 15	-	-	-	10 - 15	10 - 15	-	-	10 - 15
Hilary Ruth Barnes	Associate Lay Member	Resigned 29.07.2016	2	0 - 5	-	-	-	0 - 5	0 - 5	-	-	0 - 5
Joanna Brown	Associate Lay Member	Appointed 1.08.2016	2	0 - 5	-	-	-	0 - 5	-	-	-	-
Mukesh Panchal	Associate Lay Member		2	0 - 5	-	-	-	0 - 5	0 - 5	-	-	0 - 5
Rob Larkman	Accountable Officer		2	45 - 50	-	0 - 5	7.5 - 10	55 - 60	45 - 50	-	7.5 - 10	50 - 55
Paul Jenkins	Interim Chief Operating Officer	Appointed 11.01.17	3	45 - 50	-	-	-	45 - 50	-	-	-	-
Javina Sehgal	Chief Operating Officer	Seconded out 23.01.2017		85 - 90	-	0 - 5	27.5 - 30	115 - 120	105 - 110	-	27.5 - 30	135 - 140
Neil Ferrelly	Chief Finance Officer	Appointed 1.03.2016	2	30 - 35	-	-	45 - 47.5	80 - 85	0 - 5	-	5 - 7.5	5 - 10
Alex Stiles	Acting Chief Finance Officer	Acting 1.01.2016 to 29.02.2016		-	-	-	-	-	0 - 5	-	25 - 27.5	25 - 30
Jonathan Wise	Chief Finance Officer	Resigned 31.12.2015	2	-	-	-	-	-	30 - 35	-	15 - 17.5	45 - 50
Alex Faulkes	Director of Delivery and Performance	Appointed 1.04.2016	2	25 - 30	-	-	-	25 - 30				
Jeff Boateng	Acting Director of Delivery and Performance	Acting 1.02.2016 to 31.03.2016	2	-	-	-	-	-	0 - 5	-	-	0 - 5
Bernard Quinn	Director of Delivery and Performance	Resigned 31.01.2016	2	-	-	0 - 5	-	0 - 5	20 - 25	-	0 - 2.5	20 - 25
Diane Jones	Director Of Quality and Safety	Appointed 1.03.2017	2	0 - 5	-	-	20 - 22.5	20 - 25	-	-	-	-
Ann Jackson	Interim Director of Quality and Safety	Appointed 1.01.2017, Resigned 28.02.2017	2,3	0 - 5	-	-	-	0 - 5	-	-	-	-
Jan Norman	Director of Quality and Safety	Appointed 19.08.2015, Resigned 31.12.2016	2	20 - 25	-	-	20 - 22.5	40 - 45	15 - 20	-	17.5 - 20	35 - 40
Carole Matlock	Joint Interim Director of Quality & Safety	Appointed 1.05.2015, Resigned 18.08.2015	2,3	-	-	-	-	-	5 - 10	-	-	5 - 10
Pauline Johnson	Joint Interim Director of Quality & Safety	Appointed 1.05.2015, Resigned 18.08.2015	2,3	-	-	-	-	-	5 - 10	-	-	5 - 10
Professor Ursula Gallagher	Nurse Consultant and Director of Patient Quality & Safety	Resigned 1.05.2015	2	-	-	-	-	-	0 - 5	-	7.5 - 10	10 - 15
Andrew Howe	Director of Public Health, Harrow Council		4	-	-	-	-	-	-	-	-	-
Mina Kakaiya	Representative, Healthwatch Ltd		5	-	-	-	-	-	-	-	-	-

6.4.3 Senior Managers: Salaries and allowances – joint appointments (has been subject to audit)

The following Senior Managers work across Brent, Harrow and Hillingdon CCGs and their costs have been shared across these CCGs. This table gives their total salaries and allowances. The “salaries and allowances” table 6.4.2 only shows Brent CCG’s share of their costs.

			2016/17					2015/16			
Name	Title	Dates	Salary & Fees (bands of £5,000) £000	Expense Payments (taxable) (nearest £00) £00	Performance Pay and Bonuses (bands of £5,000) £000	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) (nearest £00) £00	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Rob Larkman	Accountable Officer		160 - 165	-	0 - 5	30 - 32.5	195 - 200	160 - 165	-	25 - 27.5	185 - 190
Neil Ferrelly	Chief Finance Officer	Appointed 1.03.2016	120 - 125	-	-	162.5 - 165	285 - 290	10 - 15	-	22.5 - 25	30 - 35
Jonathan Wise	Chief Finance Officer	Resigned 31.12.2015	-	-	-	-	-	105 - 110	-	60 - 62.5	170 - 175
Alex Faulkes	Director of Delivery and Performance	Appointed 1.04.2016	95 - 100	-	-	-	95 - 100				
Jeff Boateng	Acting Director of Delivery and Performance	Acting 1.02.2016 to 31.03.2016	-	-	-	-	-	15 - 20	-	-	15 - 20
Bernard Quinn	Director of Delivery and Performance	Resigned 31.01.2016	-	-	0 - 5	-	0 - 5	85 - 90	1	0 - 2.5	85 - 90
Diane Jones	Director of Quality and Safety	Appointed 1.03.2017	5 - 10	-	-	75 - 77.5	80 - 85	-	-	-	-
Ann Jackson	Interim Director of Quality and Safety	Appointed 1.01.2017, Resigned 28.02.2017	5 - 10	-	-	-	5 - 10	-	-	-	-
Jan Norman	Director of Quality and Safety	Appointed 19.08.2015, Resigned 31.12.2016	85 - 90	-	-	72.5 - 75	155 - 160	65 - 70	-	67.5 - 70	135 - 140
Carole Mattock	Interim Joint Director of Quality & Safety	Appointed 1.05.2015, Resigned 18.08.2015	-	-	-	-	-	30 - 35	-	-	30 - 35
Pauline Johnson	Interim Joint Director of Quality & Safety	Appointed 1.05.2015, Resigned 18.08.2015	-	-	-	-	-	25 - 30	-	-	25 - 30
Professor Ursula Gallagher	Nurse Consultant and Director of Patient Quality & Safety	Resigned 1.05.2015	-	-	-	-	-	5 - 10	-	32.5 - 35	40 - 45
Ian Holder	BHH Lay Member (Governance), Chair of BHH Audit & Remuneration Committees	Appointed 21.07.2016	10 - 15	-	-	-	10 - 15	-	-	-	-
Tom Challenor	BHH Lay Member (Governance), Chair of BHH Audit & Remuneration Committees	Resigned 31.05.2016	0 - 5	-	-	-	0 - 5	15 - 20	-	-	15 - 20
Hilary Ruth Barnes	Associate Lay Member	Resigned 29.06.2016	0 - 5	-	-	-	0 - 5	5 - 10	-	-	5 - 10
Joanna Brown	Associate Lay Member	Appointed 1.08.2016	5 - 10	-	-	-	5 - 10	-	-	-	-
Mukesh Panchal	Associate Lay Member		5 - 10	-	-	-	5 - 10	5 - 10	-	-	5 - 10

Notes to Salaries and allowances and joint arrangements table

1. Salary and fees includes £20k (2015/16: £30k) in respect of other services provided to the CCG.
2. Joint appointments – a number of Senior Managers work across NHS Brent, Harrow and Hillingdon CCGs and their share is calculated on the relative population of each CCG. These costs were shared as follows: 38% NHS Brent CCG, 28% NHS Harrow CCG and 34% NHS Hillingdon CCG.
   The "Senior Managers – salaries and allowances" table 6.4.2 shows NHS Harrow CCGs share of the costs of such staff and the "Senior Managers - Salaries and allowances – Joint arrangements" table 6.4.3 shows their total salaries and allowances.
3. Paid through agency or consultancy company and includes agency commission but excludes VAT.
4. Paid by Harrow Council/Non voting member.
5. Paid by Healthwatch Harrow/Non voting member.

* The pension figures supplied by NHS Pensions Agency are based on their current salary compared to that of their last officer employment (which could have been many years ago) uplifted for inflation. Therefore this does not necessarily reflect the increase in pension benefits during 2016/17 only.

Performance Pay and Bonuses
With effect from 1 April 2015, the CCG established performance related pay and bonuses for Senior Managers linked to annual appraisal of performance and the CCG achieving its strategic objectives in line with the Senior Manager Pay and Reward Policy. The performance pay and bonus included in the table above relates to the financial year 2015/16 which was agreed and paid in 2016/17. For 2016/17, any performance related pay has yet to be assessed and agreed. If awarded, they will be shown in 2017/18.

Long Term Performance Pay and Bonuses
There were no "long term performance pay and bonus" awards during 2016/17 and 2015/16.

Definitions

Salary and fees – All amounts paid or payable by the clinical commissioning group, including recharges from any other health body but excluding recharges to other health bodies.
Expense payments (taxable) – This is the gross value of taxable expenses and benefits before tax.
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 as a result of achievement of performance measures or targets.
All pension related benefits – This figure includes 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). In summary, for defined benefit schemes, the amount included here is the annual increase in pension entitlement. Zero amounts are shown for individuals for whom:
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 CCG.

6.4.4 Senior Managers: pension benefits (has been subject to audit)

Name	Title	Dates	Note	Real increase / (decrease) in pension at pension age (bands of £2,500) £000	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2017 (bands of £5,000 £000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2016 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2017 £000		Employer's contribution to stakeholder pension £00
Dr Amol Kelshiker	Chair and Clinical Director		1	0 - 2.5	2.5 - 5	10 - 15	35 - 40	246	38	284		-
Dr Dilip Patel	Clinical Director	Resigned 31.03.2017	1	0 - 2.5	0 - 2.5	5 - 10	25 - 30	-	-	-	*	
Dr Genevieve Small	Clinical Director		1	0 - 2.5	0 - 2.5	10 - 15	30 - 35	173	24	198		-
Dr Shahla Ahmad	Clinical Director	Appointed 20.06.2016	1	5 - 7.5	15 - 17.5	5 - 10	15 - 20	-	93	120		-
Dr Shaheen Jinah	Clinical Director	Appointed 6.06.2016	1	5 - 7.5	12.5 - 15	5 - 10	15 - 20	-	85	103		-
Dr Sharanjit Takher	Clinical Director		1	2.5 - 5	5 - 7.5	5 - 10	20 - 25	66	44	110		-
Dr Sandeep Gupta	Secondary Care Consultant		1	0 - 2.5	5 - 7.5	40 - 45	125 - 130	774	61	835		-
Rob Larkman	Accountable Officer		2	0 - 2.5	5 - 7.5	45 - 50	140 - 145	1,016	-	-	*	
Javina Sehgal	Chief Operating Officer	Seconded out 23.01.2017		0 - 2.5	-	15 - 20	-	164	23	193		-
Neil Ferrelly	Chief Finance Officer		2	7.5 - 10	22.5 - 25	50 - 55	160 - 165	924	181	1,105		-
Diane Jones	Director of Quality and Safety	Appointed 1.03.2017	2	0 - 2.5	0 - 2.5	15 - 20	40 - 45	217	5	276		-
Jan Norman	Director of Quality and Safety	Resigned 31.12.2016	2	0 - 2.5	0 - 2.5	50 - 55	150 - 155	1,051	-	-	*	

Notes to Pension benefits table:

1. Figures are supplied by the NHS Pensions Agency and are based on their employment as Governing Body Members of the CCG only. Pension relation to Practitioner employments are not included.
2. The disclosure for these individuals who are shared across Brent, Harrow and Hillingdon CCGs is their total amount and not their share applicable to each individual CCG

* There is no cash equivalent transfer value as at 31 March 2017 as these members have reached normal retirement age.

Certain members, including interims, do not receive pensionable remuneration or have opted out of the pension scheme and therefore there are no entries in respect of pensions for these Members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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.

6.5 Compensation on early retirement or for loss of office (has been subject to audit)

There have been no compensation on early retirement or loss of office payments.

6.6 Payments to past senior managers (has been subject to audit)

There have been no payments made to past senior managers.

6.7 Fair pay disclosure (has been 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 banded remuneration of the highest paid Governing Body member in NHS Harrow CCG during the financial year 2016/17 was £105k - £110k (2015/16: £105k – £110k). This was 2.53 (2015/16: 2.45) times the median remuneration of the workforce, which was £42.4k (2015/16: £44.1k). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

In 2016/17, no employees received remuneration in excess of the highest-paid member.

The workforce median calculation is based on the average cost of staff on the NHS Harrow CCG payroll. This includes full costs for staff directly working for NHS Harrow CCG, as well as a small number of Commissioning Support Service staff.

7 Staff Report

7.1 Number of senior managers by band

Number	Band
19	VSM

7.2 Staff numbers and costs

The average number of people in the CCG's workforce is as follows and includes staff recharged to and from the CCG:

Staff numbers (has been subject to audit)	2016/17	2015/16
	No.	No.
Permanently Employed	79	68
Other	21	20
Total	100	88

Included within the above whole time equivalent staff numbers are 28.5 (2015/16: 26.5) relating to commissioning support services.

These figures include staff which NHS Brent CCG hosts the employment of but are shared across the Brent, Harrow and Hillingdon federation, and commissioning support functions shared across all eight NW London CCGs.

Workforce benefits (has been subject to audit)

2016/17

	Admin			Programme			Total		
	Employees	Other	Total	Employees	Other	Total	Employees	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	1,276	1,398	2,674	1,128	1,441	2,569	2,404	2,839	5,243
Social security costs	171	59	230	135	43	178	306	102	408
Employer Contributions to NHS Pension Scheme	195	80	275	140	58	198	335	138	473
Workforce benefits expenditure	**1,642**	**1,537**	**3,179**	**1,403**	**1,542**	**2,945**	**3,045**	**3,079**	**6,124**

2015/16

	Admin			Programme			Total		
	Employees	Other	Total	Employees	Other	Total	Employees	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	1,390	1,269	2,659	945	1,954	2,899	2,335	3,223	5,558
Social security costs	133	42	175	89	32	121	222	74	296
Employer Contributions to NHS Pension Scheme	183	55	238	116	43	159	299	98	397
Workforce benefits expenditure	**1,706**	**1,366**	**3,072**	**1,150**	**2,029**	**3,179**	**2,856**	**3,395**	**6,251**

7.3 Staff composition

Staff numbers	Female	Male
Governing Body	4	8
Other senior managers and clinical leads (not included in Governing Body figures)	0	1
CCG staff	23	12

These figures show all staff on NHS Harrow CCG's payroll which includes staff shared across the BHH CCGs Federation, and commissioning support functions shared across all eight North West London CCGs.

The membership body of the CCG is made up of its individual member practices whose staff are not employed by the CCG. As such, we do not record information on the gender of staff in general practices.

7.4 Sickness absence data

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 NW London CCGs. Human Resources has undertaken process training for CCG managers, including the efficient use of sickness absence management protocols to refresh knowledge and reminding mangers of their role in the management of absence.

A table is included in the workforce benefits note 3.4 of the Financial Statements with sickness absence data.

7.5 Staff policies

The CCG has a number people management policies in place to ensure effective recruitment and employment of its staff. The people management policies promote best practice and a non-discriminatory approach to all aspects of employment within the organisation. These policies recognise the importance of a good employment relationships and commitment to employee engagement.

These robust people management policies are reviewed regularly and Equality Impact Assessments undertaken. The policies are approved through the CCGs' HR Committee that meets on a monthly basis and thereafter agreed by the Remuneration Committee before implementation.

All staff policies are accessible to all staff via an internal intranet site and the HR Staff Handbook.

7.5.1 Equality

The CCGs 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 abides by the principles of the 'Disability Confident Scheme' 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.

7.6 Expenditure on consultancy

During the year, NHS Harrow CCG incurred £234.5k on consultancy services. This was largely attributed to QIPP consultancy.

7.7 Off-payroll engagements

Table 1 – Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2017, 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 2017	7
of which, the number that have existed:	
For less than 1 year at the time of reporting	6
For between 1 and 2 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

The CCG confirms 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 – New off-payroll engagements

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, 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 2016 and 31 March 2017	11
Number of new engagements which include contractual clauses giving Harrow CCG the right to request assurance in relation to Income Tax and National Insurance obligations	11
Number for whom assurance has been requested	9
of which:	
Assurance has been received	8
Assurance has not been received	1
Engagements terminated as a result of assurance not being received	0

Table 3 – Off-payroll engagements / senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017:

	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements	24

The substantive Chief Operating officer was seconded out on 23 January 2017. Therefore, to cover this position, an interim has been appointed from 11 January 2017 to 11 July 2017.

7.8 Exit packages (has been subject to audit)

Please refer to note 3.3 of the Financial Statements for details on exit packages.

8 Parliamentary Accountability and Audit Report

NHS Harrow CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on contingent liabilities are included in note 11 of the Financial Statements within this report. An audit certificate and report is also included in this Annual Report.

Independent Auditor's Report and Financial Statements

Involving patients in planning future healthcare in Harrow

Rob Larkman
Accountable Officer
NHS Brent, Harrow and Hillingdon CCGs
Date: 24 May 2017

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

We have audited the financial statements of NHS Harrow Clinical Commissioning Group (the CCG) for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. 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. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2016-17 Government Financial Reporting Manual (the 2016-17 FReM) as contained in the Department of Health Group Accounting Manual 2016-17 (the 2016-17 GAM) and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is described in that report as having been audited.

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for 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 and is also responsible for ensuring the regularity of expenditure and income. 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 Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (the "Code of Audit Practice").

As explained in the Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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 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.

In addition, we read all the financial and non-financial information in the annual report and accounts 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 recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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 criterion issued by the Comptroller and Auditor General in November 2016, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the 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 2017.

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.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2017 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Direction issued thereunder.

Qualified opinion on regularity arising from non-compliance with governing authorities

The CCG has reported the following breaches in its financial performance targets in note 18 to the financial statements.

Financial duty	Target £000s	Performance £000's	Excess £000's
Expenditure not to exceed income	305,988	307,310	£1,322
Revenue resource use does not exceed the amount specified in Directions	302,371	303,693	£1,322

Except for the incurrence of expenditure in excess of total income and also in excess of the specified resource limit, in our opinion, in all material respects 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 other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Annual Report Directions made under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012); and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception - Use of resources

Auditor's responsibilities
We report to you if we are not satisfied that the CCG has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Our assessment of arrangements is made by reference to the overall criterion: In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

Basis for qualified conclusion
The CCG has reported a deficit of £1.322 million in the year ending 31 March 2017, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012, to break even on its commissioning budget.

The CCG has not yet succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit of £21.2 million for 2017/18.

Consequently, there remain material uncertainties in the CCG's financial position and ability to return to financial balance in the medium term. This issue is evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified Conclusion
On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2016, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, the CCG has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Matters on which we are required to report by exception - Referral to the Secretary of State under section 30(a) and 30(b) of the Local Audit and Accountability Act 2014

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure (section 30(a)), or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency (section 30(b)).

On 26 May 2017 we referred the breaches of the CCG's financial performance targets for 2016/17 to the Secretary of State under section 30(a) and that the CCG had set a deficit budget for 2017/18 under section 30(b) of the Local Audit and Accountability Act 2014.

Other matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

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 Local Audit and Accountability Act 2014 and the Code of Audit Practice.

BDO LLP

Leigh Lloyd-Thomas
For and on behalf of BDO LLP, Appointed Auditor
London, UK
26 May 2017

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

10

NHS Harrow CCG
Financial Statements
2016-17

This year ended: 31 March 2016
This year commencing: 1 May 2017

NHS Harrow CCG - Annual Accounts 2016/17

CONTENTS

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2017

	Note	2016/17 £'000	2015/16 £'000
Income from sale of services	2	(576)	(634)
Other operating income	2	(3,041)	(1,626)
Total operating income		**(3,617)**	**(2,260)**
Workforce costs	3	6,124	6,251
Purchase of services	4	300,718	280,203
Provision expense	4	20	(30)
Other Operating Expenditure	4	448	435
Total operating expenditure		**307,310**	**286,859**
Net Operating Expenditure		**303,693**	**284,599**
Total Comprehensive Expenditure for the Year		**303,693**	**284,599**

The notes on pages 5 to 18 form part of this statement.

Statement of Financial Position as at 31 March 2017

	Note	31 March 2017 £000	31 March 2016 £000
Current assets			
Trade and other receivables	7	3,627	3,842
Cash and cash equivalents	8	86	122
Total current assets		**3,713**	3,964
Current liabilities			
Trade and other payables	9	(34,092)	(34,959)
Provisions	10	(57)	(37)
Total current liabilities		**(34,149)**	(34,996)
Assets less Liabilities		**(30,436)**	(31,032)
Financed by Taxpayers' Equity			
General fund		(30,436)	(31,032)
Total taxpayers' equity		**(30,436)**	(31,032)

The balance sheet movement of £0.6m on the general fund reflects the difference between the cash funding and net operating costs for the financial year.

The notes on pages 5 to 18 form part of this statement.

The financial statements on pages 1 to 18 were approved by the Governing Body on 23 May 2017 and signed on its behalf by:

Rob Larkman
Accountable Officer

Statement of Changes In Taxpayers Equity for the Year Ended 31 March 2017

2016/17 Changes in taxpayers' equity

	General fund £000
Balance as at 1 April 2016	**(31,032)**
2016/17 Changes in Clinical Commissioning Group taxpayers' equity	
Net operating expenditure for the financial year	(303,693)
Cash funding	304,289
Balance as at 31 March 2017	**(30,436)**

The cash funding of £304.3m represents the drawing of cash the CCG made during the year from the Department of Health.

2015/16 Changes in taxpayers' equity

	General fund £000
Balance as at 1 April 2015	**(34,245)**
2015/16 Changes in Clinical Commissioning Group taxpayers' equity	
Net operating costs for the financial year	(284,599)
Cash funding	287,812
Balance as at 31 March 2016	**(31,032)**

The notes on pages 5 to 18 form part of this statement.

Statement of Cash Flows for the Year Ended 31 March 2017

	Note	2016/17 £000	2015/16 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(303,693)	(284,599)
Decrease / (increase) in trade & other receivables	7	215	(1,187)
Decrease in trade & other payables	9	(867)	(1,889)
Increase / (decrease) in provisions	10	20	(30)
Net Cash Outflow from Operating Activities		**(304,325)**	(287,705)
Cash Flows from Financing Activities			
Cash funding received		304,289	287,812
Net Cash Inflow from Financing Activities		**304,289**	287,812
Net (Decrease) / increase in Cash	8	**(36)**	107
Cash at the Beginning of the Financial Year		**122**	15
Cash at the End of the Financial Year		**86**	122

The notes on pages 5 to 18 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016/17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014). Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 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.

The clinical commissioning group accounts for this as a joint operation and recognises its share of:

- assets the clinical commissioning group controls;
- liabilities the clinical commissioning group incurs;
- expenses the clinical commissioning group incurs; and,
- clinical commissioning group's share of the income from the pooled budget activities.

1.4 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make 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.

1.4.1 *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:

1.4.1.1 *Brent CCG Federation Recharge to Harrow and Hillingdon CCGs*

Certain functions such as Quality and Safety are delivered across all three CCG's using a federation model. Each CCG is responsible for its proportionate share of total costs. All federation costs are

initially paid by NHS Brent CCG with an appropriate proportion recharged to the other CCG's on a net accounting basis. The share of costs for the CCG are shown in operating expenses, note 4. The split for the period 1 April 2016 to 31 March 2017 has been determined as 38% for NHS Brent CCG, 28% for NHS Harrow CCG and 34% for NHS Hillingdon CCG. This is based on the relative running cost allocation for each CCG and has been updated for a small change in 2016/17.

1.4.1.2 ***Accounting for Commissioning Support Services (CSS)***

The CSS service is managed by NHS Brent CCG for the CCGs in North West London and NHS Brent CCG charges the other CCGs for the costs of providing the service. NHS Brent CCG is currently subject to a greater degree of financial and operational risk for managing this service than the other CCGs, therefore NHS Brent CCG acts as a principal and accounts on a gross basis for all expenditure incurred including workforce, consultancy and other costs. These are shown as revenue amounts charged to the other CCGs within 'recoveries in respect of workforce benefits' and 'non-patient care services to other bodies'. The other CCGs show their costs charged by NHS Brent CCG as either 'workforce benefits – other staff' and 'Services from other CCGs and NHS England'.

1.4.1.3 ***NHS 111 Shared Commissioning Arrangement***

NHS Hounslow CCG commissions 111 service from Care UK on behalf of NHS Brent CCG, NHS Harrow CCG and NHS Ealing CCG. NHS Hounslow CCG acts as an agent and each CCG is responsible for its proportion share of the total costs. The share of costs for NHS Brent CCG are shown in operating expenses, note 4. The service cost is recharged out to CCGs based on the population size on a net accounting basis in the following proportions: NHS Hounslow 23%, NHS Ealing CCG 29%, NHS Brent CCG 27% and NHS Harrow CCG 21%.

1.4.2 **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:

1.4.2.1 ***Prescription Pricing Authority Expenditure***

The Prescription Pricing Authority (PPA) currently provides details of the monthly expenditure incurred by independent contractors in respect of pharmacy contract payments and drug costs for the CCG. There is a two month delay in notifying the CCG of its expenditure for a particular month. Actual costs for February are available in April and therefore used, however the CCG accrues its estimated prescribing costs for March based on the annual PPA profile.

1.4.2.2 ***Acute Contracts Expenditure***

Healthcare services from acute NHS providers are commissioned under service level agreements. Providers use the monthly activity data to inform their monthly Service Level Agreement Monitoring (SLAM) reports and to charge the CCG for activity provided. The latest available SLAM information covers February (Month 11) data and this is available at the beginning of April. Providers estimate the activity delivered in March to forecast the full year activity levels and amounts to be charged to the CCG. The CCG will review this un-validated March activity for reasonableness before estimating the expenditure for that month at various points. Throughout the year, the CCG may issue contract challenges against invoiced activity and, where these have yet to be resolved, will make an estimate of the amounts that it believes will not need to be paid. The CCG also estimate amounts recoverable against payments to date where activity has fallen below contracted levels or additional amounts payable where activity exceeds contracted activity.

1.5 **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.

1.6 **Employee Benefits**

1.6.1 **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.

1.6.2 **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.

1.7 **Other Expenses**
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 **Operating Leases**

1.8.1 **The Clinical Commissioning Group as Lessee**
Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

1.9 **Cash**
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.
In the Statement of Cash Flows, cash is shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.10 **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.

1.11 **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.

1.12 **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.

1.13 **Continuing Healthcare Risk Pooling**

In 2014/15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme the clinical commissioning group contributed annually to a pooled fund, which is used to settle the claims. 2016/17 is the final year that clinical commissioning groups will contribute into this scheme.

1.14 **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.

The CCGs financial assets are classified as:

· Loans and receivables.

They are measured at amortised cost less any impairment.

At the end of the reporting period, the clinical commissioning group assesses whether these 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.

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. 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.

1.15 **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. The CCGs financial liabilities are classified as other financial liabilities and are measured at amortised cost.

1.16 **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. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 **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 2016/17, all of which are subject to consultation:

· IFRS 9: Financial Instruments (application from 1 January 2018)
· IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
· IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
· IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016/17, were they applied in that year.

2. Other Operating Revenue

	2016/17			2015/16
	Admin	Programme	Total	Total
	£000	£000	£000	£000
Education, training and research	-	323	323	208
Charitable and other contributions to revenue expenditure: non-NHS	-	18	18	18
Non-patient care services to other bodies	-	253	253	426
Other revenue	7	3,016	3,023	1,608
Total other operating revenue	**7**	**3,610**	**3,617**	**2,260**

Notes:

1) Programme Revenue

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

2) 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. Workforce benefits and numbers

3.1 2016/17 Workforce benefits

	Admin			Programme			Total		
	Employees	Other	Total	Employees	Other	Total	Employees	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	1,276	1,398	2,674	1,128	1,441	2,569	2,404	2,839	5,243
Social security costs	171	59	230	135	43	178	306	102	408
Employer Contributions to NHS Pension Scheme	195	80	275	140	58	198	335	138	473
Workforce benefits expenditure	**1,642**	**1,537**	**3,179**	**1,403**	**1,542**	**2,945**	**3,045**	**3,079**	**6,124**

2015/16 Workforce benefits

	Admin			Programme			Total		
	Employees	Other	Total	Employees	Other	Total	Employees	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	1,390	1,269	2,659	945	1,954	2,899	2,335	3,223	5,558
Social security costs	133	42	175	89	32	121	222	74	296
Employer Contributions to NHS Pension Scheme	183	55	238	116	43	159	299	98	397
Workforce benefits expenditure	**1,706**	**1,366**	**3,072**	**1,150**	**2,029**	**3,179**	**2,856**	**3,395**	**6,251**

3.2 Average number of workforce

	2016/17			2015/16
	Employees	Other	Total	Total
	No.	No.	No.	No.
Total	79	20	**99**	88

3.3 Exit packages agreed

The clinical commissioning group has not agreed any exit packages during 2016/17 (2015/16: None).

3. Workforce benefits and numbers (contd.)

3.4 Staff sickness absence

	2016/17 Number	2015/16 Number
Total Days Lost	138	35
Total Staff Years	34	28
Average working Days Lost	**4.1**	**1.3**

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

3.5 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 scheme is an unfunded, defined benefit scheme that covers NHS employers, GP 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.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:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

4. Operating expenses

	2016/17			2015/16
	Admin	Programme	Total	Total
	£000	£000	£000	£000
Gross workforce benefits				
Workforce benefits excluding Governing Body members	2,935	2,852	5,787	5,921
Executive Governing Body members	244	93	337	330
Total gross workforce benefits	**3,179**	**2,945**	**6,124**	**6,251**
Other costs				
Services from other CCGs and NHS England	357	406	763	2,351
Services from foundation trusts	-	57,045	57,045	57,217
Services from other NHS trusts	-	158,071	158,071	144,360
Services from other NHS bodies	-	-	-	5
Purchase of healthcare from non-NHS bodies	-	42,429	42,429	35,827
Chair, GP Members and Lay Members	428	21	449	421
Supplies and services – clinical	-	544	544	2,331
Supplies and services – general	66	2,351	2,417	928
Consultancy services	77	157	234	90
Establishment	67	136	203	292
Transport	1	-	1	1
Premises	152	815	967	1,034
Impairments and reversals of receivables	-	24	24	8
External audit fees	62	-	62	62
Prescribing costs	-	32,110	32,110	31,827
GMS, PMS and APMS	-	3,827	3,827	1,754
Other professional fees incl. internal audit fees	112	877	989	324
Clinical negligence	-	6	6	6
Education and training	25	401	426	224
Provisions	-	20	20	(30)
CHC Risk Pool contributions	-	630	630	1,576
Other expenditure	-	(31)	(31)	-
Total other costs	**1,347**	**299,839**	**301,186**	**280,608**
Total operating expenses	**4,526**	**302,784**	**307,310**	**286,859**

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) Acronyms

GMS - General Medical Services, PMS - Personal Medical Services, APMS - Alternative Provider Medical Services and CHC - Continuing Health Care.

4) External Audit Fees

The External Audit fees net of VAT is £52k. The figure above is inclusive of VAT as not recoverable by the CCG.

5. Better Payment Practice Code

Measure of compliance	2016/17 Number	2016/17 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Period	9,925	51,990
Total Non-NHS Trade Invoices paid within target	9,386	47,700
Percentage of Non-NHS Trade invoices paid within target	**94.6%**	**91.7%**
NHS Payables		
Total NHS Trade Invoices Paid in the Period	3,276	224,557
Total NHS Trade Invoices Paid within target	3,188	219,549
Percentage of NHS Trade Invoices paid within target	**97.3%**	**97.8%**

	2015/16 Number	2015/16 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	8,294	43,999
Total Non-NHS Trade Invoices paid within target	8,026	41,325
Percentage of Non-NHS Trade invoices paid within target	**96.8%**	**93.9%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	3,124	213,462
Total NHS Trade Invoices Paid within target	3,086	212,552
Percentage of NHS Trade Invoices paid within target	**98.8%**	**99.6%**

The Better Payment Practice Code requires NHS organisations to aim to pay 95% of all valid invoices, by value and volume, within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

6. Operating Leases - as lessee

6.1 Payments recognised as an Expense

2016/17	Buildings £000	Other £000	Total £000
Minimum lease payments	635	1	**636**
Total	**635**	**1**	**636**

2015/16	Buildings £000	Other £000	Total £000
Minimum lease payments	985	-	**985**
Contingent rents	-	-	**-**
Sub-lease payments	-	-	**-**
Total	**985**	**-**	**985**

The clinical commissioning group is charged for property owned or managed by NHS Property Services Ltd, Community Health Partnerships Ltd and NHS Brent CCG for NHS Harrow CCG's share of BHH Federation and CSS charges for their headquarters at The Heights. Other payments relate to a photocopier lease.

6.2 Future minimum lease payments

2016/17	Other £000	Total £000
Payable:		
No later than one year	2	**2**
Between one and five years	3	**3**
Total	**5**	**5**

6.2 Future minimum lease payments (contd.)

The future minimum lease payments shown in the table above are in respect of a lease with Xerox (UK) Ltd. for rental of a photocopier.

There were no future minimum lease payments in respect of Other payments during 2015/16.

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

7. Current trade and other receivables

	31 March 2017	31 March 2016
	£000	£000
NHS receivables: Revenue	1,184	1,278
NHS prepayments	1,711	1,243
NHS accrued income	90	324
Non-NHS receivables: Revenue	226	261
Non-NHS prepayments	160	41
Non-NHS accrued income	206	729
Provision for the impairment of receivables	(140)	(147)
VAT	190	113
Total current trade and other receivables	**3,627**	**3,842**

The great majority of trade is with NHS England and other CCGs. As NHS England and CCGs are funded by the Government, no credit scoring of them is considered necessary.

7.1 Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000	£000
By up to three months	-	320
By three to six months	17	8
By more than six months	21	-
Total	**38**	**328**

7.2 Provision for impairment of receivables	2016/17	2015/16
	£000	£000
Balance at 1 April 2016	**(147)**	**(139)**
Amounts recovered during the year	31	-
Increase in receivables impaired	(24)	(8)
Balance at 31 March 2017	**(140)**	**(147)**

8. Cash and cash equivalents

	2016/17	2015/16
	£000	£000
Balance at 1 April 2016	**122**	**15**
Net change in year	(36)	107
Balance at 31 March 2017	**86**	**122**
Made up of:		
Cash with the Government Banking Service	86	122

9. Current trade and other payables

	31 March 2017 £000	31 March 2016 £000
NHS payables: revenue	5,450	11,244
NHS accruals	10,562	7,995
Non-NHS payables: revenue	7,682	7,650
Non-NHS accruals	9,389	7,552
Non-NHS deferred income	-	167
Social security costs	34	22
Tax	29	22
Other payables	946	307
Total current trade and other payables	**34,092**	**34,959**

Other payables include £40k outstanding pension contributions at 31 March 2017 (31 March 2016: £32k).

10. Current provisions

	31 March 2017 £000	31 March 2016 £000
Continuing care	57	37
Total	**57**	**37**

	Total Continuing Care £000
Balance at 1 April 2016	**37**
Arising during the period	57
Reversed unused	(37)
Balance at 31 March 2017	**57**
Expected timing of cash flows:	
Within one year	57
Balance at 31 March 2017	**57**

The clinical commissioning group had a provision of £57k relating to 4 continuing care claims as at 31 March 2017 (31 March 2016: £37k relates to 1 case).

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 2017 is £40k (31 March 2016: £769k). NHSE also hold a contingent liability of £53k relating to 2 cases.

11. Contingent liabilities

	31 March 2017 £000	31 March 2016 £000
Continuing Healthcare (6 cases)	114	-
Net value of contingent liabilities	114	-

12. Financial instruments

12.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.
Because the 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 clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group and internal auditors.

12.1.1 Currency risk

The clinical commissioning group is principally a domestic organisation with all transactions, assets and liabilities being in the UK and sterling based.

12.1.2 Credit risk

Because the majority of the clinical commissioning group's revenue comes from parliamentary funding, it has low exposure to credit risk. The maximum exposures as at the end of the period are in receivables from customers, as disclosed in the trade and other receivables note.

12.1.3 Liquidity risk

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

12.2 Financial assets

	31 March 2017 Loans and Receivables £000	31 March 2016 Loans and Receivables £000
Receivables: NHS	1,274	1,602
Non-NHS	432	990
Cash at bank and in hand	86	122
Total	**1,792**	**2,714**

12.3 Financial liabilities

	31 March 2017 Other £000	31 March 2016 Other £000
Payables: NHS	16,012	19,239
Non-NHS	18,017	15,509
Total	**34,029**	**34,748**

13. Operating segments

The clinical commissioning group has one operating segment, which is the commissioning of healthcare.

14. Pooled budgets

The clinical commissioning group has a Pooled Budget under Section 75 of the NHS Act 2006 with the London Borough of Harrow in respect of the Better Care Fund (BCF) which it entered into during 2015/16.

The BCF is hosted by The London Borough of Harrow and was announced by the Government in the June 2013 spending round to drive the transformation of local services to ensure that the people receive better and more integrated care and support. The fund is to be deployed locally on health and social care through pooled budget arrangements between local authorities and clinical commissioning groups.

The clinical commissioning group's share of the income and expenditure handled by the BCF pooled budget was:

	2016/17 £000	2015/16 £000
Income	(8,519)	(7,772)
Expenditure	8,519	7,814

15. Related party transactions

Members of the Governing Body are required to declare any interests that they hold, either directly or through family members, in organisations other than the clinical commissioning group. Where the CCG incurs expenditure with or receives income from those organisations, the organisations are known as related parties and the transactions must be reported. Those transactions, together with the nature of the interest and the nature of the transaction, are shown below.

During the year none of the Executive or Lay Members, or parties related to them, have 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 services provided to the clinical commissioning group by the practice which the member is a partner rather than payments to members themselves, and comprise payments made during 2016/17 and outstanding invoices):

GP Member	GP Practice	2016/17 Expenditure with Related Party £000	Amounts owed to Related Party £000
Dr Amol Kelshiker	Pinn Medical Centre	680	-
Dr Kaushik Karia	Aspri Medical Centre	70	-
Dr Dilip Patel	Civic Medical Centre	47	-
Dr Shahla Ahmad	GP Direct	3	-
Dr Genevieve Small	Ridgeway Surgery	1,466	82
Dr Sharanjit Takher	Endley Road Medical Centre	24	-

Dr Amol Kelshiker, Dr Kaushik Karia and Dr Shahla Ahmad are shareholders in Harrow Health CIC.
For Dr Dilip Patel, Dr Genevieve Small and Dr Sharanjit Takher, their practices hold shares in Harrow Health CIC.

GP Network	2016/17 Expenditure with Related Party £000	2016/17 Income from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Harrow Health CIC	3,072	51	80	51

NHS Brent, Harrow and Hillingdon CCGs are related parties of each other due to the BHH Federation arrangements whereby the management have joint control.

15. Related party transactions (contd.)

NHS Brent CCG incurred £7k expenditure with the Good Governance Institute, of which Ian Holder, BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees, is a Senior Associate. This was in respect of professional services provided across BHH CCGs, and therefore these costs were shared across the three CCGs.

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 their Parent. Details of related party transactions with such entities is as follows:

	2016/17 Expenditure with Related Party	2016/17 Income from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
NHS England including CCG's:				
NHS England	730	-	-	569
NHS Brent CCG	2,036	234	-	129
NHS Hillingdon CCG	60	424	6	143
NHS Central London (Westminster) CCG	478	4	460	1
NHS Foundation Trusts:				
Central And North West London MH NHS Foundation Trust	23,332	-	1,209	-
Chelsea And Westminster Hospital NHS Foundation Trust	1,377	-	468	8
Great Ormond Street Hospital for Children NHS Foundation Trust	438	-	-	36
Guys And St Thomas NHS Foundation Trust	1,318	-	167	13
King's College Hospital NHS Foundation Trust	273	-	-	-
Moorfields Eye Hospital NHS Foundation Trust	7,459	-	282	-
Royal Brompton And Harefield NHS Foundation Trust	2,613	-	349	-
Royal Free London NHS Foundation Trust	9,415	-	40	189
The Hillingdon Hospital NHS Foundation Trust	6,089	-	466	-
University College London NHS Foundation Trust	3,632	-	197	33
NHS Trusts:				
Barts Health NHS Trust	721	-	92	-
Central London Community Healthcare NHS Trust	10,900	-	730	-
East And North Hertfordshire NHS Trust	725	-	21	-
Imperial College Healthcare NHS Trust	12,251	-	670	124
London Ambulance Service NHS Trust	7,368	-	286	-
London North West Healthcare NHS Trust	116,608	-	5,635	1,356
Royal National Orthopaedic Hospital NHS Trust	3,500	-	186	-
West Hertfordshire Hospitals NHS Trust	2,798	-	-	233

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	437	-	820	-
Health Education England	-	469	22	-
London Borough of Harrow	9,000	1,015	731	206
NHS Property Services Ltd	506	-	634	-
HMRC [1]	306	-	63	190
NHS Pensions Agency [1]	335	-	40	-

[1] Transactions with HMRC and NHS Pensions Agency are in respect of receipts and payments relating to 2016/17.

16. Events after the end of the reporting period

Delegated primary care responsibilities

NHS England recently announced details of the clinical commissioning groups approved to take on greater delegated responsibility or to jointly commission GP services from 1 April 2017. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View.

NHS Harrow CCG has been approved under delegated commissioning arrangements which mean that the CCG will assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1 April 2017.

17. Losses

The total number of clinical commissioning group losses, and their total value, was as follows:

	2016/17	
	Total Number of cases Number	Total Value of Cases £'000
Administrative write-offs	4	24
Total	**4**	**24**

There were no losses during 2015/16.

18. Financial performance targets

The clinical commissioning group has a number of financial duties under the NHS Act 2006 (as amended).

Performance against those duties was as follows:

	2016/17		2015/16	
	Target £000	Performance £000	Target £000	Performance £000
Expenditure not to exceed income	305,988	307,310	288,947	286,859
Revenue resource use does not exceed the amount specified in Directions	302,371	303,693	286,687	284,599
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	5,237	4,519	5,674	4,423

A deficit on programme costs of (£2m) and a surplus on running costs of £0.7m together equal NHS Harrow CCG's in-year deficit of (£1.3m).