MEETING

HEALTH & WELL-BEING BOARD

DATE AND TIME

THURSDAY 4TH JUNE, 2015

AT 10.00 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

Dear Health and Well-Being Board,

Please find enclosed additional papers relating to the following items for the above mentioned meeting which were not available at the time of collation of the agenda.

Item No	Title of Report	Pages
10.	CCG ANNUAL REPORT AND ACCOUNTS	1 - 122

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	Health and Well-Being Board **4 June 2015**
Title	**NHS Barnet CCG Annual Report and Accounts 2014/2015**
Report of	NHS Barnet Clinical Commissioning Group- Chair
Wards	All
Date added to Forward Plan	May 2015
Status	Public
Enclosures	NHS Barnet CCG Annual Report and Accounts 2014/2015
Officer Contact Details	Hugh McGarel-Groves, Chief Financial Officer Hugh.McGarel-Groves@barnetccg.nhs.uk Matt Powls Matthew.Powls@barnetccg.nhs.uk

Summary

The Health and Well-Being Board (HWBB) is asked to consider NHS Barnet CCG's Annual Report and Accounts and comment on the extent to which the CCG has met the priorities set out in the annual Health and Wellbeing Strategy.

Members of the HWB are asked to note:

- They are receiving a draft version of the NHS Barnet CCG Annual Report and Accounts as of the 22 May 2015.
- The NHS Barnet CCG Annual Report and Accounts are subject to review and approval at the NHS Barnet Audit Committee meeting and Governing Body meeting held on 28 May 2015.

Recommendation

1. **That the Committee consider NHS Barnet CCG's Annual Report and Accounts and comment on the extent to which the CCG has met the priorities set out in the Annual Health and Wellbeing Strategy.**

1. WHY THIS REPORT IS NEEDED

1.1 The CCG's Annual Report and Accounts are drawn up in line with International Financial Reporting Standards (IFRS) and national guidance, primarily the NHS Manual for Accounts and CCG Annual Reporting Guidance, and to a national completion deadline date. The format of the annual report and accounts is nationally prescribed, although the CCG can add further disclosures / notes, where necessary.

1.2 In preparing the Annual Report and Accounts there has been a requirement to work closely with a number of other organisations, including:

a) North Central London CSU.
b) Other NHS organisations, for the agreement of payable and receivable and income and expenditure balances.
c) NHS England.
d) Health and Wellbeing Board (HWBB)

2. REASONS FOR RECOMMENDATIONS

2.1 Local Authorities are required to work with CCGs to draft an Annual Health and Wellbeing Strategy for the area, based on the Joint Strategic Needs Assessment (a measure of health and wellbeing people in the area).

2.2 The Health and Wellbeing Board (HWBB) is asked to consider NHS Barnet CCG's annual report and accounts.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The process for review and approval of the CCG's Annual Report and Accounts includes provision for comment and review by the Health and Well Being Board.

4. POST DECISION IMPLEMENTATION

4.1 NHSE have instructed all CCGs to publish their Annual Report and Accounts on their websites by no later than 5 June 2015.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 This report will help towards delivering the overarching aims of the Barnet Health and Well-Being Strategy 2012 to 2015, LBB Commissioning Intentions and BCCG 5 year Strategic Plans.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 N/A

5.3 Legal and Constitutional References

5.3.1 The Department of Health Guidance states that Clinical Commissioning Groups should ensure they include sufficient information on the delivery of their statutory duties to comply with the requirements of Section 14Z15 Paragraph 2 of the National Health Service Act 2006 (as amended) and the CCG Assurance Framework.

The NHS Act 2006 (as amended) at Section 14Z15 states:

(1) In each financial year other than its first financial year, a clinical commissioning group must prepare a report (an "annual report") on how it has discharged its functions in the previous financial year.

(2) An annual report must, in particular- (a) Explain how the clinical commissioning group has discharged its duties under sections 14R, 14T and 14Z, and

(b) Review the extent to which the group has contributed to the delivery of any joint health and wellbeing strategy to which it was required to have regard under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

(6) A clinical commissioning group must- (a) Publish its annual report, and (b) Hold a meeting for the purpose of presenting the report to members of the public.

5.3.2 The Health and Social Care Act 2012 ("the 2012 Act) creates a common flexible framework, by requiring the establishment of a Health and Wellbeing Board for every upper tier local authority. This took effect from April 2013.

The Terms of Reference of the Health and Well-Being Board are set out in the Council's Constitution – Responsibility for Functions (Appendix A) which sets out the following responsibilities:

- To jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies.

- To consider all relevant commissioning strategies from the CCG and the NHS Commissioning Board and its regional structures to ensure that they are in accordance with the JSNA and the HWBS and refer them back for reconsideration.

- To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients.

- To directly address health inequalities through its strategies and have a specific responsibility for regeneration and development as they relate to health and care. To champion the commissioning of services and activities across the range of responsibilities of all partners in order to achieve this.

- To promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health.

5.5 **Risk Management**

N/A

5.6 **Equalities and Diversity**

5.6.1 Ensures that BCCG meets its Equalities Duties

5.7 **Consultation and Engagement**

5.7.1 Engagement has taken place with multiple internal stakeholders including the CCGs Internal Audit and External Audit providers during the development of the Annual Report and Accounts**.**

6. BACKGROUND PAPERS

Department of Health Guidance, Group Manual for Accounts 2014-15
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389082/FRAB_122_09_-_2014-15_MfA_untracked.pdf

NHS
Barnet Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS

2014/15

'Working with local people to develop seamless, accessible care for a healthier Barnet'

ANNUAL REPORT AND ACCOUNTS

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Annual Report and Accounts

INTRODUCTION FROM CHAIR AND ACCOUNTABLE OFFICER

Welcome to Barnet Clinical Commissioning Group's Annual Report and Accounts for 2014/15.

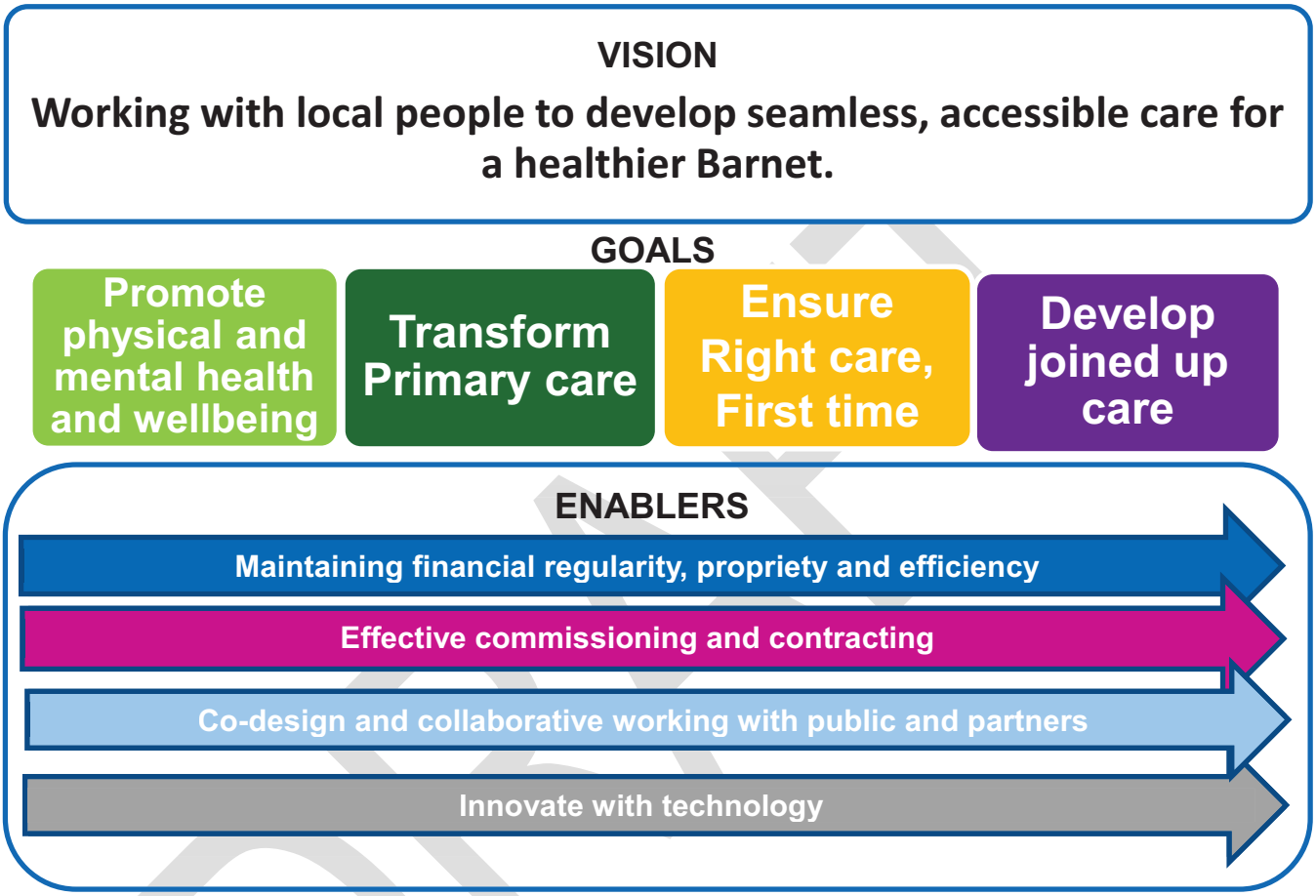
The last 12 months has been a year of opportunity and delivery, and throughout this report we will highlight the many areas where we believe we are making a positive impact on the health and wellbeing of our local population, led by our clinical commissioners, local clinicians who serve our community and drive our progress.

In our first year we started to make some very significant changes in the local health system, and these continue to gain momentum, with primary, secondary and community services becoming more joined up.

BARNET CCG VALUES

- Treat everyone with compassion, dignity and respect
- Person-centred care that supports people to be as healthy as they can be
- Work in partnership and collaborate with all
- Reduce dependency and promote self-care

BARNET CCG STRATEGIC OBJECTIVES AND VISION



In order to realise its vision, the CCG's Governing Body has agreed the organisation's commissioning priorities.

Barnet CCG's commitment to develop more local and joined up care for the benefit of our population – working with the London Borough of Barnet, and our other health and social care partners – is the key driver for our commissioning priorities. We want the best health outcomes for everyone.

COMMISSIONING PRIORITIES

Primary Care

We will review our Primary Care Strategy and engage with our wider GP membership to provide support to develop primary care and primary care networks to enhance services. Our work will include improving care for people in care homes; joining up the work of GPs and community services to ensure patients receive seamless care; supporting primary care to manage more care out of hospital; improve the management of patients of 75 years and those with complex conditions; and prioritise primary care support for vulnerable groups such as looked after children and the homeless.

Mental Health

We will continue to review the needs, models and gaps in mental health services and commission services based on outcomes, and those that best meet the needs of patients.

Information Management and Technology Strategy (IMT)

To support the delivery of more joined up care, Barnet CCG is developing an IMT strategy, which will identify the needs and agree the business case for GP IT and future investment.

End of Life Care

We recognise and support the importance of patient choice, as set out in the NHS Constitution. The CCG is fully committed to supporting the improved provision of end of life care within primary care, as well as increasing the capacity to support people who want to die at home or in a place of their choice.

Service Quality

The quality of our services we buy are critical in making sure patients get the best outcomes and have a good experience. We will continue to rigorously assure and monitor the services we buy; ensure that the systems and processes are in place to promote the wellbeing of children and vulnerable adults; and ensure the quality and safety of care is maintained and enhanced, embedding the key recommendations from the Francis Report.

This will be done by working with our patients and stakeholders to understand the issues impacting on the quality of care.

Value for Money

It is important that we are spending taxpayers' money wisely. At the start of our first year of operation, Barnet CCG was one of the most financially challenged CCGs in England. In order to get to begin to get our finances back on an even keel, we developed a medium-term Financial Recovery Plan, which outlined how we were going to achieve financial balance.

One of our key priorities is to ensure we are progressing satisfactorily with our Financial Recovery Plan and that we are meeting our financial obligations to enable us to achieve our priorities.

Contracts Performance

The way we manage our contracts with our providers will be reviewed to make sure we getting the maximum value for the services we buy and spending money on the right services. This will involve the introduction of performance metrics of our main providers, and renegotiating the Service Level Agreement with the north east London Commissioning Support Unit around improving support and responsiveness to the CCG.

Health and Social Care Integration

We already work closely with the London Borough of Barnet on joint commissioning of services, and have shared resources across both organisations. Our plans are to further establish the CCG as the health system leader in Barnet, working closely with Camden, Enfield, Haringey and Islington CCGs to create a resilient health system in north central London (NCL).

This will be achieved through our contribution to the development of the North Central Health Strategy and the collaboration with NCL partners to deliver agreed strategic priorities.

With the local authority we all also deliver the ambitions of the Barnet Call to Action, which aims to improve integration between health and social care.

WHAT WE ARE DOING TO DELIVER THE CCG'S OBJECTIVES

We have some real success stories, making a positive difference to the health and wellbeing of the people of Barnet. Here are just a couple of examples of service developments that are meeting the health needs of our population.

A Dementia Friendly Commissioning Organisation

Barnet CCG has achieved the 67% national diagnosis rate, one of only 14 in London to achieve the ambition. This is higher than the London regional rate of 65%. In 12 months, Barnet CCG achieved an increase of more than 10%. This is through the efforts of our member practices.

Barnet Council has recently confirmed additional funding for two extra dementia advisors taking the total to three. The dementia advisors are provided through the Alzheimer's Society and support people with dementia following diagnosis throughout the life course of their condition.

The CCG implemented a local enhanced scheme to support practices to ensure an appropriate level of monitoring of the impact of medication.

Successfully Commissioning Integrated Services

In August, we launched what has become a very successful pilot in the West Locality. The Barnet Integrated Locality Team brings health and social care professionals together in **one team in one place** to support older people with complex needs, taking care to the individual who needs it. This involves a designated care coordinator who holds overall responsibility for each client and ensures plans for their care are implemented.

The team works with these older people and their families to:

- agree and deliver personalised care and support to meet their physical, mental and social care needs and
- help them to remain independent for as long as possible

ANNUAL REPORT AND ACCOUNTS

INTRODUCTION FROM MEMBER PRACTICES

Barnet CCG is a membership organisation. A significant amount of hard work has taken place over the last year, since we published our first annual report. Much of this has been in direct response to what our member practices told us in 2013.

In our second year of operation we have made great strides in driving improvements in safety, quality and effective health services for our local population.

This has been achieved through collaborative partnerships with our providers, and robust steps taken to tackle our financial deficit. By the 2016/17 financial year, we are confident we will be in a position to report a positive financial balance.

Our work in public and patient engagement has been strengthened through our Patient Reference Group, Patient and Public Engagement Committee and dedicated internal resource.

We realised savings of £10m this year principally through the Demand Management Scheme which relies on appropriate referrals to secondary care through the Referral Management Service (RMS) and our member practices have worked hard to release these resources so that we can put them to good use to serve our local population.

As a clinically-led organisation, the work of our GP Governing Body members is having wide-reaching impact on our patients. Below is a snapshot of a range of successful commissioning work led by our GP members.

Pathway Redesign led by Dr. Ahmer Farooqi

Following the Royal Free acquisition of Barnet and Chase Farm Hospitals NHS Trust, Barnet CCG has been working on a huge redesign programme across Royal Free London and its commissioning CCGs, looking at different specialties over a five-year period to 2019. The aim is to ensure patients receive a diagnosis and treatment plan at the earliest opportunity, in the most appropriate location and with minimum duplication, to achieve excellent patient experience and deliver the best outcomes within limited resources.

In Phase 1 of the programme we focused on eight specialties:

- Cardiology
- Gynaecology
- Hepatology
- MSK
- Respiratory
- Dermatology
- Gastroenterology
- Urology

Within each specialty a number of pathways have been identified, for instance, within MSK one of the pathways is shoulder pain. Each pathway has been mapped and will go through a rigorous process before it is approved. This includes clinical quality assurance, resource assessment and patient impact. All pathways are tested against NICE guidance and benchmarked against best practice models.

The next stage of Phase 1 is for CCGs to start implementation locally. Patient engagement will be an integral part of this to ensure services are delivered, that work for local residents.

GP IT Review led by Dr. Jonathan Lubin

The CCG worked extensively with the London Borough of Barnet (LBB) to understand the health needs of people living in Barnet and has used the findings as the basis for developing both the Integrated Strategic and Operational Plan and Clinical Commissioning Programmes. The CCG and LBB recognise the potential of Information Management and Technology (IM&T) and have identified the use of innovative technology as a core enabler in the CCG's plans.

The CCG prioritised the development of an IM&T strategy as one of the six priorities for the 2014/15 financial year, and we will go on to develop an integrated health care system which connects and shares information across our community.

This will be achieved by:

- Ensuring access to the right information, in the right place at the right time;
- Using technology and information to drive a paperless environment;
- Recognising technology as an enabler for service transformation;
- Using technology to support patient access, patient choice and reduce health inequalities;
- Harnessing technology and information to improve the quality, safety and consistency of our patient care and enhance commissioning decision making;
- Developing a digital healthcare environment that supports and enables the integrated care model;
- Using consistent information standards that enable data to flow between systems whilst keeping out confidential information safe and secure;
- Developing a culture where health and care professionals take responsibility for recording, sharing and using information to improve the quality and safety of patient care.

Mental Health led by Dr. Charlotte Benjamin

Barnet CCG focused strongly on mental health provision in the borough. This involved a comprehensive needs assessment carried out by UCLP, a financial assessment of the CCG's investment in mental health, a strategic assessment of change to current mental health commissioning and a review of alternative mental health models. These were captured in a report which was accepted by Barnet CCG's Governing Body in October 2014, with a decision to commit extra funds to mental health in primary and community settings.

Our direction in transforming mental health services in the community continues to progress and we have adopted the title 'Reimagining Mental Health. We work by co-design, that is involving service users, commissioners and providers in secondary mental health, community and voluntary sectors to agree what good looks like and to secure it.

In 2014/15 Barnet CCG together with Enfield and Haringey CCGs, worked closely with Barnet, Enfield and Haringey Mental Health Trust to reduce delayed transfers of care (DTOC) for patients using mental health services. This this resulted in significant

reductions, improving efficiency in the use of mental health beds. We also commissioned Kaleidoscope Community Interest Company (CIC) to map the existing pathway for patients in crisis and develop a concordat and action plan. In Barnet we have made this this part of our Reimagining Mental Health programme.

The concordat sets out how organisations will work together better, to make sure that people get the help they need when they are having a mental health crisis. It focuses on:

- Access to support before crisis point
- Urgent and emergency access to crisis care –treated with the same urgency as a physical health emergency
- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect
- Recovery and staying well – preventing future crises through referral to appropriate services
- Prevention and intervention

You can read more http://www.crisiscareconcordat.org.uk/areas/barnet/#action-plans-content

Co-commissioning led by Dr. Michelle Newman

From 1st October 2014 changes were made to the Health and Social Care Act 2012 to allow CCGs to take on joint responsibility with NHS England for primary care contracts, embracing many of the responsibilities previously held by Primary Care Trusts. We welcomed this.

Initially co-commissioning is about the contracts NHS England holds with general practice but in later years is likely to include the contracts with opticians, pharmacists and dentists. Barnet CCG, with its north-central London CCG partners, is taking on joint responsibility with NHS England for:

- General Medical, Personal Medical and A…..Medical services contracts
- Newly designed enhanced services (“Local Enhanced Services (LES)” and “Directed Enhanced Services (DES)”) which augment the key medical services practices reply
- Design of local incentive schemes as an alternative to the national Quality and Outcomes Framework (QOF) so that we can focus on the key quality improvements we believe will benefit our patients
- The ability to establish new GP practices in an area

- Making decisions on “discretionary” payments (e.g. schemes which enable doctors who haven’t been practicing to return to the workforce)

Following a vote of our GP membership in March 2015, we have approved the adoption of a co-commissioning approach and have made changes to our constitution.

Rob Larkman Interim Accountable Officer 28th May 2015	Dr. Debbie Frost Chair 28th May 2015

Strategic Report

REVIEW OF THE LAST TWELVE MONTHS OF BARNET CCG

This part of the document is to inform you about the work of the CCG in our second year of operation.

Here is a summary of some the key achievements over the last year.

KEY ACHIEVEMENTS IN 2014/15

INTEGRATED CARE

We have made significant progress in implementing a shared approach to delivering integrated care across Barnet. A risk profiling tool (electronic case finding tool) is now in use in our practices, identifying those patients at a higher risk of an unplanned attendance or admission to hospital. The Care Navigation Service (is a team that supports the delivery of integrated care plans for people with frailty and long term conditions; and the Multi-Disciplinary Team plans and manages the delivery of the most complex care. It includes GPs, acute consultants and professionals in, social care, specialist mental health and community health). They have been supporting general practice to manage those patients identified using the risk profiling tool.

In addition, we launched the care homes locally commissioned service in September 2014. This scheme is enhancing relationships between GPs and care homes, offering a more holistic service to care homes with more proactive and preventative care on offer, anticipation people's needs helping to prevent crisis and avoidable emergency admissions to hospital.

DEMENTIA PATHWAY REDESIGN

During 2014/15 we continued to develop the dementia pathway as a priority, from fully implementing the new Memory Assessment Service for diagnosis to integrating post-diagnostic support and including the Dementia Advisor Service into diagnostic services. Patients and carers can now receive support from the point of diagnosis, including support training sessions for carers with the development of Strategies for Relatives (STaRT) and the Carer Information and Support Programme (CRiSP). Barnet's

services provide support for the life course of the condition including a day opportunities service, dementia cafes, continued support with the dementia advisor service and a range of other activities such as library initiatives.

The CCG together with the London Borough of Barnet ran a successful dementia awareness day at Hendon Town Hall in November 2014 which included a Dementia Friends session, presentations from UCL-Partners, the Memory Assessment Service Team (MAS), and Alzheimer's Society. It was attended by GPs, clinic nurses and receptionists, and representatives from social care.

In partnership with UCL Partners and the Community Education Provider Network (CEPN), Barnet CCG has also successfully trained a range of healthcare support professionals in dementia awareness over the previous 12 months.

The CCG is now being supported by two GP clinical leads that job share the role – Dr. Sharon Lawrence and Dr. Sanchita Sen - as well as the Governing Body in developing dementia services.

REFERRAL MANAGEMENT SERVICE

It is important that the benefit for patients is maximised with the budget made available to us and equally important that patients access the right service according to their clinical need with the correct information available beforehand. This in turn means that clinicians are able to carry out treatments more effectively and efficiently and any savings made are reinvested back into new and improved services for our patients.

The Referral Management Service (RMS) acts as a central point for referrals in Barnet to ensure patients are seen by the right person, in the right place and at the right time.

Led by a team of experienced local doctors, the RMS processes approximately 7,000 to 8,000 referrals a month. Approximately 80% of these referrals are triaged. The team will decide on the best place for the patient to be seen. This may be a community clinic (which is also often consultant led), a hospital, or they might ask the GP to carry out further tests, for example an x-ray before making a decision about which treatment is offered. Once the decision is made, where possible, the patient is given a choice of which provider to book in order to carry out the treatment.

The remaining 20% of referrals relate to specialist services and these referrals are sent directly on to the provider.

The RMS is also a central point for patient queries and practice queries regarding patient referrals.

PATIENT CARE AND TREATMENT REVIEWS (WINTERBOURNE)

We have been working closely with NHS England to undertake detailed Care and Treatment Reviews (CTRs) for patients with Learning Disabilities (PWLD) and Autism who meet the criteria of the Assuring Transformation (Winterbourne) concordat. The aim of the CTRs is to assess the needs of people with Learning Disabilities and how their future care needs could best be met.

The reviews which took place over a full day listened to the views of patients, their advocates, family members and representatives. Twelve patient reviews were completed between December 2014 and end of February 2015.

The priority themes emerging from the reviews were:

- *Providers to review training for care teams and staff and monitor impact on service quality and patient experience;*
- *Providers to produce updated, comprehensive, individualised and operationalised plans including how Positive Behaviour Support is embedded in their organisations, risk assessment, communication passports and person centred plans;*
- *Work with care co-ordinators and other stakeholders such as advocates to improve engagement and communication with family members, carers and appointed representatives in decision-making, discharge planning and particularly to look at the range of alternatives and options available;*
- *Providers to offer and engage in a variety of activities to improve patients' experiences and quality of life and to help identify patients' likes and dislikes and to have a broader view of goals and aspirations through effective person-centred planning;*
- *Providers to adopt appropriate methods and assessment tools to understand function of behaviours of patients; and*
- *A need for improved rights based advocacy – although advocacy was in place there were difficulties because of communication problems and understanding of complex needs and behaviours that challenge.*

Provider focused action plans and the recommendations for each individual patient were reported to NHS England and updated fortnightly.

SYSTEMS RESILIENCE

The Systems Resilience Group (SRG) has provided the opportunity for all parts of the local health and social care system to work closely together to develop strategies and plan safe and efficient services for the local population. In 2014/15 its focus was on urgent care.

Barnet CCG was allocated two tranches of national resilience funding to be shared amongst local partners to the total of £4.328m.The funds were used to implement and enhance services during the winter period to ensure that there was enough capacity in the system to cope with increased demand. Below is a selection of the schemes

- Increased investment with the British Red Cross Home from Hospital service;
- Additional nursing home bed capacity;
- Increased enablement at home capacity;
- 24-hour mental health liaison service;
- Increased social work support at weekends;
- Increased Urgent Care Centre opening hours;
- Increased therapy support at the Royal Free and Barnet Hospital sites;
- Increased investment within the community rapid response service;
- Additional general practitioner appointments; and

QUALITY IMPROVEMENT

Barnet CCG considers patient safety, high quality care and service users' experience to be amongst its key priorities as a commissioner of health care services for the communities in Barnet. The quality of care in the NHS has been under constant scrutiny over the past few years because of a number of high profile inquiries and reviews. Barnet CCG's Governing Body members would like to provide assurance that there are many areas of excellence and good practice within the wide range of services that its commissions, but at the same time, it acknowledges that there are also areas that require further work in order to improve the clinical outcomes, patient experience and improve and sustain existing good levels in patient safety.

We monitor and focus on the qualitative aspects of our commissioned services through the monthly Clinical Quality Review Group meetings in collaboration with other neighbouring CCGs in order to provide commissioning scrutiny and oversight on the performance of our provider organisations (hospital and community health services). The CCG's Clinical Quality and Risk Committee has overall responsibility for undertaking the detailed review and monitoring of our provider services' compliance with quality and safety standards which include national standards such as: 62 day cancer waits; 18 weeks wait for Referral to Treatment (RTT); six weeks targets for diagnostics; compliance with Infection Prevention and Control targets such as Clostridium Difficile and Methicillin Resistant Staphylococcus Aureus (MRSA); maternity services standards; Mixed Sex Accommodation breaches; reduction on serious patient safety incidents and never events and the rolling out of Friends and Family Test (FFT).

Our Governing Body meetings receive a Quality and Risk assurance report from the Chair of the Clinical Quality and Safety Committee, which provides updates on how the CCG is obtaining the right level of assurance for all quality improvement measures with its providers and most importantly, to ensure that they are adhering to national standards for quality and safety and locally set priorities as identified in the CCG's Quality Strategy.

In 2014, NHS England identified that Barnet CCG was facing significant challenges given that it was situated in a uniquely complex health economy with a combination of sustainability, performance and quality concerns playing out for a number of years by the poor performance of Barnet and Chase Farm Hospital. NHSE felt that the CCG was effectively engaged in a number of major transformational programmes within the local health economy and also, across North Central London with the proposed acquisition of Barnet and Chase Farm (BCF) Hospitals by the Royal Free Hospital (RFL) NHS Foundation Trust. At an assurance meeting with NHSE in May 2014, the CCG's Governing Body members agreed that it required leadership support from NHSE to manage the proposed acquisition of BCF by RFL.

We took over lead commissioner responsibilities of Barnet and Chase Farm Hospitals NHS Trust in April 2014. With support from NHS England, the CCG took over the lead commissioner for Royal Free London post acquisition of BCF on 1st July 2014 following approval of the Secretary State for Health. It was recognised by NHSE that the acquisition of BCF by RFL has and would continue to add to the significant challenges and workload

of the CCG and as a result, NHSE issued legal directions to Barnet CCG under the NHS Act 2006 in July 2014.

During the course of 2014/15, Barnet CCG has worked collaboratively with RFL, NHSE, and the RTT National Intensive Support Team on managing the RTT waiting list so that RFL can meet national standards' compliance.

BCCG has met NHSE for assurance checkpoint discussions in respect of Legal Directions and following an exchange of correspondence a pack of supporting evidence is being drawn together by BCCG to support NHSE London's advice to remove the directions.

More recently, our internal auditors have given substantial assurance on the CCG's performance on quality and safety standards such safeguarding, risk management, patient and public engagement, information governance and compliance with infection control standards.

STRATEGIC REPORT

FINANCIAL OVERVIEW

In 2013/14 Barnet CCG started its journey as a newly created organisation and, one of the most financially challenged clinical commissioning groups in England.

This was largely due to the historic position which was inherited on 1st April 2013 from the former Barnet Primary Care Trust (PCT) and for which the CCG assumed responsibility. We are very clear about the reasons for this historic position and these were set out in our 2013/14 Recovery Plan.

The initial Barnet CCG Recovery Plan published in May 2013 set out the financial challenges faced by Barnet and planned for repayment of the growing cumulative deficit over a five year period. In the two years since then, the financial position has significantly improved.

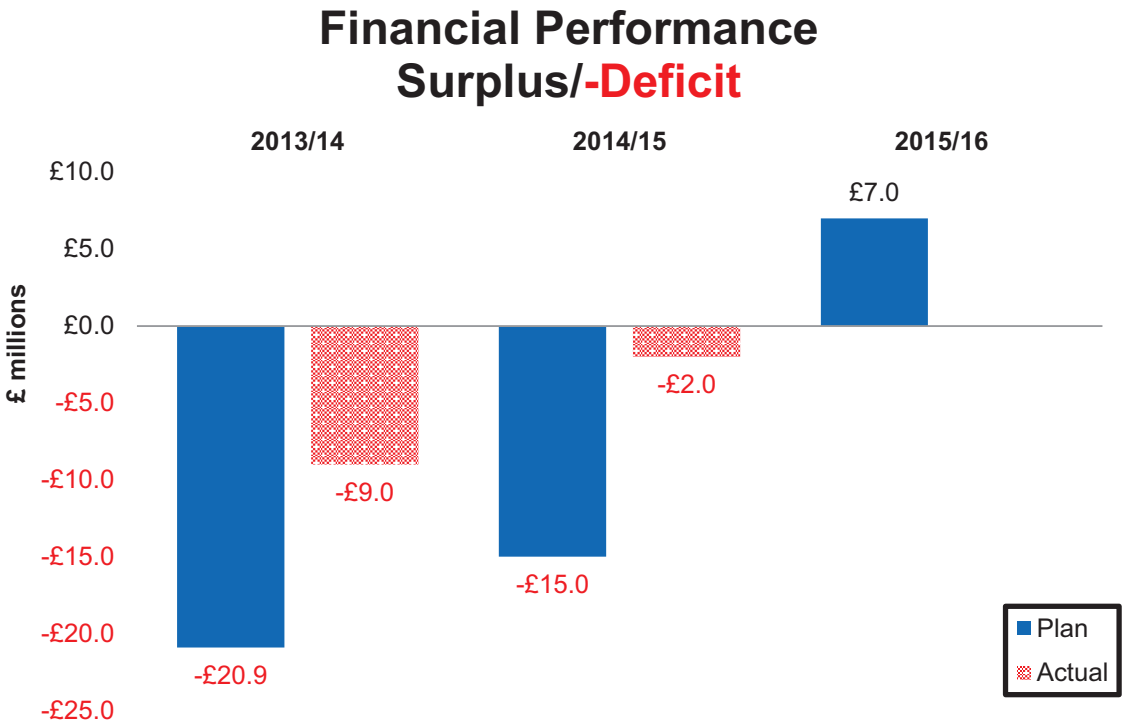
The original CCG 2013/14 financial plan was for a £20.9m deficit. The final outcome for 2013/14 was a significant improvement of a £9m deficit.

The financial improvement continued in 2014/15 with the CCG bettering by £13m its planned £15m in year deficit (cumulative £24m planned deficit including the previous year's £9m carried forward deficit). Our in year deficit was £2m and our cumulative deficit at 31st March2015 is therefore £11m. The improvement against plan arose due to a number of factors including some additional NHS England funding, but principally due to close monitoring and control of expenditure throughout the year.

During the latter part of 2014/15, the CCG had an external financial assessment which concluded that the overall financial controls were sound. It recommended that the CCG should challenge itself more and aim to set a breakeven budget for 2015/16 based on the announced 2015/16 allocation at that time, a surplus the year after and repay the deficit within three to four years.

The CCG accepted this and initially planned a breakeven budget for 2015/16. In December 2014, the Government announced an additional £2 billion of funding for the NHS, to be targeted towards underfunded CCGs. Barnet CCG received an additional £11m for 2015/16 of which £4m has been set aside as resilience funding to improve patient services during the winter period. Even after the £11m additional funds, the CCG remains 2.5% below its target allocation.

The recovery plan was updated in January 2015 and the additional funding enabled the CCG to plan a £7m in year surplus for 2015/16 and forecast repayment of its total accumulated deficit by 2016/17.



STRATEGIC REPORT

EQUALITIES REPORT

How the CCG is meeting the public sector equality duty

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It replaced previous antidiscrimination laws with a single act, making the law easier to understand and strengthening protection in some situations. It sets out the different ways in which it is unlawful to treat someone. The intention of the general equality duty is to ensure that a public authority like NHS Barnet CCG must, in the exercise of its functions as a public sector organisation, have due regard to three main aims to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The specific duties of the Equality Act require the CCG to publish equality objectives at least once every four years and to publish annual equality information to demonstrate how the CCG is meeting its general duty.

Equality Information

Our Equality Information is our annual performance report which we have published in January 2015 to meet our public sector equality duty (PSED). The report outlines the work we have done since April 2013 in relation to policy development, commissioning, engagement, current workforce and recruitment of staff from diverse backgrounds. It also provides further links to our main providers' equality information about how our providers are meeting their equality duty.

For equality information report please visit NHS Barnet CCG's website
http://www.barnetccg.nhs.uk/Downloads/Document%20Library/Barnet%20Equality%20Information%20-%20January%202015.pdf

Equality Objectives

Our equality objectives set out what equality outcomes we intend to achieve in our organisation both in workforce and commissioning, and how we want to achieve them.

We have refreshed our equality objectives in consultation with our partners, providers and the community and voluntary organisations. We have also developed an action plan to deliver equality objectives and to ensure relevance to our priorities as well as monitoring progress. The CCG is required by the PSED to develop and publish equality objectives once every four year. Our current equality objectives 2012-16 are revised every year and we have delivered our equality objectives to meet the public sector equality duty.

Equality Analyses

We routinely analyse our existing and new policies to ensure there is no unintended negative or disproportionate impact on equality groups that are protected by the Equality Act. At NHS Barnet CCG no policy decision is made without an equality analysis of the policy. Our governing body report cover sheet includes a section specifically about equality impact prompting managers to carrying out an equality analysis of the policy or the function they are reporting to the governing body. We maintain a log for all our equality analyses and ensure the actions arising from the analyses are implemented and monitored. Staff receive appropriate training and support to complete equality analysis.

Equality Delivery System (EDS2)

NHS Barnet CCG has adopted the Equality Delivery System, EDS2. We are working with NEL CSU, Healthwatch and our providers to have assessed our performance against four EDS2 goals and 18 outcomes and determine grade. This has helped us identify gaps, set priorities and develop action plans. Our equality objectives and the action plan will be designed and delivered through EDS2. Our January 2015 Equality Information include information about the CCG's current grades and the targets for the future.

Workforce Race Equality Standard

The Workforce Race Equality Standard (WRES) will, for the first time, require organisations employing almost all of the 1.4 million NHS workforce, to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of Black and Minority Ethnic (BME) Board representation. All providers, as holders of the NHS standard contract 2015/16, except 'small providers', will be expected to implement the WRES from April 2015. An annual report will be required to be submitted to the co-ordinating commissioner outlining progress on the WRES. The CCG is working with its providers to ensure through contract monitoring that they meet the standard.

NHS Employers Organisation Equality and Diversity Partners Programme

Out of many applications NHS Barnet CCG was selected as one of the Equality and Diversity Partners by the NHS Employers organisation for 2014/15 programme. This was the result of north east London Commissioning Support Unit's work with the CCG and its partners and providers. Since then the CCG has been an active partner in the programme and the work has been recognised as a good practice, particularly the implementation of EDS2 to deliver equality objectives. The Director of Quality and Governance was selected for the Diversity Award for her role in providing leadership in the CCG to take the equality and diversity agenda forward.

STRATEGIC REPORT

MANAGEMENT OF RISK

Barnet CCG has a comprehensive Risk Management Strategy that enables the organisation to have a clear view of the key risks affecting each area of its activities; how these risks are being managed; the likelihood of occurrence; and their potential impact on the successful achievement of the CCG's key objectives.

The two key documents that support the CCG's Risk Management Strategy are the Governing Body's Assurance Framework (GBAF) and its high level Corporate Risk Register. The GBAF identifies the key risks, actions, controls and assurance that have been put in place by the relevant directorates and departments that may have an impact on the CCG's principal and strategic objectives. Similarly, the high level Risk Register identifies those risks that are managed by the CCG's respective executive team members that could threaten the achievement of the CCG's key operational objectives.

Both the GBAF and the Corporate Risk Register are reviewed regularly by the CCG's Governing Body, Audit Committee, Clinical Quality & Risk Committee, the Executive Management team, and Finance, Performance & QIPP Committee. In addition, to the Risk Management Strategy, the CCG has a number of key policies in place such as the Information Governance Policy; Serious Incident Policy; Incident Reporting Policy; and Complaints Policy in order to report and investigate incidents, complaints and other significant concerns.

The Risk Management Strategy additionally provides the policy framework for the CCG and its entire staff to work within its protocols in order to identify and manage its risks. Both the GBAF and Corporate Risk Register provide a clear indication of how well risk management is being embedded at both organisational level and at directorate level. The ownership of risk is evident at all levels and the CCG is moving towards embedding risks at directorate, departmental and project management level so that there is comprehensive overview of risks across all sections of the organisation. This is reflected by the proactive culture of risk management adopted by the CCG's Governing Body.

STRATEGIC REPORT

THE CLINICAL COMMISSIONING GROUP INTERNAL CONTROL FRAMEWORK

A system of internal control is a set of processes and procedures in place in an organisation and which enables it to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise risks, to evaluate the likelihood of those risks materialising and the impact should they materialise, and to manage them efficiently, effectively and economically.

The system of internal control allows risks to be managed to an acceptable level if these risks cannot be eliminated; it can, therefore, only provide reasonable and not complete assurance of effectiveness.

RISK ASSESSMENT IN RELATION TO GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

The CCG's risk assessment process is embedded in its Risk Management Strategy. The purpose of a risk assessment is to provide a systematic and methodical tool for identifying risks associated with legal, ethical and financial duties, removing or mitigating such risks, where possible, or otherwise adopting all the control measures and precautions that are reasonable and practical in the circumstances. The CCG has adopted the NPSA (2006) Risk Assessment Tool and the (5x5) Risk Matrix in order to grade risk.

The Risk Assessment Tool forms part of the overall risk assurance process in order to continue to update the Governing Body Assurance Framework.

The Risk Assessment Tool, together with the appropriate training and use of other tools, such as the risk matrix, provides guidance to staff to ensure that risks are graded objectively and based on their actual or potential impact or consequences.

The Audit Committee monitors the CCG's systems of internal controls and this Committee is chaired by a lay member. The systems of internal controls include the Governing Body Assurance Framework, Corporate Risk Register, relevant Strategies and Policies, for example, Standing Financial Instructions, Standing Orders, Complaints Policy, Incidents and Serious Incidents Reporting Policy, Conflicts of Interests Policy, Whistleblowing Policy, Anti-Fraud and Bribery Policy and Information Governance Policy and other related reporting systems.

Assurance is obtained from a number of sources such as internal and external audits, management and committee reports, reports from the north east London Commissioning Support Unit and external reviews and NHS England assurance process. Baker Tilly is the CCG's internal auditors

The CGG's system of internal control is based on an ongoing process which is designed to identify, review, evaluate and prioritise the risks that compromise the achievement of its principal objectives. The CCG's Assurance Framework provides an overarching document which details its key risks, controls, actions and risk scores. The Assurance Framework is reviewed by the CCG's key committees and the Audit Committee provides assurance to the Governing Body that its key risks are being continuously reviewed and mitigated in accordance with its Risk Management Strategy.

Prevention and deterrents of risks

Below is a non-exhaustive list of examples:

- The internal auditors adjusted their audit programmes to focus on areas where particular assurance was required by the Governing Body;
- The Clinical Quality and Risk Committee reviews a range of quality and safety issues including performance reports and action plans from provider organisations;
- The Corporate Risk Register demonstrates improvements in reducing levels of risks through the relevant management actions by the Executive Team;
- The organisation has introduced cover sheets for reports, templates, incident and risk assessment forms;
- There is a mandatory training programme in place for all staff including agency and bank staff;
- Individual directorates and departmental risk registers have been developed and feed into the Corporate Risk Register;
- There is a Project Management Office IT system, Project Vision, that also captures all risks relating to project management;
- The CCG's whistleblowing policy was updated in May 2014 following key changes in legislation.

CAPACITY TO HANDLE RISK

The CCG has received reasonable assurance from internal audit in November 2014 that it has sound systems and processes for identifying and managing risks from a Quality and Safety perspective. However, there are areas of improvement which the CCG continues to review in order that all its system of internal controls are strengthened.

The Risk Management Strategy clearly defines the accountability framework and key responsibilities for risk management for all staff within the CCG. The management for key risks is assigned to the executive team and responsibilities delegated to individual risk owners within each of the directorates and departments. Risks are escalated onto the Assurance Framework through either a lead director exercising his/her executive discretion or these are discussed at the executive team meeting on a monthly basis where a consensus decision is reached for escalating or de-escalating risks from the Assurance Framework and the Risk Register. The CCG's Governing Body has overall accountability and responsibility for the management of its key risks.

Through its scheme of delegation, the CCG devolves appropriate responsibilities to all directorates and departments to create and manage their respective risk registers, including project risk registers to ensure that a culture of proactive engagement and maintenance is embedded throughout the CCG.

The accountability for risk management sits with the Governing Body and its committees as described in its constitution and its risk management strategy.

The Director of Quality and Governance is the lead director for risk management and retains overall responsibility for ensuring that the CCG's Assurance Framework and Risk Register are updated on a regular basis. This work stream is a core function of the Quality and Governance Directorate.

The Head of Governance and Corporate Affairs supports the Director of Quality and Governance, in ensuring that both the Governing Body Assurance Framework and Corporate Risk Register are reviewed by the Executive Team on at least a monthly basis. In this way all key committees receive up to date risk information.

The CCG's Risk and Governance Manager, ensures that the respective executive team members and risk owners are maintaining robust control on their identified risks and that there is an evidential system of review, such that action plans are being

implemented in a timely manner and in accordance with the CCG's Risk Management Strategy.

During 2014/15, the CCG purchased new risk management software to improve and strengthen its systems of internal control and risk management. Risks are classified and stratified in accordance with key directorate responsibilities. For instance, risks relating to finance and allocation of resources sit within the remit of the Finance Directorate and risks relating to Quality, Patient Safety, Safeguarding and Infection Control sit within the remit of the Quality and Governance Directorate. The respective lead directors are the Chief Finance Officer and the Director of Quality and Governance.

All key operational and strategic risks, including corporate governance functions, fall under the responsibility of the Chief Officer. Senior managers within the CCG have received high level training commensurate with the job role specifically on risk management. Risk management training is provided as part of the corporate and local induction.

The table below provides a brief summary of the key risks that the CCG faced in 2014/15 but a detailed Assurance Framework can be accessed via the Barnet CCG website. http://www.barnetccg.nhs.uk/Downloads/boardpapers/26%20Feb%202015/Paper%2014.0%20-%20Governing%20Body%20Assurance%20Framework.pdf.

Risks that feature on the CCG's Assurance Framework as at 31st March 2015

Assurance Framework	Description	Inherent Risk Score	Current Risk Score
1b	CQC, LBB and BCCG have raised significant concerns relating to quality and safety and the safety of care at BEHMHT	20	12
3b	RFL Barnet Chase Farm site is experiencing significant performance issues relating to long wait patients and is failing to deliver national Referral to treatment times (RTT) and diagnostic waits. It is also failing to report against national standards. The level of performance could lead to clinical harm for patients.	16	16
3c	The current system wide resilience plan will not be sufficient to meet demand over the winter period because of increased pressure (patient activity) on all provider organisations	16	16
3d	There are 10 Key Quality and safety risks identified by the RFL post acquisition of BCF that could impact on the provision of safe, effective and responsive quality care at RFL.	16	12
3p	Potential delay in the transformation of clinical pathways and the implementation of joint clinical strategy during and post RFH/BCF	15	15

	acquisition may not deliver whole system-wide change including significant cost savings, efficient clinical services and improve clinical outcomes		
4a	Budgeted outturn may not be achieved and future years as per the Financial Recovery Plans due to acute contract over performance not related to QIPP delivery	20	15
5a	The CCG carries a reputational and operational risk in that the CCG has 2 conditions on finance and financial planning	20	20
5c(i)	Non-Compliance with the Referral to Treatment direction by NHSE There is a risk that inadequate reporting on planned care activity leads to adverse financial consequences to the CCG and impairs the CCG's ability to set a planned care activity baseline for 2015/16	20	16
5c(ii)	There is a risk to the reputation of the CCG as a consequence of Legal Directions by NHS England in relation to the lead commissioner role of Barnet CCG of the Royal Free London Foundation Trust's performance in achieving national Referral to Treatment Standards	16	12

Two strategic risks relating to the CCG's compliance with NHS England's conditions and directions.

- The CCG carries a reputational and operational risk in that the CCG has 2 conditions on finance and financial planning; and
- There is a risk to the reputation of the CCG as a consequence of Legal Directions by NHS England in relation to the lead commissioner role of Barnet CCG of the Royal Free London Foundation Trust's performance in achieving national Referral to Treatment Standards

STRATEGIC REPORT

REVIEW OF EFFECTIVENESS – INTERIM ACCOUNTABLE OFFICER

The review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive team, senior managers and clinical leads within the Clinical Commissioning Group, who have overall responsibility for the development and maintenance of the internal control framework.

As the Accountable Officer I have drawn on performance information available. My review is also informed by comments made by the external auditors in their management letter and other reports.

The *Governing Body's Assurance Framework* itself provides me with the evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, the Finance Performance and QIPP Committee, and the Clinical Quality and Risk Committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Following completion of the planned audit work for the financial year for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control.

Rob Larkman Interim Accountable Officer 28th May 2015

HEAD OF INTERNAL AUDIT OPINION FOR THE YEAR END 31 MARCH 2015

Roles and Responsibilities

The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The CCG's Assurance Framework is one of the key mechanisms that the Accountable Officer can use to support their AGS.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) 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 (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have 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, it is one component that the Governing Body takes into account in making its AGS.

The Head of Internal Audit Opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accounting Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Governing Body in the completion of its AGS.

My opinion, based on work undertaken up to 22nd May 2015, is set out as follows:

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

However; there was one review where we could only provide some assurance. We issued an **Amber RED** opinion on the review of the Procurement of Interim Staff. The CCG had specifically requested a review in this area.

Key issues from these reviews were as follows:

- The CCG did not appear to have robust arrangements with regards to obtaining assurance that employees engaged through a limited company were compliant with IR35 requirements;
- There was no formal policy or guideline document in place at the CCG relating to the Procurement of interim Staff which covered the processes required to be followed when recruiting staff via agencies or personal service companies; and
- There was no formal process that required formal authorisation and reasons for recruiting interims to be documented.

An action plan was agreed for each of recommendations and these are included within the action tracker which is regularly updated and reported back to each meeting of the Audit Committee. Since the issuing of our findings, the CCG, assisted by specialist tax advisors, has developed a policy on Recruitment of Interim Staff which addresses the points above. This policy was tabled at the Directors meeting and is now being applied. The policy has been approved by the Audit Committee. The CCG has also retrospectively sought for 2014/15 assurance from interims of their compliance with IR35.

Internal Audit has been able to deliver substantial or reasonable assurance in all other areas reviewed

Further issues relevant to this opinion

We have considered the findings of the Service Auditor report carried out by the internal auditors of NHS England at the North East London Commissioning Support Unit (CSU),

on behalf of the CSU customers, including Barnet CCG. Whilst we note a number of exceptions have been identified, we have liaised with the CSU and do not believe that there is anything significant requiring inclusion within the AGS.

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 internal control issues within the 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.

Nick Atkinson Head of Internal Audit 28th May 2015

DATA QUALITY

The Governing Body members consider data quality to be integral part of its systems of internal controls in order that it can assess both the effectiveness and performance of the organisation and also, its contracted services. During the course of 2014/15, the business information and activity data supplied to the CCG by its contracted services did not consistently meet the standards expected by the Governing Body in order that it can make informed commissioning decisions. As a result of this, the CCG has taken appropriate steps to ensure that there is a continuous improvement in the quality of data provided by its commissioned services.

BUSINESS CRITICAL MODELS

CCG business-critical models primarily rely on activity and finance data produced by the CSU which is assured through their own processes. The CCG reviews CSU data regularly and its use is checked internally by the executive team and externally through audit of key systems and processes. The output of business-critical models is validated by NHS England through their assurance process of the CCG.

DATA SECURITY

We have submitted information to the NHS Information Governance Toolkit and have achieved compliance with Level 2 with the toolkit standards.

DISCHARGE OF STATUTORY FUNCTIONS

During establishment, the arrangements put in place by the Clinical Commissioning Group and explained within the *Corporate Governance Framework* were developed with extensive expert external legal input. This was to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decisions and the scheme of delegation.

INFORMATION GOVERNANCE

Barnet CCG's Information Governance Strategy brings together all the requirements, standards and best practice that apply to the handling of information allowing implementation of the NHS Information Governance Framework and guidance; compliance with the legal requirements; and an implementation improvement plan.

In addition to the Information Governance Strategy, the CCG has a number of key Information Governance policies which allow the organisation and its staff to ensure that personal and commercially sensitive information is handled legally, securely, efficiently and effectively, in order to deliver the best possible care.

Barnet CCG has put in place procedures and processes for how it handles corporate information that support the efficient management of services and resources. Information governance plays a key role in supporting all areas of governance (clinical, financial and corporate), commissioning, service planning, contracting and performance framework. We recognise the importance of reliable information, both in terms of commissioning services, efficient management of the CCG's day-to-day business and resources.

The submission of the annual NHS Information Governance Toolkit was undertaken in March 2015 by North East Central London Commissioning Support Unit and the CCG achieved Level 2 compliance. The management of information governance risk falls under the responsibility of the Clinical Quality & Risk Committee. The Director of Quality and Governance is the Senior Information Risk Officer and the Clinical Chair of the Quality Committee is the Caldicott Guardian.

The CCG has put systems and processes in place to ensure it fulfils its information governance responsibilities. The Clinical Quality and Risk Committee and the Quality and Risk Working Group Meetings, Senior Information Risk Owner (SIRO), Caldicott Guardian and internal auditors have reviewed the information governance arrangements, associated evidence and information has been submitted to the NHS Information Governance Toolkit.

There were no incidents relating to data loss between April 2014 and March 2015 directly attributable to Barnet CCG. However, there were incidents relating to minor information governance breaches.

All incidents relating to information governance are reported and investigated in accordance with the CCG's Incident Reporting Policy. We have introduced secure printing for confidential information and all staff have completed mandatory annual information governance training. Risks relating to information governance and information management continue to feature on the CCG's Risk Register which is reported to the

Clinical Quality & Risk Committee, Finance, Performance and QIPP Committee and the Audit Committee.

We handle all electronic confidential information via nhs.net and have created dedicated secure nhs.net email addresses for complaints and incident reporting. The CCG has updated its information asset register in order to meet compliance with the NHS Information Governance Toolkit.

SUSTAINABILITY REPORT

The Clinical Commissioning Group takes its social and environmental responsibilities seriously and reports its progress in delivering against sustainable development indicators as required.

We seek continuous improvement in assessing the risks, enhancing our performance and reducing our impact on our environment, including against carbon reduction and climate change adaptation objectives. We maintain and where necessary establish mechanisms to embed social and environmental sustainability across policy development, business planning and in our commissioning activities.

By working closely with our providers (and their landlords and premises providers) to monitor their own policies and procedures we ensure the Clinical Commissioning Group continues to comply with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

In November 2014 the CCG relocated to North London Business Park in New Southgate, where we now work together with the London Borough of Barnet.

MEMBERS REPORT

Members Report

The CCG Governing Body is responsible for NHS clinical commissioning decisions across Barnet. It meets formally once every two months and is a mixture of primary care and secondary care clinicians, experienced NHS managers, lay members and representatives from other key stakeholder organisations such as the London Borough of Barnet and Healthwatch Barnet. The Governing Body is constituted of 15 members, nine of whom are elected GP members including the Chair. The Accountable Officer (Chief Officer), Chief Financial Officer, Lay Member with governance remit, Lay Member with patient and public engagement remit, a registered nurse member and secondary care doctor are appointed.

DETAILS OF MEMBERS OF THE MEMBERSHIP BODY AND GOVERNING BODY

CHAIR

Dr. Debbie Frost is the Chair of the Clinical Commissioning Group.

ACCOUNTABLE OFFICER

John Morton was the Accountable Officer and Chief Officer from 1st April 2013 to 31st July 2014. Rob Larkman was appointed Interim Accountable Officer from 1st August 2014.

COMPOSITION OF THE GOVERNING BODY

Governing Body Members as at 31st March 2015	
Elected Voting Members:	
Dr. Debbie Frost	GP member and Chair
Dr. John Bentley	GP member and Lead for Quality and Safety
Dr. Ahmer Farooqi	GP member and Lead for Clinical Pathways
Dr. Charlotte Benjamin	GP Member, Lead for Mental Health
Dr. Barry Subel	GP Member, Deputy Clinical Chair, Lead for Urgent and Unscheduled Care
Dr. Michelle Newman	GP Member, Lead for Primary Care since May 2014

MEMBERS REPORT

Dr. Swati Dholakia	GP Member, Lead for Pharmacy since May 2014
Dr. Clare Stephens	GP Member, Lead for Children
Dr. Jonathan Lubin	GP Member, Lead for Older People
Appointed Voting Members:	
John Morton	Chief Officer/Accountable Officer (to 31st July 2014)
Hugh McGarel-Groves	Chief Finance Officer
Rob Larkman	Interim Accountable Officer (from 1st August 2014)
Bernadette Conroy	Lay member, Audit Committee Chair
David Riddle	Lay Member, Vice-Chair
Helen Donovan	GB Registered Nurse Member
Karl Marlowe	GB Secondary Care Doctor
Members with Speaking Rights and Non-Voting:	
Regina Shakespeare	Interim Chief Operating Officer and Director of Clinical Commissioning (from 1st December 2014)
Andrew Harrington	Director of Clinical Commissioning (to19th December 2014)
Peter Coles	Interim Chief Operating Officer (1st August 2014 - 1st December 2014)
Vivienne Stimpson	Director of Quality and Governance
Maria O'Dwyer	Director of Integrated Commissioning
Matt Powls	Interim Director of Performance and Planning (from October 2014)
Kate Kennally	Strategic Director for Communities, London Borough of Barnet
Andrew Howe	Director of Public Health, London Borough of Barnet
Healthwatch & Community Barnet Representatives:	
Selina Rodrigues	Head of Healthwatch
Julie Pal	Chief Executive, Community Barnet

MEMBERS REPORT

AUDIT COMMITTEE AND AUDIT COMMITTEE MEMBERS

The Governing Body is not aware of any relevant audit information that has been withheld from the clinical commissioning group's external auditors, and members of the Governing Body take all necessary steps to ensure they are aware of relevant information and to ensure that this is passed to the external auditors where appropriate.

Members	
Bernadette Conroy	Chair and Lay Member
David Riddle	Lay Member and Vice Chair of the CCG
Dr. John Bentley	GP Governing Body Member
Dr. Barry Subel	GP Governing Body Member

REGISTER OF INTERESTS OF GOVERNING BODY MEMBERS

The CCG maintains a Register of Interests which is updated every two months and posted on the CCG's website prior to its Governing Body meetings.

At the start of each meeting of the Governing Body and formal committee/sub- committee meetings, members are required to declare any conflicts of interests in the items for consideration on the agenda and these are formally recorded.

The CCG has set out how it will formally manage any declared conflicts of interests within its Constitution.

During the last financial quarter of 2014/14, the CCG has undertaken a review of its Conflicts of Interest Policy to ensure that it aligns with the statutory guidance published by NHS England in December 2014.

Please refer to the Governance Statement for the list of member practices, details of members of other committees and sub-committees and details on all committees and sub-committees. (ADD TABLE)

PENSION LIABILITIES

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

MEMBERS REPORT

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 NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Further details on pension liabilities can be found in the accounting policy note included in the financial statements and the remuneration report.

SICKNESS AND ABSENCE DATA

Barnet CCG generally has low levels of sickness absence and turnover amongst its staff compared with similar organisations locally, showing a good level of staff motivation and retention. For 2014/15 (to date), the average sickness absence rate has been 1.71%. (NHS average is 4.38%). The average turnover rate is 1% (NHS average is 8.8%).

The CCG has a robust process for managing sickness absence and supporting employees who experience periods of ill health. The CCG through the North and East London Commissioning Support Unit purchase an occupational health and staff support service through AXA PPP Healthcare.

EXTERNAL AUDIT

Grant Thornton is the external auditor for NHS Barnet Clinical Commissioning Group. The cost of work performed by the external auditor for the financial year 2014/15 was £114,000 (£116,000 in 2013/14) for audit services. No other services were provided.

We certify that the Clinical Commissioning Group has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

DISCLOSURE OF SERIOUS INCIDENTS OR NEVER EVENTS

During 2014/15, the CCG did not report any serious incidents or Never Events to NHS England or the any other external statutory bodies such as the Care Quality Commission or the Information Commissioner's Office.

PRINCIPLES FOR REMEDY

The CCG continues to manage all complaints in accordance with the Local Authority Social Services and NHS Complaints Regulations 2009. Our Complaints Policy sets out the process for handling complaints and how lessons can be learnt and shared across the organisation. Whilst the CCG has outsourced the process for complaints management to the north east London Commissioning Support Unit (NELCSU) it acknowledges that the accountability and responsibility for ensuring that the governance process in managing and handling complaints lies with the CCG.

The CCG has incorporated the key principles of the Equality Act 2010, the Human Rights Act 1998 and NHS Constitution into its Complaints Policy and Procedure. This is in line with the Principles of Good Administration and the Principles of Good Complaint Handling; which encapsulate the six key principles of remedy which are defined as - getting it right; being customer focused; being open and accountable; acting fairly and proportionately; putting things right and seeking continuous improvement.

The CCG's Accountable Officer and Chair are accountable for signing off complaints responses on behalf of the CCG. This responsibility is sometimes delegated to Chief Operating Officer in the absence of the Accountable Officer and the Chair.

The underlying key principle of the CCG's Complaints Policy is to ensure that all complainants are treated fairly, proportionately and with respect and dignity. This is in line with the CCG's duty of candour and openness to services users, patients and members of the public who access NHS services within the borough of Barnet.

The CCG's aim is to secure suitable and proportionate remedies for complainants whose complaints are upheld, and where appropriate, for others who have suffered unfair treatment or injustice or hardship as a result of poor service or maladministration by the CCG.

We also use these opportunities to learn from complaints in order to improve our services. We have established a Patient Reference Group where we encourage participation from our local residents to effectively engage with the CCG.

MEMBERS REPORT

CLINICAL EFFECTIVENESS

The CCG has a robust QIPP quality assurance process in place; it has been designed to provide the Governing Body with assurance that clinical effectiveness is being tested within all areas of transformation.

The North Central London (NCL) Joint Formulary Committee (JFC) advises commissioners and provider Trusts on appropriate, equitable, evidence-based and cost-effective medicines use. The JFC, through its work programme scientifically assesses medicines in terms of comparative efficacy, safety, convenience and cost-effectiveness. All the CCGs and secondary/tertiary care acute Trusts are represented on this committee.

Barnet CCG has implemented the North Central London Individual Funding Review policy and is a key contributor in writing up cases, presenting and voting on the panel.

EMPLOYEE CONSULTATION

Barnet CCG is committed to working in partnership with trade unions and actively encourages staff to join a trade union and participate in union activities. The CCG is a member of the North Central London CCGs Joint Staffside Partnership Group a collaborative committee of management, human resources and trade union representatives from across the five CCGs in north central London. The committee meets quarterly to provide an environment where management representatives and CCG staff representatives can review and discuss changes affecting the organisation.

DISABLED EMPLOYEES

The CCG has an active policy on equalities which covers the treatment of all employees with protected characteristics. The CCG recognises that discrimination and victimisation is unacceptable and that it is in the interests of the organisation and its employees to utilise the skills of the total workforce.

It is the aim of the organisation to ensure that no employee or job applicant receives less favourable facilities or treatment (either directly or indirectly) in recruitment or employment on grounds of age, disability, gender / gender reassignment, marriage / civil partnership, pregnancy / maternity, race, religion or belief, sex, or sexual orientation. Please see the equality report for further detail.

MEMBERS REPORT

EMERGENCY PREPAREDNESS

Barnet CCG Business Continuity Management (BCM) Policy Statement

'Business Continuity Management' (BCM) is an important part of Barnet CCG's risk management arrangements. The Civil Contingencies Act (CCA) 2004 identifies all CCGs as category 2 responders and imposes a statutory requirement on each CCG to have robust BCM arrangements in place to manage the disruptions to the delivery of services.

The Chief Officer is the Accountable Officer for emergency planning, supported by the office manager. This means that we will support the Emergency Services, NHS providers, NHS England and our local authority, responding to any emergency affecting our population.

It is the policy of Barnet CCG to develop and maintain a Business Continuity Management System (BCMS) that ensures the prompt and efficient recovery of our critical functions from any incident or physical disaster affecting our ability to operate and deliver our services in support of the NHS economy.

In accordance with NHS England Guidance on the Business Continuity Framework 2013, the NHS Barnet CCG BCMS will be aligned with ISO 22301.

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

MEMBERS REPORT

STATEMENT AS TO DISCLOSURE TO AUDITORS

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

So far as the member is aware, that there is no relevant audit information of which the Clinical Commissioning Group's external auditor is unaware; and that the member has taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the Clinical Commissioning Group's auditor is aware of that information.

Rob Larkman Interim Accountable Officer 28th May 2015

MEMBERS REPORT

REMUNERATION REPORT

The NHS has adopted the recommendations outlined in the Greenbury Report in respect of the disclosure of senior managers remuneration and the manner in which it is determined. Senior managers are the persons in senior positions having authority or responsibility for directing or controlling the major activities of the Clinical Commissioning Group. This means they influence the decisions of the Clinical Commissioning Group as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.

This report outlines how those recommendations have been implemented by the CCG in the year to 31st March 2015.

MEMBERSHIP OF THE REMUNERATION AND TERMS OF SERVICES COMMITTEE

Clinical Commissioning Groups are required to have a Remuneration Committee to oversee the pay, terms and conditions of service of senior managers.

The main function of the Committee is to make recommendations to the Governing Body on the remuneration, allowances and terms of service of other officer members to ensure they are fairly rewarded for their individual contribution to the organisation, having regard for the organisation's circumstances and performance, and taking into account national arrangements.

The Remuneration Committee is a key committee under the CCG's constitution and its membership comprises lay and independent members who are not employees of the CCG. The Committee meets as required and make recommendations to the Governing Body based on financial and Human Resources independent reviews.

POLICY ON REMUNERATION OF SENIOR MANAGERS

The Remuneration Committee sets salaries and terms and conditions of service for all Governing Body Members, including clinical members, lay members and the two executive team members (Chief Officer and Chief Finance Officer) on an annual basis in accordance with the CCG's constitution.

MEMBERS REPORT

All salaries are set with regard to the guidance laid out in NHS England's Annex 2: Principles relating to reimbursement and remuneration for governing body members April 2012 and also to local benchmarking provided by NELCSU.

The executive team members have their pay and terms and conditions of service set in accordance with the NHS Very Senior Manager (VSM) framework and the NHS London Pay Framework for Very Senior Managers in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts (June 2013).

Pay and terms and conditions for other executive team members who do not sit on the Governing Body are governed by the national Agenda for Change regulations.

SALARIES AND ALLOWANCES OF SENIOR MANAGERS FOR 2014/15 AND 2013/14 (CCG SHARE)

	NAME	TITLE	2014-15 Salary (Bands of £5,000) '£000	2014-15 All Pension Related Benefits (Bands of £2,500) '£000	2014-15 Total (Bands of £5,000) '£000	Dates served Commenced	Ceased
	VOTING MEMBERS						
	Executive Directors						
	Mr John Morton	Chief Officer	45 - 50	5 - 7.5	50 - 55	01/04/2013	31/07/2014
	Mr Rob Larkman	Interim Accountable Officer	0 - 5	0	0 - 5	01/08/2014	
(4)	Mr Peter Coles	Interim Chief Operating Officer	85 - 90	0	85 - 90	24/07/2014	11/12/2014
(1)	Ms Regina Shakespeare	Interim Chief Operating Officer and Director of Clinical Commissioning	145 - 150	0	145 - 150	24/11/2014	
	Mr Hugh Mc Garel-Groves	Chief Finance Officer	120 - 125	20 - 22.5	140 - 145	12/08/2013	
	Lay Members						
	Mr David Riddle	Vice Chair Lay Member Engagement	20 - 25	0	20 - 25	01/04/2013	
	Ms Bernadette Conroy	Lay Member for Audit	20 - 25	0	20 - 25	01/04/2013	
	GP/ Clinical Members						
(2)	Dr Jonathan Lubin	CCG GP Member	10 - 15	0	10 - 15	01/04/2013	30/09/2014
	Dr Jonathan Lubin	CCG GP Member	10 - 15		10 - 15	01/10/2014	
(3)	Dr Karl Marlowe	Board Secondary Care Doctor	15 - 20	0	15 - 20	01/04/2013	
	Mrs Helen Donovan	CCG Registered Board Nurse	10 - 15	(22.5) - (20.0)	(10) - (5)	01/04/2013	
	Dr Ahmer Farooqi	CCG GP Member	30 - 35	0	30 - 35	01/04/2013	
	Dr Deborah Frost	Chair	80 - 85	0	80 - 85	01/04/2013	
	Dr Clare Stephens	CCG GP Member	25 - 30	0	25 -30	01/04/2013	
	Dr Barry Subel	CCG GP Member	35 - 40	0	35-40	01/07/2013	
	Dr Lyndon Wagman	CCG GP Member	0 - 5	0	0 - 5	01/04/2013	30/04/2014
	Dr Charlotte Benjamin	CCG GP Member	25 - 30	0	25 - 30	01/04/2013	
	Dr John Bentley	CCG GP Member	20 - 25	0	20 - 25	01/04/2013	
	Dr Swati Dholakia	CCG GP Member	25 - 30	0	25 - 30	01/05/2014	
	Dr Michelle Kurer	CCG GP Member	25 - 30	0	25 - 30	01/05/2014	
	NON VOTING MEMBERS						
	Miss Vivienne Stimpson	Director of Quality & Governance	80 - 85	37.5 - 40	120 - 125	01/04/2013	
	Ms Maria O'Dwyer	Director of Integrated Commissioning	80 - 85	40 - 42.5	120 - 125	01/04/2013	
	Mr Andrew Harrington	Director of Clinical Commissioning	75 - 80	0	75 - 80	09/12/2013	31/12/2014
(1)	Ms Dianne Prescott	Director of Planning and Performance	115 - 120	0	115 - 120	20/05/2014	26/09/2014
(4)	Ms Alison Alsbury	Director of Planning and Performance	40 - 45	0	40 - 45	20/01/2014	27/05/2014
(1)	Mr Matthew Powls	Director of Planning and Performance	140 - 145	0	140 - 145	09/10/2014	

(1) **Paid to an agency not to the individual.**
(2) **Payment made to practice.**
(3) **Secondment from other NHS organisation.**
(4) **Paid through a consultancy company.**

Nil Taxable benefits, Annual Performance Related Bonuses and Long term performance related bonuses (2013-14 also Nil)

Salaries and allowances of Senior Managers 2013/14 (Comparator)

	NAME	TITLE	2013-14 Salary (Bands of £5,000) '£000	2013-14 All Pension Related Benefits (Bands of £2,500) '£000	2013-14 Total (Bands of £5,000) '£000	Dates served Commenced	Ceased
	VOTING MEMBERS						
	Executive Directors						
	Mr John Morton	Chief Officer	135-140	487.5-490	625-630	01/04/2013	
(1)	Mr Stephen Hobbs	Interim Chief Finance Officer	110-115	0	0	01/04/2013	26/09/2013
	Mr Hugh Mc Garel-Groves	Chief Finance Officer	75-80	7.5-10	85-90	12/08/2013	
	Lay Members						
	Mr David Riddle	Vice Chair Lay Member Engagement	20-25	0	0	01/04/2013	
	Ms Bernadette Conroy	Lay Member for Audit	20-25	0	0	01/04/2013	
	GP/ Clinical Members						
(2)	Dr Jonathan Lubin	CCG GP Member	20-25	0	0	01/04/2013	
(3)	Dr Karl Marlowe	Board Secondary Care Doctor	15-20	0	0	01/04/2013	
	Mrs Helen Donovan	CCG Registered Board Nurse	10-15	567.5-570	575-580	01/04/2013	
(a)	Dr Ahmer Farooqi	CCG GP Member	20-25	0	0	01/04/2013	
(a)	Dr Deborah Frost	CCG GP Member / Chair	40-45	0	0	01/04/2013	
(a)	Dr Clare Stephens	CCG GP Member	25-30	0	0	01/04/2013	
(4)	Dr Barry Subel	CCG GP Member	10-15	0	0	01/04/2013	30/06/2013
(a)	Dr Barry Subel	CCG GP Member	20-25	0	0	01/07/2013	
	Dr Sue Sumners	Chair / CCG GP Member	60-65	0	0	01/04/2013	
(a)	Dr Lyndon Wagman	CCG GP Member	25-30	0	0	01/04/2013	
(a)	Dr Charlotte Benjamin	CCG GP Member	25-30	0	0	01/04/2013	
(a)	Dr John Bentley	CCG GP Member	20-25	0	0	01/04/2013	
	NON VOTING MEMBERS						
	Dr Phillipa Curran	CCG Associate Member	20-25	0	0	01/04/2013	
	Miss Vivienne Stimpson	Director of Quality & Governance	75-80	7.5-10	80-85	01/04/2013	
	Ms Maria O'Dwyer	Director of Integrated Commissioning	70-75	7.5-10	80-85	01/04/2013	
	Mr Ian Fisher	Transformation Director	95-100	0	0	09/05/2013	16/01/2014
	Mr Andrew Harrington	Director of Clinical Commissioning	30-35	0	0	09/12/2013	

(1) **Paid to an agency not to the individual.**
(2) **Payment made to practice.**
(3) **Secondment from other NHS organisation.**
(4) **Paid through a consultancy company.**
(a) **Restated to include employer pension contributions now a requirement in 2014/15**

SENIOR MANAGERS PERFORMANCE RELATED PAY

We do not operate a system of performance-related pay for those senior management posts subject to the Very Senior Managers (VSM) pay framework.

Future performance related pay for executive team members will be subject to the terms and conditions of service for very senior managers and will be considered by the Remuneration Committee.

No compensation was payable during the year and no amounts are included that are payable to third parties for the services of senior managers. In the event of redundancy, standard NHS packages will apply.

The CCG has a local 'pay progression' policy for staff with Agenda for Change contracts, which requires senior managers with NHS contracts to meet the standards of performance set by the individual's line manager in order to receive incremental progression increases to pay. No performance related bonuses are paid to any senior managers.

POLICY ON SENIOR MANAGERS CONTRACTS

The Chair, GP members and Lay Members of the Governing Body are all engaged via a contract for services. The duration and other terms of office of these are set in accordance with the CCG's constitution.

Notice periods for governing body members engaged via a contract for services are set at one month. No termination payments are made on expiry of the contract.

Employed senior managers (the executive team members) are all directly employed on permanent contracts and have notice periods of three months, unless employed on interim contracts. No payments are made on termination except in circumstances of redundancy.

PAYMENTS FOR LOSS OF OFFICE

No significant awards or payments have been made during the financial year 2014/15

PAYMENTS TO PAST SENIOR MANAGERS

No significant awards or payments have been made to past senior managers.

PENSIONS

Certain Members do not receive pensionable remuneration therefore there will be no entries in respect to pensions for certain Members.

MEMBERS REPORT

All staff, including senior managers are eligible to join the NHS Pensions scheme. The scheme has fixed the employer's contribution at 14% of the individual's salary as per the NHS Pension Agency regulations. Employee contribution rates for CCG officers and practice staff are as follows:

MEMBER CONTRIBUTION RATES BEFORE TAX RELIEF (GROSS)

Scheme benefits are set by the NHS Pensions Agency and are applicable to all members.

Past and present employees are covered by the provisions of the NHS pension scheme. For full details of how pension liabilities are treated please see note 12 in the annual accounts.

TERMINATION AGREEMENTS OR EXIT PACKAGES

Termination arrangements are applied in accordance with statutory regulations as modified by national NHS conditions of service agreements (specified in Agenda for Change), and the NHS pension scheme. Specific termination arrangements will vary according to age, length of service and salary levels. The Remuneration Committee will agree any severance arrangements.

SALARY AND PENSION ENTITLEMENTS OF EXECUTIVE TEAM MEMBERS

The following schedules disclose further information regarding remuneration and pension entitlements for 2014/15 and 2013/14.

Table 1 - 2014/15

Name	Title	Real increase /decrease in pension at age 60 (bands of 2500)	Real increase /decrease in related lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5000)	Total accrued related lump sum at age 60 at 31 March 2015 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31 March 2015	Cash Equivalent Transfer Value (CETV) at 31 March 2014	Real increase / decrease in Cash Equivalent Transfer Value	Employers Contribution to Partnership Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Board Members									
Mr John Morton	Chief Officer	0 - 2.5	0 - 2.5	60 - 65	190 - 195	1,394	1,294	22	20
Mr Hugh Mc Garel-Groves	Chief Finance Officer	0 - 2.5	0	0 - 5	0	55	21	34	17
Non Voting									
Miss Vivienne Stimpson	Director of Quality & Governance	0 - 2.5	5 - 7.5	15 - 20	55 - 60	371	311	52	12
Ms Maria O'Dwyer	Director of Integrated Commissioning	0 - 2.5	5 - 7.5	15 - 20	45 - 50	333	271	55	12
Mrs Helen Donovan	CCG Registered Board Nurse	(2.5) - 0	(2.5) - 0	35 - 40	105 - 110	631	610	4	2

Table 2 - 2013/14

Name	Title	Real increase /decrease in pension at age 60 (bands of 2500)	Real increase /decrease in related lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2014 (bands of £5000)	Total accrued related lump sum at age 60 at 31 March 2014 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31 March 2014	Cash Equivalent Transfer Value (CETV) at 31 March 2013	Real increase / decrease in Cash Equivalent Transfer Value	Employers Contribution to Partnership Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Board Members									
Mr John Morton	Chief Officer	20-22.50	65-67.50	60-65	182-187	1,294	788	489	0
Mr Hugh Mc Garel-Groves	Chief Finance Officer	0-2.5	0	0-5	0	20	0	20	0
Non Voting									
Miss Vivienne Stimpson	Director of Quality & Governance	0-2.5	2.5-5	15-20	45-50	310	287	17	0
Ms Maria O'Dwyer	Director of Integrated Commissioning	0.2.5	2.5-5	10-15	40-45	271	236	30	0
Mrs Helen Donovan	CCG Registered Board Nurse	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA

GP clinical lead members on the Governing Body of the CCG, are being paid gross and will be responsible for the passing on of the relevant pension contribution to the pension agency.

CASH EQUIVALENT TRANSFER VALUES

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

a) 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.

b) The Relationship between the Highest Paid Director and Median Remuneration

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 member of the Barnet Clinical Commissioning Group in the financial year 2014/15 was £140-£145k (£140-£145k in 2013/14). This was 2.9 times (3.8 in 2013/14) the median remuneration of the workforce, which was £48k (£39k in 2013/14).

In 2014/15 two employees received remuneration in excess of the highest paid member of the Barnet Clinical Commissioning Group. For 2013/14 no employees received remuneration in excess of the highest paid member of the Clinical Commissioning Group. Remuneration ranged from £12k to £140k (£11k to £145k in 2013/14).

Total remuneration includes salary, non-consolidated performance-related pay, and benefits in kind.

It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The Hutton Review of Fair Pay in the Public Sector guidance suggests that all staff irrespective of any recharges should be shown as 100% charged to Barnet CCG compared to the highest paid director as only being shown as the element of cost the CCG is charged for that director's service.

OFF-PAYROLL ENGAGEMENTS

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23rd May 2012. Clinical Commissioning Groups must publish information on their highly paid and/or senior off-payroll engagements.

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

	Number
Number of existing engagements as 31st March 2015	9
Of which, the number that have existed	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	4
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	

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

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

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	10
Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to Income Tax and National Insurance obligations	
Number for whom assurance has been requested	8
Of which:	
for whom assurance has been received *	4
for whom assurance has not been received	4
that have been terminated as a result of assurance not being received, or ended before assurance received.	0

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	3
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements	24

*All four left during 2014/15 and before assurance was requested. Follow-up correspondence was sent but no response has been received.

Rob Larkman
Interim Accountable Officer
28th May 2015

MEMBERS REPORT

MEMBERSHIP AND GOVERNING BODY PROFILES

Dr. Debbie Frost
Chair and GP Member (West Locality)

David Riddle
Lay Member and Vice Chair

Bernadette Conroy
Lay Member

Rob Larkman
Interim Accountable Officer

Regina Shakespeare
Interim Chief Operating Officer

Hugh McGarel-Groves
Chief Finance Officer

Dr. John Bentley
GP Member (South Locality)

Dr. Charlotte Benjamin
GP Member (South Locality)

Dr. Jonathan Lubin
GP Member (North Locality)

Dr. Clare Stephens
GP Member (North Locality)

MEMBERS REPORT

Dr. Barry Subel
Clinical Vice Chair and GP Member (South Locality)

Dr. Ahmer Farooqi
GP Member (North Locality)

Dr. Michelle Newman
GP Member (West Locality)

Dr. Swati Dholakia
GP Member (West Locality)

Helen Donovan
Registered Nurse Governing Body Member

Dr. Karl Marlowe
Secondary Care Consultant Governing Body Member

Governing Body Members left during the year

John Morton left the CCG this year.

MEMBERS REPORT

SENIOR MANAGEMENT

Executive Team	
Regina Shakespeare	Interim Chief Operating Officer
Hugh McGarel-Groves	Chief Finance Officer
Vivienne Stimpson	Director of Quality and Governance
Maria O'Dwyer	Director of Integrated Commissioning
Matt Powls	Interim Director of Performance and Planning
Sarah Thompson	Interim Director of Clinical Commissioning
Left during the year	
John Morton	Accountable Officer (to 31st July 2014)
Alison Alsbury	Interim Director of Planning (January to April 2014)
Dianne Prescott	Interim Director of Strategy and Planning (April to October 2014)
Andrew Harrington	Director of Clinical Commissioning (9th December 2013 to 19th December 2014)
Peter Coles	Interim Chief Operating Officer (August to December 2014)

COMMITTEE MEMBERSHIP – NON-GOVERNING BODY (EXTERNAL)

a) Remuneration Committee

Dr. Sanjiv Ahluwalia	Local GP
Dr. Anthony Uzoka	Local GP
John Hooton	Representing Barnet Health and Wellbeing Board

b) Clinical Quality & Risk Committee

Selina Rodrigues	Healthwatch Barnet

c) Patient and Public Engagement Committee

Selina Rodrigues	Healthwatch Barnet
Anthony Pritchard	Central London Community Healthcare Trust
Christina Z	Royal Free London NHS Foundation Trust
Emily Bowler	London Borough of Barnet
Sarah Perrin	London Borough of Barnet
Jeff Lake	Public Health (Barnet & Harrow)
Michael Benson	Barnet, Enfield & Haringey Mental Health Trust
Julie Pal	Community Barnet
Keren Lewin	Patient representative

MEMBERS REPORT

GOVERNING BODY REGISTER OF INTERESTS

NHS BARNET CCG GOVERNING BODY MEMBERS REGISTER OF CONFLICTS OF INTEREST APRIL 2015					
NAME	**TITLE**	**NAME OF ORGANISATION AND NATURE OF ITS BUSINESS**	**POSITION HELD/ NATURE OF INTEREST**	**DATE DECLARED**	**DATE UPDATED**
Voting Members					
Rob Larkman	Interim Accountable Officer	Brent, Harrow and Hilingdon CCG	Chief Officer	24/07/14	23/04/2015
David Riddle	Lay Member	General Pharmaceutical Council (Professional Regulation of Pharmacists)	Deputy Chair of Investigating Committee	24/05/12	13/08/2013
		Governing Council of Royal Free London FT	Appointed Member as representative of the CCG		
Bernadette Conroy	Lay Member	Bancrofts School	Governor	08/09/14	08/09/2014
		Poplar Harca (Reg. Charity - Resident Social Landlord in Tower Hamlets)	Chair	03/03/12	05/06/2013
		North London NHS Estates Partnership	Non-Executive Director	22/02/13	
		Royal Free Hospital	Husband is Consultant Anaesthetist	03/03/12	
		St Paul's Way Trust School	Trustee	13/10/2013	30/10/2013
		Community Health Partnership	Non-Executive Director	01/12/2014	18/12/2014
Dr Barry Subel	Elected GP Representative	Ravenscroft Medical Centre	GP Principal in practice	17/04/12	05/06/2013
		Royal Free Hospital	Wife is a nurse specialist in haemophilia	13/10/12	30/10/2013

NHS BARNET CCG GOVERNING BODY MEMBERS REGISTER OF CONFLICTS OF INTEREST APRIL 2015					
Dr Charlotte Benjamin	Elected GP Representative	St George's Medical Centre	GP Partner	23/05/12	13/08/2013
		Barnet LMC	Member		
		Charing Cross Hospital and Chelsea and Westminster Hospital	Husband is a surgeon		
Dr Clare Stephens	Elected GP Representative	Speedwell Practice, Torrington Park Healthcentre	GP Partner - PMS Practice	23/11/12	13/08/2013
		Barnet LMC	Member		
		Barndoc Health Care Ltd.	Shareholder - 50 shares		
		Speedwellness	Director		
		Finchley Catholic High School	School Governor		
Dr Debbie Frost	Chair	1)Millway Medical Practice 2)Highgate Hospital	1) GP Partner - PMS Practice 2) Highgate Hospital use consulting room facilities in Milway Practice to attend to NHS Patients sent to them via Choose and Book. As from April 2015 Highgate Hospital has stopped using the facilities at Millway Medical Practice.	01/06/12	12/09/2014 30/11/2014 updated on 01/04/2015
Dr Jonathan Lubin	Elected GP Representative	North Barnet Network	Assisting with formation of this organisation	20/08/14	20/08/2014
		Derwent Crescent Medical Centre	GP Principal/Partner	27/09/12	13/08/2013 Resigned from position at Barndoc as at 2nd Feb 2015
		Barndoc Health Care LTD.	Shareholder - 50 shares		

MEMBERS REPORT

NHS BARNET CCG GOVERNING BODY MEMBERS REGISTER OF CONFLICTS OF INTEREST APRIL 2015					
Dr John Bentley	Elected GP Representative	The Practice @ 188 (PMS)	GP Partner	20/03/13	05/06/2013
		Barnet LMC	Member		
		Barndoc Health Care Ltd.	Barndoc Shareholder - 50 shares		
Dr Ahmer Farooqi	Elected GP Representative	The Old Courthouse Surgery, Barnet Barndoc Health Care Ltd. Barnet LMC General Dental Practitioners (Haringey) Parent Governor Monkfrith School	GP Principal Barndoc Shareholder - 50 shares and Service Provider Member Wife Wife	18/06/13	07/03/2014
Dr Swati Dholakia	Elected GP Representative	King's College Hospital	Sister is Renal Consultant	08/05/14	08/05/2014
		Jai Medical Centre	Salaried GP		
Dr Michelle Newman	Elected GP Representative	Lane End Surgery	Partner	12/05/2014	12/05/2014
		Barndoc Health Care Ltd.	Barndoc Shareholder - 50 shares		
Dr Karl Marlowe	Secondary Care Representative	Medical Support Union (MEDSU). Tower Hamlets' Adult Mental Health Services. Queen Mary University & City University, Uni of London. Cancer Research UK. Good Innovation Consultancy	Non-Executive Director (unpaid.) Consultant Psychiatrist. Honorary Senior Clinical Lecturer post at each University.	13/08/13	16/01/2014 20/11/2014
			Wife is Head of Innovation-Fund Raising. 5. Wife to commence work at Good Innovation Consultancy in February 2015	13/08/13	16/01/2014 20/11/2014
Helen Donovan	Registered Nurse Representative	Royal College of Nursing	Public Health Adviser	13/08/2013	05/06/2013
		City University and University of Hertfordshire	Senior Lecturer (Honorary Contract)	13/08/2013	20/08/2013
Hugh McGarel-Groves	Chief Finance Officer	Home Farm Services Ltd - Company was wound up and deregistered at Companies House in September 2014.	Director - self and wife -N/A	13/08/13	13/08/2013 20/11/2014

NHS BARNET CCG GOVERNING BODY MEMBERS REGISTER OF CONFLICTS OF INTEREST APRIL 2015					
Non-Voting Members					
Vivienne Stimpson	Director of Quality & Governance	None to declare	None to declare	23/04/2015	23/04/2015
Maria O'Dwyer	Director of Integrated Commissioning	None to declare	None to declare	23/04/2015	23/04/2015
Matthew Powls	Interim Director of Performance & Planning	Director, Pentland Healthcare Consulting Ltd: 100% share ownership.	Director, Pentland Healthcare Consulting Ltd: 100% share ownership.	23/04/2015	23/04/2015
Regina Shakespeare	Interim Chief Operating Officer/Director Of Clinical Commissioning	Regina Shakespeare Consulting	Managing Director	17/11/2014	17/11/2014
Andrew Howe	Joint Director of Public Health, Barnet & Harrow	No interests declared	No Interests declared	30/06/14	30/06/2014
Kate Kennally	Director for People, Commissioning Group, London Borough of Barnet	No interests declared	No Interests declared	13/08/2013	13/08/2013
Julie Pal	Community Barnet (Healthwatch)	No interests declared	No Interests declared	18/09/2013	18/09/2013

MEMBERS REPORT

STATEMENTS BY THE ACCOUNTABLE OFFICER

Statement as the Accountable Officer of NHS Barnet CCG

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

Barnet CCG's former Chief Officer, John Morton resigned from his position in July 2014 and NHS England appointed Rob Larkman, as Interim Accountable Officer for Barnet CCG. Rob Larkman started in his interim position with the CCG on 1st August 2014. In addition to this, NHS England also agreed that in order to support the Interim Accountable Officer to discharge his duties, an interim Chief Operating Officer be appointed.

The role of the interim Chief Operating Officer is to lead and operationally direct the CCG, its commissioning of services, management of the Executive Team and to achieve national and local objectives.

The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the *Clinical Commissioning Group Accountable Officer Appointment Letter*.

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group 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 Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the *Manual for Accounts* issued by the Department of Health and in particular to:

1. Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
2. Make judgments and estimates on a reasonable basis;
3. State whether applicable accounting standards as set out in the *Manual for Accounts* issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and
4. Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my interim appointment as Accountable Officer for Barnet Clinical Commissioning Group as directed by NHS England.

In conclusion no significant internal control issues have been identified.

Rob Larkman Interim Accountable Officer 28th May 2015

MEMBERS REPORT

Barnet Clinical Commissioning Group Governance Statement

Introduction and Context

Barnet Clinical Commissioning Group was authorised from 1st April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

The Clinical Commissioning Group operated in shadow form prior to 1st April 2013, to allow for the completion of the authorisation process and the establishment of functions, systems and processes prior to the Clinical Commissioning Group taking on its full powers.

Authorisation

We have been successful in achieving the current authorisation position; which is that following a further review, we have met all remaining conditions other than the two conditions relating to finance and a financial plan.

Early in 2014 NHS England identified that the CCG was facing significant challenges given that we were situated in a uniquely complex health economy with a combination of sustainability, performance and quality concerns playing out for a number of years related to the poor performance of Barnet and Chase Farm Hospitals NHS Trust (BCF). NHS England believed t that the CCG was effectively engaged in a number of major transformational programmes within the local health economy and also across north central London with the proposed acquisition of Barnet and Chase Farm (BCF) Hospitals NHS Trust by the Royal Free London (RFL) NHS Foundation Trust.

At an assurance meeting with NHS England early in May 2014, CCG Governing Body members agreed that the CCG required leadership support from NHS England to manage the proposed acquisition of BCF by RFL.

With support from NHS England, Barnet CCG became the lead commissioner with responsibility for RFL and BCF on 1st April 2014. It was recognised by NHS England that the acquisition of BCF by RFL on 1st July 2014 following approval of the Secretary of State for Health, had and would continue to add to the significant challenges and workload of the CCG.

NHS England determined that its concerns were sufficiently high that in accordance with section 14Z21 of the NHS Act 2006 (as amended by the Health and Social Care Act

2012), it was not satisfied that the CCG was able to discharge its functions in relation to the poor performance in meeting the national 18 week Referral To Treatment (RTT) target and as a result of this concern, NHSE issued legal directions to the CCG under section 14Z21 of the NHS Act 2006.

During the course of 2014/15, we have worked collaboratively with Enfield CCG (the former lead commissioner) and with RFL, NHS England, and the National Intensive Support Team to manage RTT performance so that RFL can meet compliance with the national standards and our patients receive treatment within it.

I confirm that Barnet CCG met with NHS England for assurance discussions during 2014/15 in respect of Legal Directions and following revisions to the CCG's capability, capacity and commissioning methods it made a formal submission to support NHS England's (London) consideration of whether to advise that the directions be lifted.

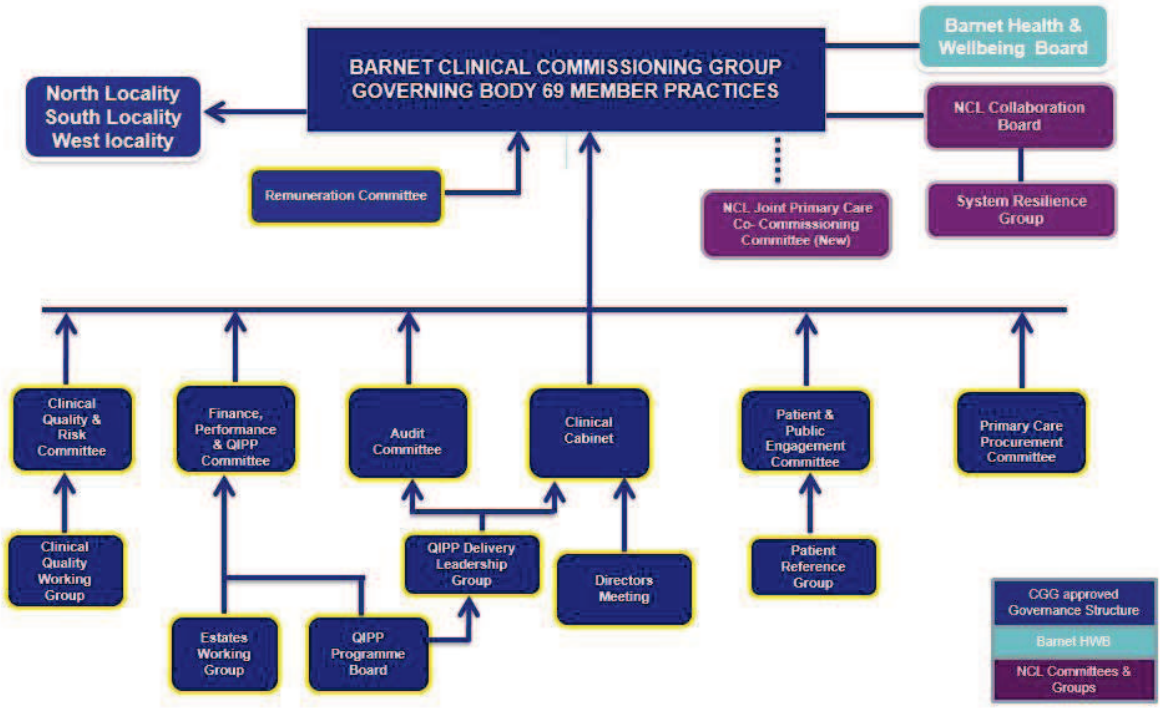
Accountability Framework Review

During the latter part of 2014, governance and financial diagnostic reviews of Barnet CCG took place, led by me as Interim Accountable Officer and by the Chief Finance Officer of Brent, Harrow and Hillingdon CCGs, Jonathan Wise. These reviews produced recommendations for strengthened governance and for additional financial performance improvements, which were accepted in full by the Barnet CCG Governing Body in December 2014. These recommendations formed the basis of the updated Recovery Plan, which Barnet CCG submitted to NHS England on 5th January 2015, as required for all CCGs in financial deficit. The Recovery Plan was approved by the Governing Body at its meeting on 26thFebruary 2015.

Our updated Recovery Plan is built around strengthened governance arrangements through a number of measures including the formation of a Clinical Cabinet and of a Quality, Innovation, Productivity and Prevention (QIPP) Leadership Group, as well as a refocused QIPP Programme Board.

MEMBERS REPORT

Revised Governance of Barnet CCG



Scope of Responsibility - Accountable Officer

Barnet CCG's former Chief Officer, John Morton resigned from his position in July 2014 and I, Rob Larkman, was appointed as Interim Accountable Officer for Barnet CCG. I started in this interim position with the CCG on 1st August 2014. In addition to this, NHS England also agreed that in order to enable me to discharge my duties as Interim Accountable Officer, an interim Chief Operating Officer be appointed.

As the Interim Accountable Officer, I have responsibility for maintaining a secure system of internal control that supports the achievement of the Clinical Commissioning Group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible. In accordance with the responsibilities assigned to me in Managing Public Money (2013), I acknowledge my responsibilities as set out in my

MEMBERS REPORT

Clinical Commissioning Group Interim Accountable Officer Appointment letter from NHS England.

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

Compliance with the UK Corporate Governance Code (September 2014)

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, we draw upon the principles of best practice from the Code which we consider suitable to meet our corporate governance responsibilities and adherence to best practice.

This governance statement demonstrates that during the course of 2014/15 we have followed corporate governance best practice, as considered relevant to the CCG, in ensuring that we comply with our public sector responsibilities in discharging our duties as a statutory organisation.

For the financial year ended 31st March 2015, and up to the date of signing this statement and to the best of my knowledge, Barnet CCG has applied the principles of the Code as best practice recommendations for the constitution of its Governing Body, Committee structure, appointment of Governing Body Members and its accountability framework.

The Clinical Commissioning Group Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L (2)(b) states:

> *'The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it'.*

MEMBERS REPORT

Principles of Good Governance for Clinical Commissioning Groups

In accordance with section 14L (2)(b) of the 2006 Act, the CCG will at all times observe "generally accepted principles of good governance" in the way it conducts its business.

These include:

The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business.

The Good Governance Standard for Public Services:

> *The standards of behaviour published by the Committee on Standards in Public Life (1995) known as the "Nolan Principles" (as set out in Appendix F);*
>
> *The seven key principles of the NHS Constitution (as set out in Appendix G);*

The overarching governance arrangements are set out in the CCG's Constitution which includes Standing Orders, Prime Financial Policies, Instructions and the Scheme of Reservation & Delegation. Barnet CCG has delegated authority to the Governing Body decision making and responsibility for the delivery of all its duties with the exception of:

- Determining the arrangements by which the members of the CCG approve those decisions that are reserved for the membership;
- Consideration and approval of applications to NHS England 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;
- Approving 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); and
- Approving 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;

MEMBERS REPORT

The Governing Body has supplemented its governance framework by the formal adoption of: the principles of the NHS Constitution; the Nolan Principles on Standards in Public Life; the Code of Conduct and Accountability for NHS Boards; the CCG Code of Conduct; Standards of Business Conduct Policy; Gifts and Hospitality Policy; Anti-Fraud and Bribery Policy; Whistleblowing Policy and a Conflicts of Interest Policy. In addition, Barnet CCG has under its constitution, created a Primary Care Procurement Committee, which consists primarily of two lay members, non-GP clinical members, and members of the Executive Team, whose primary role is to enable clearly independent decision making in relation to procurement choices where otherwise a conflict of interest could arise.

Using the NHS England guidance The Functions of Clinical Commissioning Groups, published legal guidance and the recently published statutory guidance for managing Conflicts of Interest by NHS England, 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.

In addition, under the directions of its Audit Committee and through an approved internal audit plan for 2014/15, our internal auditors were asked to undertake an audit of the CCG's governance arrangements. The overriding role of the internal auditors is to independently check compliance with legislative requirements and public sector good practice, and inform the CCG's Audit Committee of gaps in assurance in the CCG's systems of internal controls and governance arrangements which could impact the organisation's ability to meet its statutory duties and delivery of its Governing Body's Strategic Objectives, which could compromise the CCG's reputation.

The auditors concluded there was reasonable assurance that the systems of internal controls upon which Barnet CCG relies were suitably designed, consistently applied and effective throughout 2014/15. However, recommendations for improvement were made in some areas; those issues have been addressed with the Audit Committee taking a lead assurance role.

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

MEMBERS REPORT

Membership of the Clinical Commissioning Group

The providers of primary medical services are the member practices of the CCG which form the foundation of its Constitution.

The CCG consists of three localities with a total of 68 member practices forming its membership:

- North Barnet;
- South Barnet; and
- West Barnet.

Eligibility

Providers of primary medical services to a registered list of patients under General

Medical Services, Personal Medical Services or Alternative Provider Medical Services contract will be eligible to apply for membership of this CCG.

Accountability

Barnet CCG continues to demonstrate its accountability to its member practices, local population, local stakeholders and NHS England in a number of ways, including by:

- Appointing independent lay members and non-GP clinicians to its Governing Body;
- Holding meetings of the Governing Body in public (except where the CCG considers that it would not be in the public interest in relation to all or part of a meeting);
- Publishing a Commissioning Plan on an annual basis;
- Complying with London Borough of Barnet's Health Overview and Scrutiny requirements;
- Working collaboratively with the Health and WellBeing Board to address key health and social care issues;
- Meeting annually in public to publish and present its Annual Report;
- Producing annual accounts in respect of each financial year which must be externally audited;
- Working collaboratively across all five north central London CCGs to ensure that there is a consensus on the management of system resilience throughout the year, and also during winter periods;

- Publishing a clear complaints process;
- Complying with its public sector duty for ensuring that it meets the requirements of the Equality Act 2010 and Human Rights Act 1998;
- Working collaboratively with Healthwatch Barnet and patient participation groups;
- Complying with the Freedom of Information Act 2000; and
- Providing information to the NHS England as part of its assurance process.

In addition to these statutory requirements, the CCG will demonstrates accountability by:

- Holding regular engagement events for member practices, other health and social care professionals, local providers and partners and local people.
- Holding meetings in each locality at least six (6) times a year; the dates of engagement events will be made available on the CCG's website;
- Publishing its Delivery Plan and Commissioning Strategy;
- Participating in the Health and Wellbeing Board established by the London Borough of Barnet'
- Having a dedicated email address where questions and comments from the public can be addressed to the Governing Body (the "Public-Board email"); and
- Endeavouring to build and maintain a strong, open and effective collaborative relationship with the Local Medical Committee (LMC)

It shall:

- Commit to senior level representation (Chair, Chief Officer/Accountable Officer or other senior member) attending meetings of Barnet LMC;
- Keep the LMC appropriately briefed on professional issues relating to the delivery of services by GPs arising from the commissioning activities of the CCG; and
- Provide the LMC with access to the Governing Body's part 1 agenda and papers prior to each Governing Body meeting held in public and welcome attendance by representatives of the LMC at any such meetings.

The LMC chair, or his/her representative, will be afforded the opportunity to raise any issues pertaining to items on the part 1 agenda with the Chair or the Chief Officer/Accountable Officer in advance of the relevant meeting.

The LMC chair, or his/her representative may comment or question any aspects of the work of the CCG during the section of the Governing Body meeting open to the public for

comments from members of the public, at the time allotted for public questions and comment.

The Governing Body will have an on-going role in reviewing the CCG's governance arrangements and will make a formal review at least once a year to ensure that the CCG continues to reflect the principles of good governance.

The Governing Body will continue to engage and consult its member practices on key proposed constitutional changes prior to any submission to NHS England.

Authority to Act

The CCG is a membership organisation and the member practices are accountable for exercising its statutory functions as laid down in its constitution.

The CCG may grant authority to act on its behalf to:

1. The Governing Body;
2. Its employees;
3. A committee or sub-committee of the Governing Body; and
4. Any of its member practices in their localities.

Scheme of Reservation and Delegation

The extent of the authority to act of the respective bodies and individuals depends on the powers delegated to them by the CCG as expressed through the following sections in its constitution:

> *e) The CCG's scheme of Reservation and Delegation; (as set out in Appendix D of its constitution); and*
> *f) for committees and their terms of reference.*

The CCG's scheme of Reservation and Delegation sets out the key functions of the CCG and:

> *g) those decisions that the Member Practices have reserved to themselves, acting as the membership as a whole; and*
>
> *h) those decisions that are the responsibilities of the Governing Body, its committees and sub-committees and individual employees.*

MEMBERS REPORT

The CCG remains accountable for all of its functions, including those that it has delegated contractually, for example, north east London Commissioning Support Unit does provide a number of key functions on behalf of the CCG.

General

In discharging functions of the CCG that have been delegated to them, the Governing Body, its committees and sub-committees, joint committees and individuals must:

i) *comply with the CCG's principles of good governance;*

j) *operate in accordance with the CCG's scheme of Reservation and Delegation;*

k) *comply with the CCG's standing orders and for committees and sub-committees, their terms of reference;*

l) *comply with the CCG's prime financial policies;*

m) *comply with the CCG's arrangements for discharging its statutory duties;*

n) *Ensure that Member Practices have had the opportunity to contribute to the CCG's decision making process through their localities; and at ordinary meetings of the CCG (as set out at Annex 1 to Appendix C (Standing Orders)).*

Rob Larkman Interim Accountable Officer 28th May 2015

APPENDICES

Member Practices

Col	Practice	Locality	Practice Name and Address
1	E83664	N	Hampden Square Medical Centre, 22 Hampden Square, Southgate Road, N14 5JR
2	E83003	N	Oakleigh Road Health Centre, 280 Oakleigh Road North, Whetstone, N20 0HD
3	E83005	N	Lichfield Grove Surgery, 64 Lichfield Grove, Finchley, N3 2JP
4	E83644	N	Ballards Lane Surgery, 209 Ballards Lane, Finchley, N3 1LY
5	E83013	N	Cornwall House Surgery, Cornwall Avenue, Finchley, N3 1LD
6	E83037	N	Derwent Medical Centre, 20 Derwent Crescent, Whetstone, N20 0QQ
7	E83613	N	East Barnet Health Centre, 149 East Barnet Road, New Barnet, EN4 8QZ
8	E83632	N	East Barnet Health Centre, 149 East Barnet Road, New Barnet, EN4 8QZ
9	E83629	N	East Barnet Health Centre, 149 East Barnet Road, New Barnet, EN4 8QZ
10	E83050	N	East Finchley MP, 39 Baronsmere Road, Finchley, N2 9QD
11	E83045	N	Friern Barnet Medical Centre, 16 St Johns Villas, Friern Barnet Road, N11 3BH
12	E83650	N	Gloucester Road Surgery, 1B Gloucester Road, New Barnet, EN5 1RS
13	Y00105	N	Holly Park Clinic, Holly Park Road, Friern Barnet, N11 3HB
14	E83621	N	Brunswick Park Health Centre, Brunswick Park Road, New Southgate, N11 1EY
15	E83017	N	Longrove Surgery, 70 Union Street, Barnet, EN5 4HT

16	E83638	N	Mountfield Surgery, 55 Mountfield Road, Finchley, N3 3NR
17	E83645	N	Osidge Medical Centre, 182 Osidge Lane, Southgate, N14 5DR
18	E83639	N	Rosemary Medical Centre, 2 Rosemary Avenue, Finchley, N3 2QN
19	E83007	N	Squires Lane Medical Centre, 2 Squires Lane, Finchley, N3 2AU
20	E83024	N	St Andrews Medical Centre, 50 Oakleigh Road, Whetstone, N20 9EX
21	E83624	N	Station Road Surgery, 33B Station Road, EN5 1JJ
22	E83034	N	Colney Hatch Lane Surgery Medical centre, 192 Colney Hatch Lane Muswell Hill, N10 1ET
23	E83044	N	The Addington Medical Centre, 46 Station Road, New Barnet, EN5 1QH
24	E83012	N	The Old Courthouse Surgery, 27 Wood Street, New Barnet, EN5 1RS
25	E83010	N	The Speedwell Practice, The Health Centre, Torrington Park, N12 9SS
26	E83042	N	The Surgery, Vale Drive Health Centre, Vale Drive, High Barnet, EN5 2ED
27	E83031	N	The Village Surgery, 113 East Barnet Road, New Barnet, EN4 8RF
28	E83021	N	Torrington Park Practice, 16 Torrington Park, North Finchley, N12 9SS
29	E83035	N	Wentworth Medical Centre, 38 Wentworth Avenue, Finchley Central, N3 1YL
30	Y00136	N	Woodlands Medical Centre, 54 Leopold Road, Finchley, N2 8BG
31	E83600	S	682 Finchley Road, NW11 7NP

MEMBERS REPORT

Col	Practice	Locality	Practice Name and Address
32	E83653	S	Phoenix Practice, 7 Brampton Grove, NW4 1AE
33	E83631	S	Cherry Tree Surgery, 26 Southern Road, N2 9JG
34	E83006	S	Greenfield Health Centre, 143-145 Cricklewood Lane, NW2 1HS
35	Y02986	S	BARNDOC Healthcare Ltd, Britannia Business Suite, Cricklewood, Barnet, NW2 1DZ
36	E83667	S	Grovemead Health Partnership, 67 Elliot Road, NW4 3EB
37	E83008	S	Heathfielde Medical Centre, Lyttelton Road, N2 0EQ
38	E83657	S	Hillview Surgery, 114 Finchley Lane, NW4 1BG
39	E83025	S	Pennine Drive Surgery, 8 Pennine Drive, NW2 1PA
40	E83039	S	Ravenscroft Medical Centre, 166-168 Golders Green Road, NW11 8BB
41	E83020	S	St Georges Medical Centre, 7 Sunningfields Road, NW4 4QR
42	E83026	S	Supreme Medical Centre, 300 Regents Park Road, N3 2JX
43	E83622	S	Temple Fortune Health Centre, Temple Fortune Lane, NW11 7TE
44	E83651	S	Temple Fortune Health Centre, 23 Temple Fortune Lane, London, NW11 7TE
45	E83009	S	Temple Fortune HC, PHGH Doctors, 23 Temple Fortune Lane, NW11 7TE
46	E83652	S	Temple Fortune Health Centre, 23 Temple Fortune Lane, London, NW11 7TE
47	E83649	S	The Hodford Rd Surgery, 73 Hodford Road, NW11 8NH

48	E83027	S	The Practice, 188 Golders Green Road, NW11 9AY
49	E83035	W	Branch of Wentworth, 86 Audley Road, Hendon, NW4 3HB
50	E83668	W	Deans Lane MC 156 Deans Lane, Edgware, HA8 9NT
51	E83041	W	The Surgery, 1 Wakemans Hill Avenue, Colindale, NW9 0TA
52	E83030	W	39 Penshurst Gardens, Edgware, HA8 9TN
53	E83637	W	Colindale Medical Centre, 61 Colindeep Lane, Colindale, NW9 6DJ
54	E83656	W	Boyne Avenue Surgery, 57 Boyne Avenue, Hendon, NW4 2JL
55	E83038	W	Jai Medical Centre, 114 Edgwarebuty Lane, Edgware, HA8 8NB
56	E83053	W	Lane End Medical Centre, 2 Penshurst Gardens, Edgware, HA8 9GJ
57	E83016	W	Millway Medical Practice, Hartley Avenue, Mill Hill, NW7 2HX
58	E83046	W	Mulberry Medical Practice, 3 Sefton Avenue, Mill Hill, NW7 3QB
59	E83032	W	Oak Lodge Medical Centre, 234 Burnt Oak Broadway, Edgware, HA8 0AP
60	E83028	W	Park View Surgery, 36 Cressingham Road, Edgware, HA8 0RW
61	E83011	W	The Everglade Medical Practice, Grahame Park Health Centre, The Concourse, Colindale, NW9 5XT
62	E83049	W	Langstone Way, 28 Langstone Way, Mill Hill, NW7 1GR
63	E83640	W	The Raleigh Surgery, 4 Raleigh Close, Hendon NW4 2TA
64	E83633	W	Watford Way Surgery, 278 Watford Way, Hendon, NW4 4UR

65	E83018	W	Watling Medical Centre, 108 Watling Avenue, Edgware, HA8 0NR
66	E83658	W	Woodcroft Medical Centre, Gervase Road, Edgware, HA8 0NR
67	E83659	W	Staywell Practice, Woodcroft Medical Centre, Gervase Road, Edgware, HA8 8NB

Localities

Member practices are organised in three Localities. The Localities' organisation and functions are set out in the terms of reference for Localities at Annex 1 to Appendix C (Standing Orders).

In summary, the functions of the Localities are:

- To facilitate communication between Member Practices in the Localities and the Governing Body, ensuring that the views of the Localities are represented in the work of the CCG and at meetings of the Governing Body;
- To discuss Locality specific issues;
- To implement any Locality specific operational plans delegated to the relevant Locality by the Governing Body, the Chief Officer, the Chief Finance Officer or any committee of the Governing Body;
- To engage with patients and the public by inviting patient representatives to attend Locality meetings;
- To hold the Governing Body to account, and for the Member Practices to hold one another to account, for delivery of the CCG's Commissioning Plans in accordance with the CCG,s vision and values in order to deliver the CCG's strategy; and
- To facilitate Member Practices working together and supporting one another to achieve improvements in services for patients.

Joint Arrangements

Under section 75 of the NHS Act 2006, as amended by the Health & Social Care Act 2012, CCGs have the power to collaborate and exercise their commissioning functions jointly with local authorities. In addition to this, new legislative changes came into force on 1st October 2014 through a new statutory instrument called the Draft Legislative Reform (Clinical Commissioning Group) Order 2014 (LRO 2014 – SI 2014, No. 2436). This

legislative reform order formalizes the creation of joint commissioning committees between Clinical Commissioning Groups and NHS England.

During 2014/15, Barnet CCG started discussions to work collaboratively to form a Joint Primary Care Co-Commissioning Committee across north central London with four other CCGs and NHS England.

Similarly Barnet CCG has entered into a Section 75 Health and Social Care Partnership Agreement with the London Borough of Barnet to jointly commission health and social care services on behalf of Barnet residents.

The London Borough of Barnet has the following committees on which representatives of the CCG sit:

- Health and Wellbeing Board;
- Barnet Safeguarding Adults Partnership Board;
- Barnet Safeguarding Children's Board; and Children's Trust Board.

Committees under the CCG's Constitution

Name	Governing Body Meetings	Audit Committee Meetings	Clinical Quality & Risk Committee Meetings	Finance Performance & QIPP Committee Meetings	Remuneration Committee Meetings	Primary Care Procurement Committee meetings	Patient & Public Engagement Committee Meetings (NEW)	Clinical Cabinet meetings (NEW)
Elected Voting Members:	Percentage Attendance Record (%)							
Debbie Frost, Chair of the CCG	100			90				100
John Bentley, GB GP member	100	80	100					89
Ahmer Farooqui, GB GP member	100							67
Charlotte Benjamin, GB GP member	100							55
Barry Subel, GB GP member	83	40	20	72				79
Michelle Newman, GB GP member	83							100
Swati Dholakia, GB GP member	83							89
Clare Stephens, GB GP member	50							67

Jonathan Lubin, GB GP member	100			81				89
Appointed Voting Members:								
John Morton, Chief Officer/ AO, left 31st July 2014	33					40		
Hugh McGarel-Groves, Chief Finance Officer	100			100		80		
Rob Larkman, Interim AO joined from 1st August 2014	50							
Bernadette Conroy, Chair of Audit Committee & Lay member	100	100		81	100	100		
David Riddle, Vice Chair of CCG, Lay member	100	100	100	90	100	100	100	
Helen Donovan, GB Registered Nurse member	83		100			100		
Karl Marlowe, GB Secondary Care Doctor	100		60	72		100		
Members with Speaking Rights and Non-Voting:								
Regina Shakespeare, Interim Chief Operating Officer & Director of Clinical Commissioning						40		
Andrew Harrington, left on 19th December 2014								
Peter Coles, 1st August 2014 - 1st December 2014								
Vivienne Stimpson, Director of Quality & Governance			80				100	67
Maria O'Dwyer, Director of Integrated Commissioning								89
Matt Powls, Interim Director of Planning & Performance								55
Kate Kennally, Strategic Director of Communities, LBB								
Andrew Howe, Director of Public Health, LBB								
Healthwatch & Community Barnet Representatives:								
Selina Rodrgues, Head of Healthwatch Barnet			40				100	
Julie Pal, Chief Executive of Community Barnet			40				33	
Other members of Committees								
John Hooton, HWBB- LBB Representative					100			
Dr Sanjiv Ahluwalia, Non- GB Member					80			
Dr Anthony Uzoka, Non- GB member					100			

Role of the Audit Committee

The purpose of the Committee is to assist the CCG to deliver its responsibilities for the conduct of public business and the stewardship of funds under its control. In particular the Committee will seek to provide assurance to the Governing Body that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards;

- Public money is safeguarded and properly accounted for;
- Financial statements are prepared in a timely fashion, and give a true and fair view of the financial position of the CCG for the period in question;
- Affairs are managed to secure economic, efficient and effective use of resources;

Reasonable steps are taken to prevent and detect fraud and other irregularities.

Role of the Remuneration Committee

The purpose of the Remuneration Committee is to determine and approve the remuneration, fees and other allowances for employees of the CCG who are engaged to undertake responsibilities for the CCG and to determine and approve allowances.

For CCG employees under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme.

Role of the Finance, Performance and QIPP Committee

The purpose of this Committee is required by the Governing Body to oversee the delivery of QIPP, finance and performance targets and to provide assurance to the Governing Body on the CCG's performance against targets.

Role of the Clinical Quality and Risk Committee

The purpose of this Committee is responsible for assuring the quality and safety of all commissioned services and providing assurance to the Governing Body that risks are identified and mitigated.

Particular emphasis of this committee relates to CCG's statutory responsibilities for quality and safety in accordance with the Health and Social Care Act 2012.

Role of the Primary Care Procurement Committee

The Primary Care Procurement Committee has been established by the Governing Body, to ensure robust and transparent decision making regarding procurement of services that may potentially be provided by a primary care contractor. These terms of reference set out the background to the establishment of this committee, the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the constitution.

MEMBERS REPORT

Role of the Patient and Public Engagement Committee

The role of the Patient and Public Engagement Committee is to provide assurance to the CCG Governing Body and its committees that patient and public engagement is being carried out in the most effective way and meets the legal duties placed on the CCG.

Role of the Clinical Cabinet

The purpose of the Clinical Cabinet is to assist the Clinical Commissioning Group's (CCGs) Governing Body to deliver its responsibilities for the conduct of public business. The Clinical Cabinet operates as an Executive committee of NHS Barnet CCGs Governing Body and, therefore, the Cabinet holds delegated responsibility from the Governing Body for the strategic and operational management of the CCG except in so far as the Governing Body reserves certain powers to itself.

The Clinical Cabinet considers and gives guidance to the CCGs Executive and Clinical Leads on the development of strategies, policies, plans, and proposals related to the business of the CCG, prior to submission of reports on the matters to the Governing Body or a committee of the Governing Body.

Annual Accounts

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

We have audited the financial statements of NHS Barnet Clinical Commissioning Group for the year ended 31 March 2015 under the Audit Commission Act 1998. 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 the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the National Health Service in England.

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

- the table of salaries and allowances of senior managers and related narrative notes on page **Error! Bookmark not defined.**
- the table of pension benefits of senior managers and related narrative notes on page **Error! Bookmark not defined.**
- a note of pay multiples and related narrative notes on page **Error! Bookmark not defined.**

This report is made solely to the members of NHS Barnet Clinical Commissioning Group in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Clinical Commissioning Group (CCG)'s members and the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report which comprises the equality report, the sustainability report, the remuneration report and the annual governance statement to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

Opinion on regularity

In our opinion, in all material respects the expenditure and income 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 . Except for the matters referred to in the Exception report below.

Opinion on financial statements

In our opinion the financial statements:

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

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with NHS England's Guidance;
- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

Exception report

On 13 May 2014 we referred a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 in relation to the NHS Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012, which sets statutory duties for CCGs to ensure that their capital and revenue resource use in a financial year does not exceed the amount specified by the NHS Commissioning Board (the Revenue Resource Limit and Capital Resource Limit).

Reasons for making a referral under section 19 of the Audit Commission Act 1998 NHS Barnet Clinical Commissioning Group breached its revenue resource limit for the year ending 31 March 2014 and expects to do so again for the year ending 31 March 2015.

NHS Barnet Clinical Commissioning Group has reported an overspend of £11 million against its revenue resource limit for the year ended 31 March 2015.

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

Respective responsibilities of the CCG and auditor

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to

you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014

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

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

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

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

The Audit Commission has determined these two criteria as those 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 2015.

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

Basis for qualified conclusion

In considering the CCG's arrangements for securing financial resilience, we identified the following matters:

- The CCG reported a deficit of £11.1 million in its financial statements for the year ending 31 March 2015, 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 £4 million for 2015/16.

The actual and planned deficits are evidence of weaknesses in arrangements in respect of the CCG's strategic financial planning.

Qualified Conclusion

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

Certificate

We certify that we have completed the audit of the accounts of NHS Barnet CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Paul Hughes

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

Grant Thornton House
Melton Street Euston Square London NW1 2EP

[INSERT DATE] 2015

THE PRIMARY STATEMENTS

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

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	3.1	7,245	5,098
Operating Expenses	4	435,349	419,274
Other operating revenue	2	(3,102)	(139)
Net operating expenditure before interest		**439,492**	**424,233**
Of which:			
Administration Income and Expenditure			
Employee benefits	3.1	4,222	3,035
Operating Expenses	4	4,910	6,139
Other operating revenue	2	(23)	(70)
Net administration costs before interest		**9,109**	**9,104**
Programme Income and Expenditure			
Employee benefits	3.1	3,022	2,063
Operating Expenses	4	430,439	413,135
Other operating revenue	2	(3,079)	(69)
Net programme expenditure before interest		**430,383**	**415,129**

The notes from pages Error! Bookmark not defined. to Error! Bookmark not defined. form part of these financial statements

Programme expenditure relates to the commissioning of healthcare and administration relates to the CCG's own running costs.

Statement of Financial Position as at 31st March 2015

	Note	31st March 2015	31st March 2014
		£000	£000
Current assets:			
Trade and other receivables	7	5,567	3,625
Cash and cash equivalents	8	18	186
Total current assets		**5,585**	3,811
Total assets		**5,585**	3,811
Current liabilities			
Trade and other payables	9	(41,771)	(38,995)
Total current liabilities		**(41,771)**	(38,995)
Total Assets less Current Liabilities		**(36,185)**	(35,184)
Provisions	10	0	(2,000)
Total current provisions		**0**	(2,000)
Assets less Liabilities		**(36,185)**	(37,184)
Financed by Taxpayers' Equity			
General fund	SOCITE	(36,185)	(37,184)
Total taxpayers' equity:		**(36,185)**	(37,184)

The notes from pages **Error! Bookmark not defined.** to **Error! Bookmark not defined.** form part of these financial statements
The financial statements on pages **Error! Bookmark not defined.** to**Error! Bookmark not defined.** were approved by the Governing Body on 28th May 2015 and signed on its behalf by:

Rob Larkman
Interim Accountable Officer
NHS Barnet CCG

Statement of Changes in Taxpayers' Equity for the year ended 31st March 2015

	Note	General Fund £000
Changes in taxpayers' equity for 2014-15		
Balance at 1 April 2014		(37,184)
Net operating expenditure for the financial year	SOCNE	(439,492)
Net Recognised CCG Expenditure for the Financial Year		**(439,492)**
Net funding		440,491
Balance at 31 March 2015		**(36,185)**

	General Fund £000
Changes in taxpayers' equity for 2013-14	
Balance at 1 April 2013	**0**
Net operating costs for the financial year	(424,233)
Net Recognised CCG Expenditure for the Financial Year	**(424,233)**
Net funding	387,049
Balance at 31 March 2014	**(37,184)**

The statement of changes in taxpayers' equity represents the taxpayers' investment and analyses the cumulative movement on reserves. The net funding represents the main actual cash funding requested by the CCG for the year. Refer to note 18 for the Financial Performance of the CCG, summarised below.

Financial Performance:

During 2014/15 NHS Barnet CCG received Revenue Resource Limit (RRL) funds of £428,473,000 (£415,267,000 2013/14) and incurred expenditure of £439,492,000 (£424,233,000, 2013/14) thus resulting in a deficit for the year of £11,019,000 (£8,966,000 deficit 2013/14).

The notes from pages **Error! Bookmark not defined.** to**Error! Bookmark not defined.** form part of these financial statements

Statement of Cash Flows for the year ended 31st March 2015

	Note	2014-15 £000	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(439,492)	(424,233)
Finance Costs		(1)	0
(Increase)/decrease in trade & other receivables	7	(1,942)	(3,625)
Increase/(decrease) in trade & other payables	9	2,776	38,995
Provisions utilised	10	(2,000)	0
Increase/(decrease) in provisions	10	0	2,000
Net Cash Inflow (Outflow) from Operating Activities		**(440,659)**	(386,863)
Cash Flows from Financing Activities			
Net funding received		440,491	387,049
Net Cash Inflow (Outflow) from Financing Activities		**440,491**	387,049
Net Increase (Decrease) in Cash & Cash Equivalents	8	**(168)**	186
Cash & Cash Equivalents at the Beginning of the Financial Year		**186**	0
Cash & Cash Equivalents (inc bank overdrafts) at the End of the Financial Year		**18**	186

The Statement of Cash Flows analyses the cash implications of the actions taken by the CCG during the year. The operating activities (total operating costs for the year adjusted with payables and receivables working balances) netted off with the actual cash funding received from NHS England, resulting in a year-end actual cashbook balance of £18k.

The notes from pages **Error! Bookmark not defined.** to **Error! Bookmark not defined.** form part of these financial statements

NOTES TO THE FINANCIAL STATEMENTS

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

Presentation of Financial Statements requires management to assess, as part of the Annual Accounts preparation process, the CCG's ability to continue as a going concern

The Department of Health Manual of Accounts 2014-15 outlines the following interpretations of Going Concern for the public sector in Section 4.13: 'For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision of that service in published documents, is normally sufficient evidence of going concern.'

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

The CCG commenced with a planned deficit of £20.9m in 2013-14 and is implementing a medium term financial recovery plan to comply with statutory duties. The CCG failed to achieve its statutory duty to break-even in 2013-14 (£9.0m deficit) and 2014-15 (£11m cumulative deficit) and a report was issued to the Secretary of State for Health under Section 19 of the Audit Commission Act 1998 for the anticipated or actual breach of financial duties for both 2013-14 and 2014-15.

The following is clear evidence that the CCG meets the requirement for a going concern per section 4.13 of the DH Manual of Accounts:

- Barnet CCG was established on 1st April 2013 as a separate statutory body;
- Barnet CCG has an agreed constitution and is operating to its constitution to govern its activities;
- Barnet CCG has been allocated funds from NHS England for the financial years 2013-14, 2014-15, 2015-16 and indicative allocations 2016-17, 2017-18 and 2018-19;
- Barnet CCG has a 5 year financial plan from 2014-15 to 2018-19 which has been submitted to the Governing Body and NHS England.

As a result of the above evidence Barnet CCG is considered as a Going Concern.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

1.5 Pooled Budgets

Where a 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.

Barnet Clinical Commissioning Group entered into four pooled budget arrangements with the London Borough of Barnet during 2014-15.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for (i) Learning Disabilities Campus Reprovision, (ii) Integrated Learning Disabilities Service,(iii) Voluntary Services and (iv) Community Equipment Services.

These are "jointly controlled operations", the CCG recognises both the expenditure it incurs and the CCG share of the income from the pooled budget in these accounts.

1.6 Financial Transformation and Risk Share

All CCGs are required to budget for a contingency and to set aside a proportion of their overall resource limit for non-recurrent uses.

The purpose of this note is to provide a disclosure of the financial transformation and risk-share arrangement which is operated across the CCGs in North Central London. The financial and governance arrangements for the risk-share are overseen by the North London Joint Clinical Commissioning Committee. This Committee includes representation from each of the five CCGs in North Central London.

In 2014-15, the risk-share provided financial coverage for the transformation of healthcare services. The governance and financial arrangements for the risk-share were approved by the CCG's Governing Body. The financial statements for 2014-15 include relevant contributions and receipts relating to the risk-share for Barnet CCG. In particular, Note 18, which sets out the financial performance of the CCG in 2014-15, reflects income and expenditure relating to the risk-share.

The CCG contributed £2.0m to the risk share in 2014-15. The source of funding for the contribution was an element of its budgeted contingency. The overall level of funding received by the CCG from the risk-share in 2014-15 was £8.9m. This is set out in the table below:

	£m
Primary Care Strategy	2.0
Barnet Enfield & Haringey Clinical Strategy	6.3
Royal Free / Barnet & Chase Farm Transaction Costs	0.6
	8.9

There is a firm commitment from each CCG in north central London to operate a similar transformation and risk-share arrangement for the medium term. The specific arrangements for the fund in 2015-16 have been approved by CCG Governing Bodies. Barnet CCG Governing Body approved the 2015-16 arrangements on 19th March 2015. The collaboration through the transformation and risk-share pool is seen by both the CCGs and NHS England as an important mechanism for both providing a necessary source of funding to facilitate the transformation of local health services and managing financial risk across the local health economy.

Historically, the former Primary Care Trusts in North Central London had operated a similar system of financial risk sharing. As part of the authorisation process, Clinical Commissioning Groups were advised to work collaboratively where possible, and it was agreed to continue this practice within the five North Central London CCGs.

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 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:

NHS Property Services/Community Health Partnerships Properties

Under IFRIC 4 the CCG recognises the need to account for payments to NHS Property Services Ltd and Community Health Partnerships Ltd as a lease arrangement. The indications of a lease include an arrangement comprising a transaction, or a series of related transactions, that does not take the legal form of a lease but conveys a right to use an asset in return for a payment or series of payments.

Even though there is no formal contract in place, the transactions involved do convey the right of the CCG to use property assets. As such these transactions are being accounted for as an operating lease in accordance with IAS 17.

1.7.2 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:

Partially completed spells

Expenditure relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay OR costs incurred to date compared to total expected costs. The value of the accrual in 2014/15 is £1,648,252 (2013/14 was £1,666,299)

Accruals

For goods and/or services that have been delivered but for which no invoice has been received/sent, the CCG makes an accrual based on the contractual arrangements that are in place and its legal obligation. See trade and other payables Note 9.

Prescribing liabilities

NHS England actions monthly cash charges to the CCG for prescribing contracts. These are issued approximately two months in arrears. The CCG uses a forecast based on previous in year charges from the NHS Business Authority to estimate the full year expenditure. The value of the accrual in 2014/15 is £8,018,653 (2013/14 was £7,553,610).

Maternity pathways

Expenditure relating to all antenatal maternity care is made at the start of a pathway. As a result at the year-end part completed pathways are treated as a prepayment. The CCG agrees to use the figures calculated by the local hospitals. The value of the accrual in 2014/15 is £1,658,878 (2013/14 was £2,001,587).

1.8 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 Employee Benefits

1.9.1 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.

1.9.2 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.

1.10 Other Expenses

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

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

1.11 Leases

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

1.11.1 The Clinical Commissioning Group as Lessee

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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.12 Cash & Cash Equivalents

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

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

1.13 Provisions

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

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

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

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

1.14 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.

The total value of clinical negligence claims carried by the NHSLA on behalf of the CCG at 31st March 2015 is £45,000. (31st March 2014 was nil).

1.15 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.

1.16 Continuing healthcare risk pooling

In 2014-15 a risk pool scheme has been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31st March 2013. Under the scheme clinical commissioning group contribute annually to a pooled fund, which is used to settle the claims. In 2014/15 the CCG contributed £590,000.

1.17 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.18 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.

All Financial assets are classified as loans and receivables.

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

1.19 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Clinical Commissioning Group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

1.20 Financial Liabilities

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

Financial liabilities are initially recognised at fair value.

1.21 Value Added Tax

Most of the activities of the Clinical Commissioning Group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Losses & Special Payments

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

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

1.23 Accounting Standards that have been issued but have not yet been adopted

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

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

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

2 Other Operating Revenue

	2014-15 Admin £000	**2014-15 Programme £000**	**2014-15 Total £000**	2013-14 Total £000
Prescription fees and charges	0	3	**3**	0
Education, training and research	26	4	**29**	56
Non-patient care services to other bodies	0	3,072	**3,072**	16
Other revenue	(3)	0	**(3)**	68
Total other operating revenue	**23**	**3,079**	**3,102**	**140**

Revenue is generated wholly from the supply of services. The CCG receives no revenue from the sale of goods.

Admin revenue is that which is not directly attributable to the provision of healthcare or healthcare services.

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 Employee benefits and staff numbers

2014-15	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	6,467	4,044	2,423	3,751	2,378	1,372	2,716	1,666	1,050
Social security costs	347	347	0	225	225	0	122	122	0
Employer Contributions to NHS Pension scheme	430	430	0	247	247	0	184	184	0
Gross employee benefits expenditure	**7,245**	**4,822**	**2,423**	**4,222**	**2,850**	**1,372**	**3,022**	**1,972**	**1,050**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**7,245**	**4,822**	**2,423**	**4,222**	**2,850**	**1,372**	**3,022**	**1,972**	**1,050**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**7,245**	**4,822**	**2,423**	**4,222**	**2,850**	**1,372**	**3,022**	**1,972**	**1,050**

2013-14	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	4,539	3,019	1,519	2,680	1,702	977	1,859	1,317	542
Social security costs	260	260	0	182	182	0	78	78	0
Employer Contributions to NHS Pension scheme	299	299	0	173	173	0	126	126	0
Gross employee benefits expenditure	**5,098**	**3,578**	**1,519**	**3,035**	**2,057**	**977**	**2,063**	**1,521**	**542**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**5,098**	**3,578**	**1,519**	**3,035**	**2,057**	**977**	**2,063**	**1,521**	**542**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**5,098**	**3,578**	**1,519**	**3,035**	**2,057**	**977**	**2,063**	**1,521**	**542**

3.2 Average number of people employed

	2014-15			2013-14
	Total	Permanently employed	Other	Total
	Number	Number	Number	Number
Total	**94**	**69**	**25**	74
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

3.3 Staff sickness absence and ill health retirements

	2014-15	2013-14
	Number	Number
Total Days Lost	284	124
Total Staff Years	77	58
Average working Days Lost	**3.7**	**2.1**

	2014-15	2013-14
	Number	Number
Number of persons retired early on ill health grounds	0	0
	£000	£000
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

3.4 Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions 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 NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary 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 the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 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, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set 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.

c) Scheme provisions

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

4 Operating Expenses

	2014-15 Admin £000	2014-15 Programme £000	2014-15 Total £000	2013-14 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	2,971	3,022	5,994	3,839
Executive governing body members	1,264	0	1,264	1,259
Total gross employee benefits	**4,235**	**3,022**	**7,258**	**5,098**
Other costs				
Services from other CCGs and NHS England	4,067	666	4,733	5,389
Services from foundation trusts	0	200,155	200,155	101,067
Services from other NHS trusts	0	132,100	132,100	213,634
Services from other NHS bodies	0	0	0	1,558
Purchase of healthcare from non-NHS bodies	0	43,323	43,323	40,574
Chair and Non-Executive Members	221	0	221	136
Supplies and services – clinical	0	454	454	397
Supplies and services – general	6	(593)	(587)	1,105
Consultancy services	15	258	273	69
Establishment	98	1,375	1,473	1,693
Transport	2	0	3	1
Premises	241	1,089	1,330	2,625
Audit fees	114	0	114	116
Prescribing costs	0	48,640	48,640	47,789
GPMS/APMS and PCTMS	0	1,988	1,988	586
Other professional fees excl. audit	90	80	170	449
Education and training	81	275	356	85
CHC Risk Pool contributions	0	590	590	0
Other expenditure	0	0	0	2,000
Total other costs	**4,936**	**430,440**	**435,336**	**419,274**
Total operating expenses	**9,172**	**433,423**	**442,594**	**424,372**

5 Payments

5.1 Better Payment Practice Code

Measure of compliance	2014-15 Number	2014-15 £000	2013-14 Number	2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	12,047	51,149	10,744	36,618
Total Non-NHS Trade Invoices paid within target	11,382	45,777	10,040	31,948
Percentage of Non-NHS Trade invoices paid within target	**94.48%**	**89.50%**	**93.45%**	**87.25%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,914	337,441	2,365	309,043
Total NHS Trade Invoices Paid within target	2,278	326,794	1,968	273,836
Percentage of NHS Trade Invoices paid within target	**78.17%**	**96.84%**	**83.21%**	**88.61%**

5.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2014-15 £000	2013-14 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

6 Operating Lease

6.1 As lessee

6.1.1 Payments recognised as an Expense

	Buildings £000	2014-15 Total £000	2013-14 Total £000
Payments recognised as an expense			
Minimum lease payments	1,885	**1,885**	2,308
Total	**1,885**	**1,885**	**2,308**

The Clinical Commissioning Group occupies property owned and managed by Community Health Partnerships Ltd and /or NHS Property Services Ltd. For 2014-15, a transitional occupancy rent based on annual property cost allocations was agreed. This is reflected in note 6.1.1 above.

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

7 Trade and other receivables

	2014-15	2013-14
Current	**£000**	£000
NHS receivables: Revenue	1,156	571
NHS prepayments and accrued income *	1,775	2,313
Non-NHS receivables: Revenue	18	1,139
Non-NHS prepayments and accrued income	2,570	(483)
VAT	43	84
Other receivables	5	2
Total Trade & other receivables	**5,567**	**3,625**
Non current	0	0
Total current and non current	**5,567**	**3,625**
Included above:		
Prepaid pensions contributions	0	0
NHS Maternity Pathway Prepayments *	1,659	2,002

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

7.1 Receivables past their due date but not impaired

	2014-15	2013-14
	£000	£000
By up to three months	226	272
By three to six months	13	0
By more than six months	908	0
Total	**1,147**	**272**

£0 of the amount above has subsequently been recovered post the statement of financial position date.

8 Cash and cash equivalents

	2014-15	2013-14
	£000	£000
Balance at 1st April 2014	186	0
Net change in year	(168)	186
Balance at 31st March 2015	**18**	**186**
Made up of:		
Cash with the Government Banking Service	18	186
Cash and cash equivalents as in statement of financial position	**18**	**186**
Balance at 31st March 2015	**18**	**186**

9 Trade and other payables

	2014-15 £000	2013-14 £000
Current		
NHS payables: revenue	15,684	13,607
NHS accruals and deferred income	4,467	5,667
Non-NHS payables: revenue	4,039	5,122
Non-NHS accruals and deferred income	16,724	13,695
Social security costs	52	56
Tax	54	52
Other payables	751	796
Total Trade & Other Payables	**41,771**	**38,995**
Non current	0	0
Total current and non-current	**41,771**	**38,995**

Other payables include £62k outstanding pension contributions at 31 March 2015 (2013-14 £17k)

10 Provisions

	2014-15 Other £000	2013-14 Other £000
Current		
Balance at 1st April 2014	**2,000**	**0**
Arising during the year	0	2,000
Utilised during the year	(2,000)	
Total current provisions	**0**	2,000
Non current	0	0
Total current and non-current	**0**	**2,000**
Expected timing of cash flows:		
Within one year	0	2,000
Between one and five years	0	0
After five years	0	0
Balance at 31st March 2015	**0**	**2,000**

Other provisions - related to the CCG's assessment of its expected obligation to pay for Referral to Treatment (RTT) costs incurred in 2013-14.

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 31st March 2015 is £1.0m (£8,85m at 31st March 2014).

11 Contingent Liabilities

	31st March 2015 £000	31st March 2014 £000
NHS Litigation Authority Legal Claims	(45)	0

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 NHS Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Clinical Commissioning Group and internal auditors.

12.1.1 Currency risk

The NHS Clinical Commissioning Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Clinical Commissioning Group has no overseas operations. The NHS Clinical Commissioning Group and therefore has low exposure to currency rate fluctuations.

12.1.2 Interest rate risk

The Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

12.1.3 Credit risk

Because the majority of the NHS Clinical Commissioning Group and revenue comes from parliamentary funding, NHS Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

12.1.4 Liquidity risk

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

12.2 Financial assets - Loans and Receivables

	Total 2014-15 £000	Total 2013-14 £000
Receivables:		
· NHS	1,156	571
· Non-NHS	18	1,139
Cash at bank and in hand	18	186
Other financial assets	5	2
Total at 31st March 2015	**1,197**	**1,897**

12.3 Financial liabilities - Payables

	Total 2014-15 £000	Total 2013-14 £000
Payables:		
· NHS	20,152	19,273
· Non-NHS	21,514	18,817
Total at 31st March 2015	**41,665**	**38,090**

13 Pooled budgets

The Clinical Commissioning Group entered into four pooled budget arrangements with the London Borough of Barnet during 2014-15.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for (i) Learning Disabilities Campus Reprovision, (ii) Integrated learning Disabilities Service,(iii) Voluntary Services and (iv) Community Equipment Services

The CCG expenditure balances in the statement of Comprehensive Expenditure that relates to these pooled budgets are as set out below:

	2014-15 £000	2013-14 £000
Expenditure - Learning Disabilities Campus Reprovision	723	791
Expenditure - Integrated Learning Disabilities Service	1,890	1,571
Expenditure - Voluntary services	732	732
Expenditure - Community Equipment Services	1,273	1,135
	4,618	4,229

14 Intra-government and other balances

	Current Receivables 2014-15 £000	Current Payables 2014-15 £000
Balances with:		
· Other Central Government bodies	0	105
· Local Authorities	1,476	0
Balances with NHS bodies:		
· NHS bodies outside the Departmental Group	0	0
· NHS Trusts and Foundation Trusts	2,931	20,152
Total of balances with NHS bodies:	**2,931**	**20,152**
· Bodies external to Government	1,160	21,514
Total balances at 31st March 2015	**5,567**	**41,771**

	Current Receivables 2013-14 £000	Current Payables 2013-14 £000
Balances with:		
· Other Central Government bodies	0	111
· Local Authorities	300	0
Balances with NHS bodies:		
· NHS Trusts and Foundation Trusts	2,884	19,273
Total of balances with NHS bodies:	**2,884**	**19,273**
· Bodies external to Government	441	19,611
Total balances at 31 March 2014	**3,625**	**38,995**

15 Related party transactions

The transactions listed below are in relation to interests declared, other than those relating to member general practices.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Barndoc Healthcare Ltd	2,853	0	0	0

Clinical commissioning groups are clinically led membership organisations made up of general practices. The members of the Clinical Commissioning Group are responsible for determining the governing arrangements for their organisations, which they are required to set out in a constitution.

The members of Barnet Clinical Commissioning Group are contained within Appendix B of the constitution. Where payments have been made to these practices, these are listed below. The majority of the payments are in relation to agreed locally enhanced services and some prescribing costs.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Ballards Lane Surgery	67	0	0	0
Boyne Avenue Surgery	11	0	0	0
Cherry Tree Surgery	9	0	0	0
Cornwall House Surgery	63	0	0	0
Cricklewood Health Centre	0	0	0	0
East Barnet Health Centre	16	0	0	0
East Finchley Medical Practice	47	0	5	0
Everglade Medical Practice	49	0	8	0
Greenfield Medical Centre	46	0	0	0
Grimble & Partners	46	0	0	0
Heathfields	79	0	0	0
Hendon Way Surgery	19	0	0	0
Hodford Road Surgery	21	0	0	0
Holly Park Clinic	52	0	0	0
Jai Medical Centre	338	0	0	0
Lane End Medical Group	228	0	0	0
Lichfield Grove Surgery	27	0	0	0
Longrove Surgery	74	0	0	0
Millway Medical Practice	123	0	0	0
Mulberry Medical Practice	80	0	10	0
Oak Lodge Medical Centre	402	0	1	0
Oakleigh Road Health Centre	54	0	0	0
Old Courthouse Surgery	73	0	1	0
Osidge Medical Practice	0	0	3	0

Parkview Surgery	0	0	10	0
Pennie Drive Surgery	0	0	5	0
Ravenscroft Medical Centre	50	0	0	0
Squires Lane Practice	54	0	0	0
St Andrews Medical Practice	159	0	0	0
St Georges Medical Centre	126	0	0	0
Supreme House Surgery	19	0	0	0
Team Healthcare Practice	40	0	0	0
Temple Fortune Health Centre	84	0	0	0
Torrington Park Group Practice	73	0	7	0
Torrington Speedwell Practice	62	0	0	0
Vale Drive Health Centre	36	0	0	0
Wakemans Hill Surgery	23	0	0	0
Watling Street Surgery	88	0	12	0
Wentworth Medical Practice	51	0	0	0
Woodlands Medical Practice	13	0	1	0

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. A de minimis limit of £250k has been applied in reporting these values below.

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
NHS England	510	0	24	(54)
NHS Enfield CCG	126	(300)	152	(490)
NHS North & East London CSU	5,331	0	238	0
Barnet & Chase Farm Hospitals NHS Trust	24,893	0	0	0
Barnet, Enfield & Haringey Mental Health NHS Trust	28,403	0	540	0
Barts Health NHS Trust	1,313	0	0	(28)
Central London Community Healthcare NHS Trust	34,377	(1)	1,356	(3)
Ealing Hospital NHS Trust	312	0	0	0
East & North Hertfordshire NHS Trust	336	0	258	0
Imperial College Healthcare NHS Trust	3,624	0	429	0
London Ambulance Service NHS Trust	10,647	0	139	0
London North West Healthcare NHS Trust	1,123	0	331	0
North Middlesex University Hospital NHS Trust	1,780	0	433	0
North West London Hospitals NHS Trust	7.832	0	0	0
Royal National Orthopaedic Hospital NHS Trust	5,958	0	136	0
The Whittington Hospital NHS Trust	9,182	0	210	(166)
West Hertfordshire Hospitals NHS Trust	1,059	0	322	0
Camden & Islington NHS Foundation Trust	606	0	353	0
Central & North West London NHS Foundation Trust	1,806	0	57	0

Chelsea And Westminster Hospital NHS Foundation Trust	862	0	355	0
East London NHS Foundation Trust	2,030	0	0	(5)
Great Ormond Street Hospital for Children NHS Foundation Trust	988	0	40	0
Guy's & St Thomas' NHS Foundation Trust	2,591	0	81	0
King's College Hospital NHS Foundation Trust	391	0	41	0
Moorfields Eye Hospital NHS Foundation Trust	3,746	0	383	0
Royal Brompton & Harefield NHS Foundation Trust	941	0	330	0
Royal Free London NHS Foundation Trust	160,418	0	8,328	(1,116)
Surrey & Borders Partnership NHS Foundation Trust	1,131	0	286	0
Tavistock & Portman NHS Foundation Trust	582	0	109	0
The Royal Marsden NHS Foundation Trust	314	0	71	0
University College London Hospitals NHS Foundation Trust	21,966	0	2,913	(377)
NHS Property Services	979	0	514	0
National Health Service Pension Scheme	431	0	0	0

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 Local Authorities and HMRC. A de minimis limit of £250k has been applied in reporting these figures below.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Barnet London Borough Council	8,112	(2,772)	3,089	(1,476)
HM Revenue and Customs Trust Statement	347	0	0	0

16 Events after the end of the reporting period

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

17 Losses and special payments

There are no losses or special payments to report for 2014-15 (Nil 2013-14).

18 Financial performance targets

Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended). The Clinical Commissioning Group's performance against those duties was as follows:

	2014-15 Target Performance £000	2014-15 Actual Performance £000	2014-15 Surplus / (Deficit) £000	2014-15 Duty Achieved Yes / No
Expenditure not to exceed income	431,575	442,594	(11,019)	No
Capital resource use does not exceed the amount specified in Directions	-	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions	428,473	439,492	(11,019)	No
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions - Administration	10,120	9,109	1,011	Yes

	2013-14 Target Performance £000	2013-14 Actual Performance £000	2013-14 Surplus / (Deficit) £000	2013-14 Duty Achieved Yes / No
Expenditure not to exceed income	415,406	424,372	(8,966)	No
Capital resource use does not exceed the amount specified in Directions	-	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions	415,267	424,233	(8,966)	No
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions - Administration	9,360	9,104	256	Yes

Due to a change in presentation requirements for 2014-15, the 2013-14 figures are restated to a comparable basis to 2014-15.

Note: Expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

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