MEETING

HEALTH & WELLBEING BOARD

DATE AND TIME

THURSDAY 12TH MAY, 2016

AT 9.00 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

Dear Board Members,

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
1.	CCG ANNUAL REPORT AND ACCOUNTS	1 - 96

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AGENDA ITEM 11

	Health and Wellbeing Board **12 May 2016**
Title	**Barnet CCG Draft Annual Report and Accounts 2015-16**
Report of	CCG Accountable Officer
Wards	All
Status	Public
Key	No
Enclosures	Appendix 1: NHS Barnet CCG Draft Annual Report and Accounts 2015-16 (To follow)
Officer Contact Details	Roger Hammond, Chief Financial Officer roger.hammond@barnetccg.nhs.uk Fiona Barr, (Interim) Assistant Director of Governance & Corporate Affairs fiona.barr@barnetccg.nhs.uk Adrian Phelan, (Interim) Communications Manager adrian.phelan@barnetccg.nhs.uk

Summary

In accordance with the Health & Social Care Act 2012, in preparing their annual report each clinical commissioning group must evidence how it has consulted their Health and Wellbeing Board.

The Health and Wellbeing Board (HWBB) is asked to consider NHS Barnet CCG's Draft Annual Report and Accounts and comment on the extent to which the CCG has contributed to the delivery of the Joint Health and Wellbeing Strategy 2015-2020.

Members of the Health and Wellbeing Board are asked to note:

- They are receiving a draft version of the NHS Barnet CCG Annual Report and Accounts as of the 5 May 2016
- The NHS Barnet CCG Annual Report and Accounts are subject to review and approval at the NHS Barnet Audit Committee May meeting and Governing Body meeting on 26 May 2016.

Recommendations

1. **That the Board consider NHS Barnet CCG's Draft Annual Report and Accounts and comment on the extent to which the CCG has met the priorities set out in the Joint Health and Wellbeing Strategy 2015-2020.**

1. WHY THIS REPORT IS NEEDED

1.1 The CCG's Annual Report and Accounts are prepared in accordance 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.

2. REASONS FOR RECOMMENDATIONS

2.1 In accordance with the Health and Social Care Act 2012, in preparing their annual report each CCG must evidence how it has consulted with the relevant Health and Wellbeing Board (HWBB).

2.2 The HWBB is asked to consider NHS Barnet CCG's draft 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 in line with the statutory framework. To not submit the annual report to the HWBB would mean that the requirements set out by NHS England would not be met.

4. POST DECISION IMPLEMENTATION

4.1 Following internal review by the CCG and submission to NHS England on 26 May 2016, the 2015-16 Annual Report and Accounts will be published on the CCG website on 10 June and a copy will be circulated to the Health and Wellbeing Board in July for information.

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's Joint Health and Well-Being Strategy 2015 to 2020.

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 Group Manual for Accounts 2015-16 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 CCG is required to confirm to NHS England the actions it has taken to consult with the HWB in preparing the Annual Report and Accounts and evidence how they have done this in the report.

5.3.3 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 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 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.

5.4 **Risk Management**

5.4.1 N/A

5.5 **Equalities and Diversity**

5.6 Ensures that BCCG meets its Equalities Duties

5.7 **Consultation and Engagement**

5.7.1 Engagement has taken place with multiple internal stakeholders during the development of the Annual Report and Accounts, including the CCG Chair and Accountable Officer, the CCG's Internal Audit and External Audit providers**.**

5.7 **Insight**

5.7.1 N/A

6. BACKGROUND PAPERS

6.1 Department of Health Guidance, Group Manual for Accounts 2015-16: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/427554/FRAB_123_07_2015-16_MfA.pdf

Barnet Clinical Commissioning Group

BARNET CCG ANNUAL REPORT AND ACCOUNTS 2015/16

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

Document control:

Version: 10
Latest author/editor/amender: Adrian Phelan

Date of latest amend: 4 May 2016

Contents

1. Introduction

1.1 Introduction/Welcome

[Chairman adding at later stage]

1.2 Performance Report

1.2.1 Overview

1.2.2 Who we are and what we do

Barnet is the second largest of all 32 London boroughs by population, with 369,000 people living in an area of 33 square miles. It has a particularly large elderly community, with nearly 50,000 over 65-year-olds, the second highest number in that age group after Bromley in south London.

According to the 2011 Census, just over a quarter of people in Barnet belonged to non-white ethnic groups, a rise of 18% from a decade previously. Barnet also has the largest Chinese population of any London borough.

Barnet CCG commissions NHS services for all these Barnet residents. The CCG was approved as a pathfinder in April 2011, and held elections for Board members in June 2012. We took on full responsibility for commissioning healthcare across the borough in April 2013.

Based in its offices at North London Business Park, Oakleigh Road South, New Southgate N11 1NP, Barnet CCG's role as a commissioner of NHS services in the borough is to:

- Understand the health needs of the population;
- Design and redesign services;
- Buy the services; and
- Measure the impact of services.

Services are commissioned from the following organisations, as well as providing care through its member GP practices:

- The Royal Free London NHS Foundation Trust, which runs Barnet Hospital, Chase Farm Hospital and some clinics at Edgware Community Hospital, and
- Central London Community Healthcare NHS Trust, which runs Finchley Memorial Hospital and other services at Edgware Community Hospital.

The CCG's 64 member GP practices also set out the organisation's constitution, vision, mission and values. The CCG vision is:

> "We will work in partnership with local people to improve the health and well – being of the local population of Barnet, find solutions to challenges, and commission new and improved collaborative pathways of care which address the health needs for the Barnet population".

The CCG's values are:

- Involvement and listening to staff, communities, vulnerable groups, other stakeholders
- Courage / being brave, taking risks
- Valuing evidence
- Delivering and giving best value
- Having respect
- System Leadership

In addition to its vision and values, the CCG has made the following public commitments to the residents of Barnet:

- We will continue to improve the health and well- being of the local population by focussing on preventative services, reducing health inequalities and enabling the population to take responsibility for their own health.
- We will ensure the provision of high quality, efficient and effective health services for the population, within available resources, recognising that Barnet faces considerable financial pressures.
- We will facilitate integration between health and social care services.
- We will ensure good quality, safe healthcare in all settings.
- We will deliver a Barnet strategy that is clinically led, draws on evidence and uses innovative, radical solutions to deliver the best possible care to patients and their carers within allocated resources.
- We will focus on education and development support to clinicians to improve care and ensure that high quality services are delivered. We will take action when we are not receiving high quality, efficient and effective health services from our providers.

The CCG is led by a Governing Body, chaired by a GP, which makes the strategic decisions concerning the organisation, though the Executive Team runs the CCG on a day to day basis.

1.2.3 Statement from Accountable Officer

Barnet CCG has made significant progress during 2015-2016 against a range of ongoing challenges, to ensure that it has tackled issues head on, putting patients at the heart of the health and social care system at all times.

To achieve all this, the CCG has done a lot of things very differently in 2015-2016. Among the key achievements during the year have been:

- the effective management of risk to reduce their severity and likelihood
- transforming the opening £40m deficit into a small year-end surplus
- taking a new approach to mental health services to make them easier to access and navigate
- tackling head on the findings of external reports into the CCG's governance
- continuing to make improvements on clinical quality throughout all the CCG's commissioned services.

More copy to follow

Planning

Each year CCGs are required to undertaken an annual planning cycle, to

- Agree on activity levels over the next 12 months with providers of acute, community and mental health services
- Agree improvement trajectories for the delivery of constitutional standards and targets
- Develop well-coordinated and structured plans for development
- Identify key strategic and operational risks and appropriate mitigations
- Reduce the risk of unplanned developments which may impact on expenditure, increased activity or clinical risk
- Deliver the planned level of performance against targets including Quality, Innovation, Productivity and Prevention (QIPP) schemes
- Take advantage of opportunities to work with local health and social care system partners on common plans
- Achieve agreed objectives, which are translated into specific and measurable actions and outcomes which are easily understood and delegated appropriately

- Address issues derived from the complaints process and patient feedback (including themes from stakeholder events)
- Take account of input and feedback from the CCG's providers.

The planning cycle process is based on two basic assumptions:

- A broadly steady state of output, adjusted for demographic and known trends; in particular accommodating the changes in activity delivered by the service redesigns and transformation programme;
- There is no new money available to fund adjustments, unless it is allocated or assigned to specific national or local initiatives such as mental health services, without a compensating reduction being identified elsewhere.

Key to the planning cycle process in Barnet is the continued development of a robust system of risk management coupled with an output based performance management regime underpinned by a strong sense of patient safety and quality improvements.

The CCG also actively seeks to take advantage of opportunities to work with health, social care and voluntary sector partners on joint plans or joint commissioning opportunities whenever possible.

Financial resilience and sustainability are fundamental to enable us to enable Barnet CCG to deliver high quality health outcomes whilst accommodating predicted changes in the needs of the populations, as well as developments in technology and pharmaceutical advances.

Operational Plan Development

Developing annual operational plans starts with setting activity and financial baselines for each of the CCG's providers of health services, taking in key factors for demographics, inflation, known pressures and agreed developments. Once all the activity and financial values have been agreed, these are signed off by respective parties and these then form the annual operational plans.

Barnet CCG monitors progress against these plans throughout the year –using its own internal governance structures, such as the Governing Body and its Committees, checking performance against the standards set out in the NHS Constitution and through regular dialogue with its service providers.

Twice a year, the CCG has a stocktake meeting with NHS England to review overall performance and address any areas of concern.

Accident and Emergency

Performance against the 95% Accident and Emergency four-hour wait standard has been met based on January 2016 year-to-date figures, with 96.7% of Barnet CCG patients being seen in within four hours.

Referral to Treatment

Attaining the referral to treatment (RTT) targets including the 92% 18-week RTT for incomplete pathways has been particularly challenging this year, because of under-performance at both the Royal Free London NHS Foundation Trust (RFL) and the Royal National Orthopaedic Hospital (RNOH), which are both commissioned by the CCG.

Since RFL returned to national reporting in May 2015, Barnet CCG's performance has been below standard. As lead commissioner for RFL, the CCG has applied a robust performance management approach to drive improvements in RTT waiting times and has agreed a recovery plan and trajectory with RFL for return to compliance against the national standard in 2016-2017.

Within the year, the historic backlog of patients waiting over 18 weeks has been cleared, with the number of patients waiting over 52 weeks reduced from 195 to 1. In addition, a robust clinical harm review process has been put in place with over 10,000 patients now assessed.

Cancer

Barnet CCG measures cancer waiting time performance against nine measures and exceeded national standards for eight of these measures in the year to date. The CCG has however been challenged in meeting the 62-day cancer wait for urgent GP referrals, relating to under performance on this measure at provider trusts.

As lead commissioner for RFL, the CCG has applied a robust performance management approach to drive improvements in cancer 62-day urgent GP referral waiting times and has agreed a recovery plan and trajectory with the Trust for a return to compliance against the national standard by the end of 2015-2016. Although performance has remained below the standard with no signs of significant improvements, this is a result of the strategy agreed between the CCG and RFL to treat the longest waiters first.

To clear the backlog, RFL has been over delivering its activity plan against the agreed trajectory resulting in under-performance against the standard. A robust clinical harm review process has been put in place to assess all patients that have waited over 62 days.

Diagnostics

Performance against the diagnostics six-week wait national standard has also been a challenge for the CCG in 2015-2016, due to performance by its providers. The CCG has applied a robust performance management approach to drive improvements in diagnostics waiting times and has agreed a recovery plan and trajectory with RFL, aiming for a return to compliance by the end of 2015-2016. Significant additional capacity has been put in place through various programmes including a new Endoscopy unit opening at RFL in November 2015.

Patient Care and Treatment Reviews

Care and Treatment Reviews (CTRs) were introduced in 2015 for patients with learning disabilities and autism who meet the criteria of the Assuring Transformation concordat, set up following the Winterbourne View investigations.

In 2015-2016, a CTR applied to any patient in a hospital bed on 1 April 2014 who had no discharge date or a discharge date beyond March 2015.

Barnet CCG established a RAG rated register of patients at risk of hospital admission and began a programme of community CTRs, initially for those most at risk. The aim of CTRs is to re-examine the patients' care and support needs and how these could best be met and to avoid admission to hospital where possible.

The reviews are chaired by a commissioner from the CCG and include independent clinical experts and experts by experience, appointed by NHS England and representatives from the integrated community learning disability service. The discharge plans for two of the patients are being delivered with a move to supported housing due to take place in May 2016. The CCG is currently planning updates to the reviews for the remaining patients in long stay hospitals with the support of NHSE.

Patient and provider focused action plans and the recommendations for each individual patient are reported to NHS England and patient plans are updated fortnightly. The CCG is working closely with NHS England to review progress, and the themes emerging from the CTRs to ensure the best outcomes for the patients.

The table below shows what progress has been made in 2015-2016 in Barnet in addressing the priority themes from the reviews.

• Providers to review training for care teams and staff and monitor impact on service quality and patient experience.	• Training plans reviewed and individual actions identified for example specialist Person Centred Planning consultant to work with individual staff teams
Providers to produce updated, comprehensive, individualised and operationalised plans including how Positive Behaviour Support is embedded in	• Provider psychology leads leading on training for staff updating PCPs • New Person Centred Planning documents have

their organisations, risk assessment, communication passports and person centred plans 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.	been developed. Care Coordinators working with providers to update PCPs and where appropriate individual service designs.
• Work with care co-ordinators and other stakeholders such as advocated 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.	• This is a priority theme in strategic plans to ensure that family/carers or representatives involved are not only informed but also actively involved in future plans. • Family members have been closely engaged in recent discharge planning
• Providers to adopt appropriate methods and assessment tools to understand function of behaviours of patients.	• Providers have confirmed that their psychology leads will be leading on training for staff.
• 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.	• Barnet commissioners have established links with the local advocacy provider to identify where there may be a need to strengthen the type of advocacy offered to people in this client group.

Systems Resilience

In 2015-2016, Barnet CCG commissioned a number of additional services to meet local and national assurance that patient care will be treated as a priority by all partners. These included:

- Enhanced Home From Hospital Service
- Enhanced Tracker Nurse
- Enhanced Mental Health Liaison Service
- 7 Day Social Worker
- Chase Farm Hospital Social Worker
- Enhanced Enablement Service
- 25 Enablement Beds
- Discharge Co-ordinator Role
- Enhanced Enablement
- Step Down Care Home Beds

Digital Roadmap: Enabling the Integrated Digital Shared Care Record

Barnet CCG's Information Management and Technology strategy focuses on the CCG's vision "to better exploit information and technology both within the CCG and across the whole of Health and social care, to achieve strategic objectives and to work with local people to develop seamless accessible care for a healthier Barnet".

During 2015-2016, Barnet CCG has been actively planning and scoping a strategic IDSCR Enablement Programme which it aspires to begin delivery over the next 3-5 years. This significant programme will be enabled through the following phases:

- Phase 1 – Enabling an Integrated Digital Shared Care Record (IDSCR) – The establishment of an interactive solution that would enable the flow of data seamlessly between organisations within the health and social care networks in Barnet;
- Phase 2 – Introducing an electronic Person-Held Health and Social Care Record for our Barnet residents – This will allow the individual to hold and manage their care and give consent to providers of care to view their record based on an agreed data set;
- Phase 3 – Augmenting our Business Intelligence and Information Analysis – The benefits of enabling the informatics for both commissioner and provider will allow the patient to be kept at the centre of all care pathways, provide improved and timelier decision making and plans to deliver healthcare excellence to Barnet's residents.

This is aligned with the national priorities to achieve 'Digital by 2018' as part of the NHS's overall Five Year Forward View, which includes:

- Enabling enable patients to make the right health and care choices by supporting digital services for patients and the wider public;
- Transforming general practice and its IT capability;
- Supporting care out of hospital which is fully integrated with community, mental health and social care;
- Developing a paperless healthcare system;
- Producing effective data and information which can effectively measure health outcomes and inform local research into establishing best practice.

Barnet CCG is committed to driving service transformation and integration across the local health community and has been developing its integrated care programme working alongside key health and social care colleagues, partners and providers. Enabling Interoperable Digital Shared Care Records (IDSCR) will make a real difference to patients and ensure the CCG delivers the Digital by 2018 vision and enhance access to integrated care across partners and providers.

The CCG sees the increased use of information technology benefiting both patients and practices. The emphasis in 2015-2016 has been to understand our current digital footprint and enable a collaborative Data Sharing Agreement between GPs, Providers and Local Authority. This has facilitated the scope, design and plan towards the enablement of future systems and procedures that will speed up services and move in the direction of paperless environments whilst at the same time improving data quality and data capture.

Reimagining Mental Health

Reimagining Mental Health has been adopted as an umbrella term for a complex programme that aims to encompass a range of initiatives to improve the outcomes for people with mental health needs across Barnet. It advocates a positive approach that recognises that mental health care, whilst governed within current legislation, should have proven clinical outcomes and benefits for patients under national guidance, and also allows for opportunities for varied approaches to delivering mental health and wellbeing in Barnet.

The programme will ultimately lead to redesigns of current statutory and third sector mental health care and will result in more collaborative, primary care-focused and preventative interventions being accessible at the first point of contact. The future model will also integrate with social care developments and be underpinned by the principles of enablement.

The programme has successfully engaged with a wide range of organisations and individuals and gathered extensive thoughts and ideas regarding future services and what these will look like. These have been developed into a clear and precise model and through a process of future, facilitated action learning sets, the model will be collaboratively 'detailed' in partnership with stakeholders and delivered through an agreed implementation plan.

Value for Money

[To be supplied with the final accounts]

At the start of its first year of operation, Barnet CCG was one of the most financially challenged CCGs in England and ended 2014-2015 with a £40m deficit in 2014-15.

To recover and stabilise its financial position, the CCG undertook a series of measures throughout 2015-2016 to manage its income and expenditure to return the CCG to financial balance.

In addition, the CCG benefited from adjustments to the funding formula for CCGs used by NHS England which were applied in 2015-16.

The CCG is pleased to announce that it turned its opening position of £40m deficit on 1 April 2015 to a closing position of XXX (Finance to insert) by 31 March 2016.

Primary Care

Level 2 co-commissioning status was awarded in 2015 and the CCG commenced at this level on 1st October 2015. The CCG have signalled to NHS E and NCL partners that we intend to apply for Level 3 – fully devolved commissioning - status during 2016.

A GP Federation covering all 62 member practices was established during 2015 and began to deliver a GP Access pilot service in Dec 2015 offering 250 additional appointments per week at 9 different locations across the borough in the evenings and at weekends.

All practices now have a data sharing agreement in place, with all patient records stored on the EMIS Web clinical system allowing greater degree of access by primary care clinical staff to essential information when required.

The Primary Care Strategy for Barnet has been developed during the latter half of 2015 with significant input from Healthwatch and practices prior to being heard at the Health and Wellbeing Board in May 2016.

Alongside NHS E we are completing the PMS review which will begin the process of levelling the financial allocation made to practices based on list sizes. Currently there is a wide variation in specific funding levels based on historic contractual elements. Money released from higher earning practices will be used to ensure all practices provide equitable levels of service with additional commissioned activity where our health gaps indicate.

NHS Right Care

NHS Right Care originated as part of the Quality, Innovation, Productivity and Prevention (i.e. QIPP) Programme within the Department of Health (DH) in 2009. Its focus was to expose and tackle variation with a view to securing value in terms of spend and outcomes.

It included various support and intervention products including the Atlas of Variation and Commissioning for Value Packs.

Working with individual Clinical Commissioning Groups, the Right Care approach has demonstrated real benefits, with savings in the region of 3.5 - 5%.

NHS Right Care now moved from the DH to NHS England (NHSE) and is being viewed as a key component in terms of the delivery of the *Five Year Forward View*. Its focus on value is extremely pertinent to the financial challenge being experienced by the NHS and the requirement to maximise return-on-investment (ROI) in terms of the public purse.

NHS England view the Right Care model as a key enabler in closing the both the efficiency and productivity gap, as well as the care and quality gap. NHS Barnet Clinical Commissioning Group has been chosen as an NHS England Wave 1 Pilot for the current Right Care Programme and has been assigned a specific Delivery Partner. As such, the CCG is committed to effectively utilising the Right Care model and tools in the commissioning and transformation of clinical services.

Right Care priorities for NHS Barnet Clinical Commissioning Group have been identified as:

No.	Priority	Summary
1.	Neurology	An outline business case has been approved at the QIPP Board with a full business case planned for June.
2.	IAPT	Service improvements are being met through our current contract with the providers and pathway re-design.
3.	Respiratory	This clinical area is being addressed through the 'Care Home Team' project working across the top 10 care homes with the highest number of ambulance conveyances and unplanned admissions.

Practice Nurse Development Programme

On 28 January 2016, the Primary Care Commissioning team held an exciting Practice Nurse event, the first ever of this kind held, with representatives from 50 out of the 62 General Practices in Barnet.

The aim of the workshop was to encourage Barnet practice nurses to consider the significant role they play in supporting the delivery of primary care to provide accessible, coordinated and proactive care, and to prepare them for the challenges and opportunities outlined in the Five Year Forward View. The topics covered by national and local speakers re-enforced these opportunities – encouraging nurses to work collaboratively, sharing knowledge and expertise. The role of the evolving Barnet Federation was highlighted and practice nurses were asked to explore possibilities to begin working more proactively and share specialist skills between practices. The nurses enjoyed this opportunity to network with their peers and colleagues and there was a real appetite for similar events.

The CCG is arranging a similar event in the autumn when we will invite a wider audience to include GPs, community nurses and other allied healthcare professionals alongside practice nurses to emphasise the value of multidisciplinary team working. The learning from this event will be developed further through the evolving practice nursing network, and form part of the CCG's primary care strategic plan.

1.2.4 Key Issues and Risks

[COPY ON FINANCIAL POSITION/DEFICIT TO COME LATER WITH ACCOUNTS]

1.2.5 Going Concerns

The accounts have been prepared on the going concern basis.

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

1.2.6 Performance Analysis and 1.27 Performance measures

Financial Performance

[COPY TO BE SUPPLIED LATER WITH ACCOUNTS]

The CCG Assurance Framework

NHS England's Assurance Framework for CCGs describes a continuous assurance process that aims to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively to commission safe, high-quality and sustainable services within their resources, delivering on their statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients.

The Framework recognises that assurance is a continuous process that considers the breadth of a CCG's responsibilities. It consists of the following components:

- Well-led
- Performance
- Financial Management
- Planning
- Delegated Functions

The CCG has regular meetings with NHS England which are underpinned by the Framework and this is used to monitor and effectively manage performance. The following section details those performance standards that sit within this framework and outlines performance for 2015/16.

The well-led component of the assurance framework focuses on the extent to which the CCG:

- Demonstrates it has strong and robust leadership
- Has robust governance arrangements
- Involves and engages patients and the public actively
- Works in partnership with others, including other CCGs
- Secures the range of skills an capabilities it requires to deliver all of its commissioning functions, using support functions effectively and getting the best value for money, and
- Has effective systems in place to ensure compliant with its statutory functions

This encompasses and builds on much of the previous year's assurance framework including governance arrangements. Specifically, the Good Governance Institute was commissioned by NHS England to carry out a piece of work requested by CCGs to help them assess and improve their governance arrangements.

Between November 2015 and January 2016, NHSE carried out detailed reviews into CCG Governance across North Central and East London – which includes Barnet CCG – using two of the tools developed by the Good Governance Institute:

- Governing Body meeting observations, to ascertain whether some of the beneficial outcomes of good governance are being openly demonstrated by a CCG;
- A Maturity Matrix, which provided CCGs with the opportunity to self-assess good governance practice, as well as their aspiration in achieving these outcomes in 12 months' time. It describes key elements of good governance outcomes and graduations of 'maturity'.

The feedback from the Governing Body observation in January 2016 highlighted Barnet CCG's commitment to the further development of its clarity of purpose, and that it is working towards stabilising its leadership arrangements. Other strengths noted were how the CCG engaged with the public and patients, both to fulfil statutory duties and to gain greater insight into population needs.

Barnet CCG's commitment to working as part of a whole system to improve patient outcomes was noted. Overall, the assessment of the well-led component and supporting governance arrangements were considered good with a small number of areas of improvement highlighted, such as identifying opportunities to use Key Performance Indicators to support decision making.

NHS England considered the CCG's self-assessment from the Maturity Matrix an honest and transparent assessment of the current position and generally correlated with the good governance outcomes seen during the Governing Body observation.

Better Care Fund Metrics

[COPY BEING SUPPLIED W/C 25/4]

Barnet CCG's Quality Strategy

Every person in Barnet will have access to safe, evidence based care that is personalised and responsive. (Barnet CCG Quality Strategy 2015-18, page 17)

Barnet CCG has an important statutory duty to improve quality and considers patient safety, high quality care and service users' experience to be amongst its key priorities as a commissioner of health care services for communities in Barnet.

The quality of care in the NHS remains under constant scrutiny because of a number of high profile inquiries and reviews and the need to ensure the highest possible level of quality for all people accessing services. Quality improvement and its assurance is a continuous process that is embedded into Barnet CCG commissioning activities.

The Governing Body can provide assurance that there are many excellent services and good practice within the services it commissions, it also acknowledges that there are remain areas that require further work in order to improve the clinical outcomes, patient experience and improve and sustain existing good levels in patient safety.

The CCG monitors and focuses on the qualitative aspects of commissioned services through 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, such as hospitals and community health services.

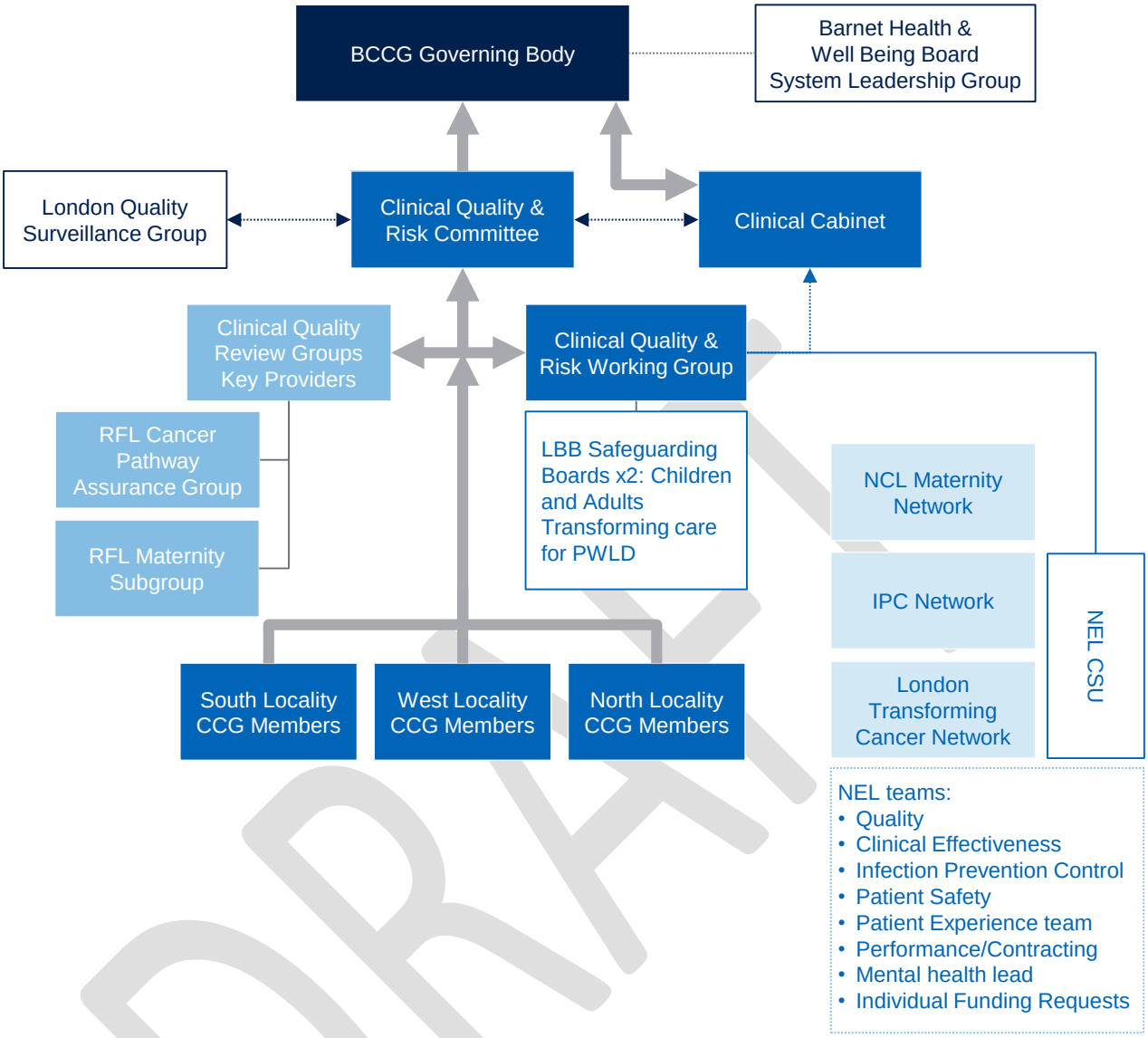
The CCG's Clinical Quality and Risk Committee has overall responsibility for undertaking the detailed review and monitoring of our provider services' compliance with quality and safety standards which include national standards and targets such as:

- 62 day cancer waits and clinical harm reviews;
- 18 weeks wait for Referral to Treatment (RTT);
- Six week 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).

The CCG Governing Body meetings receive a Quality and Risk Assurance report from the Chair of the Clinical Quality and Risk 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 November 2015 the CCG's internal auditors reported that the CCG could take substantial assurance on its performance on quality and safety standards such safeguarding, risk management, patient and public engagement, information governance and compliance with infection control standards and the governance of quality.

BARNET CCG QUALITY GOVERNANCE STRUCTURE



THE FIVE DOMAINS OF BARNET CCG QUALITY STRATEGY

Accident and Emergency Care Performance

Barnet CCG has continued to make progress in 2015-2016 against a number of key health targets, including those for Accident and Emergency (A&E) care.

The target is that 95% of patients who attend an A&E department are to be admitted, discharged or transferred to another provider within four hours of arrival. As the table below shows, Barnet CCG achieved this standard for each quarter of 2015-2016.

The table below details Barnet CCG's performance by month and aggregated for each quarter. At the time of reporting, validated and published data was available to January 2016, which was the first month during 2015/16 where the CCG was not compliant with the target. However, the CCG did achieve the standard, both monthly and quarterly for the first nine months of the year. On an aggregate basis has also achieved the target with performance of 96.7%.

			2015/16 Q1			2015/16 Q2			2015/16 Q3			2015/16 Q4			2015/16
Area	Standard		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
A&E	95%	Planned	95.00%			95.00%			95.00%			95.00%			
		Actual quarterly	98.14%			97.51%			95.84%						
		Actual monthly	97.88%	98.08%	98.45%	97.61%	97.77%	97.16%	96.98%	95.41%	95.10%	92.78%			96.70%

Throughout the year, there have been a number of initiatives which have been introduced through the local System Resilience Group (SRG). The SRG, which is chaired by the CCG, has membership from all local providers, commissioner, and social care organisations with a collaborative role in developing plans to be agreed by representatives from across the health and social care system.

The SRG also plans supports emergency care pathways (including the A&E standard), facilitates improvements in performance, reductions in clinical harm and risk and increasing patient satisfaction. The initiatives implemented through the SRG have included:

- Support to care homes, including out of hours care initiatives
- Additional capacity in primary care with GPs being based in hospitals near to GP practices
- Reducing the number of regular attendees at A&E departments
- An enablement service for patients who are 'non weight bearing', for example due to using crutches
- Improving the flow of patients through the hospitals and community facilities, and reducing delayed discharges to improve bed capacity.

At the time of writing there were a number of further initiatives being planned and due for implementation in 2016 (see also System Resilience, below).

Referral to Treatment Incomplete Waiting Time Performance

The 'incomplete waiting time' target or standard for this measure is 92%, and covers the number of patients who are waiting to start treatment, or be 'Referred To Treatment' (RTT).

Historically, there have been performance issues with the CCG's main provider, the Royal Free London NHS Foundation Trust (RFL). To address this, the CCG issued a Contract Performance Notice and there were improvements against the RTT performance during 2015-2016 as a result, including the elimination of a historic backlog, supported by a recovery trajectory agreed with the Trust.

Given the potential risk of harm to patients waiting for long periods of time before treatment, the CCG also introduced a robust clinical harm review process. This has so far seen a review of over 10,000 patients, with two cases of harm reported. No further cases of harm have been reported since and lessons learned from programme have been shared nationally.

During the latter part of 2015-2016, the CCG's performance was still below trajectory, which was attributed to two primary factors at its main provider, RFL:

- The Trust introduced a new Patient Administration System, which resulted in a change in the way patient pathways were recorded, this resulted in reduced number of patients waiting under 18-week wait denominator and an increase in the number of patients waiting 18 weeks of more;
- Implementing the Department of Health's Intensive Support rules which identified additional pathways transferring from non-RTT pathways, such as outpatients and diagnostics.

In order to monitor progress, the CCG initiated an RTT Task & Finish Group which meets monthly and has a clear remit to monitor the delivery of recovery and improvement plans until targets are met. This work has also overseen the reduction of patients waiting in excess of 52 weeks for treatment. At the start of the year there were over 200 patients waiting more than a year, and by March 2016 this historic backlog of 52 week waiters had been eliminated.

Cancer Standards Performance

There are eight standards which CCGs are required to meet which cover three elements of the cancer patient pathway: two-week wait, 31-day wait, and 62-day wait. In Barnet during 2015-2016, the two-week wait and 31-day wait targets have been achieved, but the achievement of the 62-day wait has been more challenging.

Given the challenges with its main acute provider RFL this year, particularly around the 62-day wait, the CCG has applied contractual levels in the form of Contract Performance Notices, and it has agreed a clear and robust recovery plan to address performance issues. As a result, the backlog of very long waiting patients was cleared and improvements in multi-disciplinary team working were also seen, supported by a robust framework of engagement.

To monitor ongoing performance, a number of mitigating actions were put into place by the CCG, including weekly meetings with high risk services to review patients and to support proactive planning and fortnightly 62-day pathway recovery meetings with all tumour site and diagnostic support services.

The communication framework with GPs was improved for incomplete or inappropriate referrals and identifying patients who were unavailable or unfit for long periods of time. Improvements in data quality were also made through continuous waiting list validation ensuring that every patient's progress on the cancer pathway was known.

Diagnostics Performance

Achieving the diagnostic waiting time target with no more than one per cent of patients waiting more than six weeks for referral has been challenging throughout the year in Barnet.

RFL accounts for the majority of diagnostic activity for the CCG and this is where the main performance issues have been seen this year. Non-obstetric ultrasound has had the most challenged performance with the highest backlog of all diagnostic modalities (a modality is the way in which a disease or illness is diagnosed, for example ultrasound or CT Scan). There has also been an increase in the number of referrals to the Trust from local GPs due to changes in referring protocols.

To better understand performance, the CCG met with the Trust's radiology team and agreed to review current local pathways and guidelines to ensure local protocols were aligned. The results of this review were examined in terms of required capacity for clinically effective pathways based on demand, and how effective outsourcing of work could be undertaken.

Other modalities with notable backlogs this year have included Colonoscopy, Gastroscopy, Flexi-sigmoidoscopy and Cystoscopy. In common with non-obstetric ultrasound, recovery trajectories were agreed with RFL to improve performance and return to compliance with the standard.

Improving Access to Psychological Therapies Performance

There are several targets that CCGs are required to achieve in relation to Improving Access to Psychological Therapies (IAPT).

While these two targets have been challenging to meet, access and recovery rates have improved throughout the year. Waiting times from referral to entering treatment have also been a challenge to meet as a result of a historic backlog. However there have been significant improvements in these measures throughout the year. This is reflected in waiting times from referral to first treatment, with the national standards met consistently from June 2015.

In order to improve the access rate performance and recovery rates, the CCG agreed a Remedial Action Plan (RAP) with the provider. This plan had a specific focus on increasing referrals as this was highlighted as being a key factor for access rate underperformance. Later in the year and as a result of continued

performance concerns, the CCG issued at the provider with a Contract Performance Notice (CPN), which included a renewed focus on the achievement of the key standards.

Dementia Diagnosis Performance

The target for dementia is that 67% of patients with dementia should be identified and given appropriate support. As can be seen from the table below, the CCG has consistently exceeded the target each month since formal monitoring commenced from August 2015, and on an aggregate basis to the end of February achieved performance of 73.28%.

			2015/16 Q1			2015/16 Q2			2015/16 Q3			2015/16 Q4			2015/16
Area	Standard		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Dementia diagnosis	67%	Planned	66.71%	66.71%	66.71%	66.71%	66.71%	66.71%	66.71%	66.71%	66.71%	66.71%	66.71%	66.71%	
		Actual monthly	76.33%	71.46%	74.39%	74.34%	72.37%	72.75%	73.64%	71.67%	73.88%	73.80%	71.46%		73.28%

Other Performance Measures

There are a number of other performance measures that the CCG monitors itself against and these will be provided in a later draft of the report.

1.2.8 Patient and Public Engagement

Barnet CCG is entirely committed to proper engagement with its patients and the wider public, and sees this as key to delivering the best possible, personalised and responsive services.

Core elements of the CCG's engagement strategy include creating a better understanding and knowledge of the work of Barnet CCG, engagement on the primary care strategy, and formal public consultation on service redesign and reconfiguration.

In addition to its patient, carer and public engagement work, the CCG also has a Patient Reference Group, and is developing links to the Patient Participation Groups in each of the 64 GP practices across the borough.

Barnet CCG also works closely with its local authority Barnet Borough Council, provider partners and HealthWatch, through its Patient and Public Engagement Committee. The Committee ensures joint engagement work takes place where possible and appropriate, and ensures stakeholder information is consistent across the whole system.

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.

Barnet CCG's Patient and Public Engagement Committee met three times during his year. Up until June 2015 it was Chaired by David Riddle. Following David's resignation from the CCG it has been chaired by his successor, Valerie Harrison. The CCG wishes to record its thanks to David for his work as Chair of the PPE Committee.

The Terms of Reference provide for the Committee to meet four times per year. Unfortunately, due to the changeover of Chairs and significant turnover in Committee Membership, it was not possible to hold the meeting planned for the summer quarter. We have successfully secured new representatives for the Committee and, to ensure a common understanding of the role of the Committee and secure commitment to an agreed work-plan, the Committee held a very successful workshop to review Terms of Reference and explore how to work more effectively together, focussing on the CCG's strategic priorities. Despite some difficulties, during 2015/16 the CCG held a number of very successful consultations with patients and the public:

- We held a very well attended meeting to consult with patients and the public with regard to our Commissioning intentions. The event was facilitated by HealthWatch and supported by plain English documentation. Support was also available to assist people for whom English is not their first language and for people with other communication needs. The feedback from the vent was very positive.
- Re-imagining Mental Health, our programme for working with people who have experience of mental health issues, community organisations and our public sector partners has continued throughout the year, with well attended breakfast meetings and working groups producing plans to co-produce community based support for people with mental health issues. This work is now informing a programme of change,
- Patients have been involved in significant programmes of change including the development of specifications and re-procurement processes for areas of particular concern and interest to patients and the public. These included:
  - 111 and Out of Hours services
  - Referral management service
  - Developing a primary care strategy
  - Cardiology end to end pathway
  - ENT and Audiology pathway
  - Community gynaecology pathway
  - Wheelchair service review
  - Development of Integrated Locality Teams to support people to remain independent at home
  - Developing services for people with learning disabilities and autism – in partnership with the local authority
  - Ensuring that people with learning disabilities were involved in Care and Treatment reviews to enable a smooth return to living in the community.

Examples of how Barnet CCG have engaged with patients and public in 2015-16

Workstream	Responsible Manager	Type of engagement	Details	Number of patients	When	Outcome
Re-procurement of Referral Management Service	Rajeshree Shah	Patient input into specifications	Patients comments incorporated into service specifications	2	Sept- Oct 2015	Service specification amended to reflect patient comments
		Patients part of procurement panel	Patients were involved in the scoring of procurement bids, the moderation of those scores and the interview of potential bidders	2	Feb/March 2016	Patients were fully involved in the type of questions that bidders were asked to answer as part of their bid, the scoring of those bids, the interview panel and the scoring of all questions as part of the procurement process
Re-procurement of ENT/WR/ Audiology Service	Yasmeen Farooqi	Questionnaire	Patients who had accessed the serviced between December 2014 – May 2014 were asked to complete a questionnaire to inform how the new service would look, paying particular attention to the reduction in potential sites going forward	200 questionnaires were sent to patients. There were 34 responses	Sept - Nov 2015	The patients responded as such: 48% experienced a disjoint service. 73% preferred the one stop shop service, 18% did not answer the question and only 9% opposed the one stop shop model to keep various locations option.
		Development of service specification	Patients comments were incorporated into the service specification	1	Aug –Oct 2015	The service specification was amended to reflect patient comments
		Focus Group	A discussion was had with the West locality PPG to discuss the potential new design of the service	20		Patients confirmed that they would prefer to have a one stop shop service and have their symptoms dealt with on the same day rather than receiving multiple appointments. Patients were keen to have locations however when explained why locations cannot be provided with a reduced number of appointments a vast majority voted for the one-stop shop model with fewer location choice.
		Health watch Survey	Health watch has representatives attending a clinic to talk to patients and get their comments on the	8	Nov 2015	The survey did not manage to capture many patients as the waiting area is for both acute and community patients. Not all patients spoken to were Barnet

Workstream	Responsible Manager	Type of engagement	Details	Number of patients	When	Outcome
			service.			patients. Therefore this exercise was taken as information only.
		Marketplace Event	Service users were invited to have an informal conversation about the service being proposed, to get their opinion on how the service would run and clinically advantages to the patient	30	October 2015	13 organisations from a range of geographical areas attended. With approx. 90% agreeing with this change and 10% already providing similar service in their areas. 5% were not happy as it potentially meant a loss in their business. The remaining 5% were neutral. Consultants that attended the event also clinically supported the advantages to the patient treatment.
		Local Barnet GP engagement	To provide education to GPs that are currently using the community ENT service and also ask question on the issues/problems they face with the current arrangements	30-35	April 2015	Through this event it was evident that all GPs wanted to refer patient once and if the patient ultimately required another service intervention input it to be done there and then. This therefore supported the one stop shop service model. The service proposal also ensured that GPs do not have to write two-three referral letters for patients with more complex conditions.
Re-procurement of Community Gynaecology	Beverley Wilding	Input into the development of the service specification	Opportunity for patient comments to be incorporated into the service specification	1	June-Aug 2015	
		Patient was a member of the procurement panel	Patient was involved in the scoring of the bids, the moderation of the scores and the interview of shortlisted bidders and approval of the draft procurement report	1	Aug 2015	The patient attended all meetings, including the training offered by NELCSU to support scoring of the bids. The patient commented on the proposed questions that were asked at the bidders interview.
Development of the Cardiology End to End Pathway	Beverley Wilding	Members of the Pathway Group	Patients who had experience due to their own Cardiology conditions of secondary care Cardiology services	2	May-July 2015	Provided their experience of Cardiology services, what worked well and what was difficult. Patient suggestion that the Heart Failure Service should be called the Heart Improvement Service or similar. Clinicians concerned that Heart

Workstream	Responsible Manager	Type of engagement	Details	Number of patients	When	Outcome
						Failure is a recognised clinical term across the health system and a name change could cause confusion to other clinical professions ie LAS
Primary Care Strategy	Rebecca Thornley/ Sean Barnett/ Beverley Wilding	Healthwatch - Primary Care Committee	A total of four meetings were held, including a workshop session	8	Nov-March 2015	Provided feedback on the type of access and service vision patients wanted from primary care. Highlighted need for proactive and joined up services with others in the health system.
Development of Barnet Integrated Locality Teams	Amisha Lall	Patient input into developing the service	Patients who accessed the service where asked to complete a questionnaire on the service they received. What worked well, areas of improvement	All patients who have accessed the service	Ongoing	Outputs have been used to develop the service currently being commissioned from a lead provider
		GP engagement	Workshops held with West locality GP's that participated in the pilot Attendance at GP locality meetings	7 GP practices N/A	Various throughout the year Various locality meetings throughout the year	Feedback from GP's used to make continuous improvements to pilot Raising awareness of the service
		Voluntary sector engagement	Workshops held with Healthwatch and voluntary sector providers	N/A	Various throughout the year	Feedback from the voluntary sector used to to strengthen links between BILT and voluntary sector services
		Engagement with community groups	Presentation at LBB Communities Together Network	N/A	March 2016	Links established with a few community groups
Learning Disabilities Partnership Board	Sue Tomlin	Engagement with PWLD and stakeholders (vol sec,	Workshops, presentations and discussions on Transforming Care for PWLD and Autism	Representation at LDPB varies usually	Regular meetings during 2015/16 - @ 2 – 3 months	• Comments on proposals included in responses to consultations • PWLD informed and aware of changes to service models

Workstream	Responsible Manager	Type of engagement	Details	Number of patients	When	Outcome
		carers, providers)		between 4 – 6 PWLD		
Health Development Group	Sue Tomlin	Engagement with PWLD and stakeholders (vol sec, carers, providers and clinical staff from community LD service)	PWLD are represented on the group which contributes to the development of health objectives and priorities for service development	1 - 2	Meetings during 2015/16 - @ 2 – 3 months	• Identifying issues and concerns • Developing health objectives/outcomes • Developing proposals for service development (business cases)
Autism Steering Group	Sue Tomlin	Engagement with people with Autism and stakeholders (vol sec, carers, providers)	People with Autism and carers are represented on the steering group and some task/project groups	2	The steering group met twice in 2015/16	• Contributing to Autism work and oversight of strategy • Identifying priority issues and activity required to address
Patient Care & Treatment Reviews (CTRS)	Sue Tomlin	Individual reviews of patient care and treatment (in assessment and treatment / hospitals)	NHSE requirement for CTRs within 10 days of admission and community CTRs for those e at risk of admission	15 or advocates where patients do not have capacity	N/A	• Comprehensive review of care and treatment including input form external experts (clinical and by experience) • Recommendations and action plan for each individual • Themes identified across providers
Reimagining Mental Health	Paula Arnell	Breakfast Club meetings	An event which brings together all co-design groups (see below) plus members of the community, public and third sector to discuss and celebrate the progress of Re-Imagining Mental Health Programme. (RMH)	40+	Six-weekly	• Members of community are engaged about the RMH programme / services. • Open space to discuss thoughts and ideas.
		Co-design	A professionally mixed group	2-3	Every 1 – 2	• All those involved are actively

Workstream	Responsible Manager	Type of engagement	Details	Number of patients	When	Outcome
		Groups	(voluntary, council, NHS and people with lived experience) that will focus on different agendas and subject matters for the Re-Imagining Health Programme i.e children & YP, MH training		months	contributing to the re-imagining health programme • The groups help identify priority issues which need to be addressed and also offer possible solutions.
Wheelchair Services		Service Users input into specifications	Service users comments incorporated into service specifications	tbc	tbc	Service specification developed with service user input
		Service Users part of procurement panel	Service Users were involved in the scoring of bids, the moderation of those scores and the interview of potential bidders.	3	Feb 2016	Service Users provided a critical role in the evaluation process of a contract which was heavily biased on quality (90/10% quality/finance). The final evaluation comments reflected this with the winning bidder scoring highly for their understanding of service user needs.

We are particularly pleased to have established a programme of patient story telling at our public Board meetings which provide an opportunity for the whole Board to benefit from understanding patient experiences.

The CCG is grateful to all patients and members of the public who have participated in our work over the past year.

The PPE Committee has reviewed our activities over the year in order to learn lessons and build on successes as we move into 2016/17. Our outline plan for the year ahead acknowledges our need to strengthen our capacity for patient and public engagement and focuses on the following:

- Further strengthening our ability to consult effectively on our commissioning intentions by identifying clearly the key issues of concern and interest to our population, providing readily understood information and documentation. and offering well organised and facilitated events to enable engagement,
- Working together with our local authority colleagues to develop arrangements that will enable us to consult on service changes and developments right across the health and social care pathways,
- Finding ways of making better use of our joint resources, for example, by building a directory of activities with the local authority,
- Sharing learning between organisations,
- Developing capacity for analysing data already collected about patient views,
- Developing capacity amongst less heard groups to enable greater engagement,
- Developing capacity in our commissioning teams for working with patients and the public,
- Reframing the ways we work with Patient Participation Groups, building on emerging models within Barnet,
- Supporting patient groups in engaging with Direct Payments.

We also plan to continue with our reimagining mental health programme, involving patients in pathway development and in our continuing development of strategies for primary, urgent and integrated care strategies.

In addition to working with Barnet Borough Council on the Patient and Public Engagement Committee, the CCG works with the local authority commissioning health and social care services. We also work with the local authority through the Health and Wellbeing Board and the Health Overview and Scrutiny Committee, both of which the local authority hosts.

During 2015-2016, the CCG has also been working with patients, partners and providers to address issues relating to health inequalities in the community particularly amongst protected groups.

1.2.9 Reducing Inequality

All public organisations including the CCG and public providers and commissioners of health and social care services have a duty to promote equality (Equality Act 2010).

Barnet CCG recognises that equality and human rights are about creating a fairer society in which everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense. The CCG recognises that everyone is different, and values the unique contribution that individual experiences, knowledge and skills make in delivering quality healthcare and becoming a model employer.

The CCG's ensures its services respect human rights, are fair and reflect local needs. The CCG's staff and patients are all different and therefore it is important that services and employment practices respect, promote and celebrate these differences, in relation to age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

All public organisations including the CCG and public providers and commissioners of health and social care services have a duty to promote equality (Equality Act 2010).

To ensure that we not only meet these legal requirements but go further to make equality, diversity and human rights integral in all of our decisions, the CCG is implementing the Equality Delivery System (EDS) as agreed by the NHS Equality and Diversity Council and the Department of Health.

It is planned that the EDS will become part of the system architecture of the NHS and all NHS commissioners and providers will be issued with a set of Equality Objectives and Outcomes, against which each NHS organisation will analyse and grade its performance, in collaboration with local interests.

The CCG actively promotes equality and human rights through a number of events, writing a yearly report on equality and using the Equality Impact Analysis (EQIA) to analyse, review services and policies to ensure there is no unjustifiable adverse impact on the people the CCG cares for.

The CCG does not tolerate unlawful discrimination, victimisation, bullying or harassment based on race, ethnic or national origin, nationality, age, disability, gender, gender reassignment, sexual orientation, religion or belief, HIV status, marital status or caring responsibilities. Any action counter to this is addressed in accordance with disciplinary policies and procedures.

The CCG recognises that while it sets and implements equality objectives, and publishes an annual equality performance report to meet the public sector equality duty, it must continue to work with patients, staff and stakeholders to ensure continuous improvement in advancing equality.

NHS Barnet CCG has completed its first Workforce Race Equality Standard (WRES) audit and has prepared the baseline report for 2015 which will be used to develop workforce race equality objectives and action plans.

The CCG is therefore also:

- Working with its providers to ensure effective use of EDS in grading equality performance;
- Providing equality and diversity training to staff;
- Refreshing its equality policies and guidance in 2016-2017 according to latest policy.

1.2.8 Sustainability Performance

Barnet CCG takes its social and environmental responsibilities seriously and seeks continuous improvement in assessing the risks, enhancing performance and reducing its impact on the environment, including against carbon reduction and climate change adaptation objectives. The CCG maintains and, where necessary, establishes mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning activities.

In terms of sustainable facilities, the CCG ensures all the buildings it occupies are fit for purpose and used efficiently. This means being appropriately insulated with efficient heating and ventilation systems with local controls. The buildings are well used, and do not use heat or power unnecessarily.

By working closely with its providers, and their landlords and premises providers, to monitor their own policies and procedures, the CCG ensures it 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.

The CCG also reviews the sustainable development of its key suppliers through its procurement processes.

2. Accountability Report

2.1.1 Corporate Governance Report

Introduction to be drafted

2.1.2 The Directors' Report

Dr. Debbie Frost is the Chair of the CCG.

Rob Larkman was Accountable Officer throughout 2015-16 and Cathy Gritzner joined the CCG as Accountable Officer on 1 April 2016.

2.1.3 Barnet CCG Governing Body

See Appendix A

2.1.4 Barnet CCG Audit Committee

See Appendix A

2.1.5 Register of Interests

The CCG maintains a Register of Interests in line with its Conflict of Interest Policy and details set out within its Constitution. The Register of Interests is updated bi-monthly and posted on the CCG's website prior to its Governing Body meetings.

In addition, at the start of each meeting of the Governing Body and formal committee meetings, members are required to declare any conflicts of interests in the items for consideration on the agenda and these are formally recorded in the minutes.

The register can be viewed on the CCG website at: http://www.barnetccg.nhs.uk

2.1.6 Raising Concerns and Managing Conflicts of Interest

In May 2015, a member of staff raised a concern about conflicts of interest around the commissioning of primary care services. There was a concern that GPs involved in financial decision making had not fully declared their financial interests. In addition in November 2015 two members of staff wrote letters to the Secretary of State for Health and NHS England about the recruitment and remuneration of interim staff.

In response the CCG commissioned two investigatory reviews. The first, by Verita, examined the CCG's processes for managing conflicts of interest and considered the CCG's governance structures with a focus on staff raising concerns and being listened to by the organisation. The second, by RMS Tenon, looked at the issues raised regarding interim staff, and its scope included looking at bullying and harassment in the wider context of the CCG's working culture.

Verita and RMS Tenon made a number of recommendations that resulted in the development of action plans to implement improvement to the CCG's governance systems.

Key actions included:

- A review of the policies and procedures relating to staff raising concerns, and the CCG's whistleblowing and grievance procedures.
- The CCG's structures being re-examined to ensure the organisation has the right establishment, and wherever possible permanent employees are recruited to posts.

- Staff being developed and encouraged to raise concerns openly, and as early as possible, through training, a programme or organisational development and the establishment of Freedom to Speak Up Guardians (as recommended by the Francis Report).

The result is that by June 2016 the CCG will have reformed and sustainable policies, processes and structures as well as staff and employees who are enabled to deliver best practice in good governance as part of an open and honest corporate culture.

2.1.7 Personal Data Related Incidents

In 2015/16, Barnet CCG reported no personal data related incidents to the Information Commissioner's Office.

2.1.8 Statement as to Disclosure to Auditors

[GENERIC COPY BELOW – to be checked following audit]

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

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

2.1.9 Statement of Accountable Officer's Responsibilities

[GENERIC COPY BELOW – to be checked following audit]

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

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

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

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

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

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

Signed:

Cathy Gritzner, Accountable Officer
Barnet Clinical Commissioning Group

2.3.1 Annual Governance Statement

2.3.2 Introduction and Context

Barnet CCG was licensed from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. Prior to this date, the CCG operated in shadow form to allow for the formal authorisation process and the establishment of functions, systems and processes prior to it then taking on full powers.

As part of its acquisition of the Royal Free London NHS Foundation Trust (RFL), the CCG in 2014 identified with NHS England issues relating to performance and quality as part of the due diligence process. NHS England determined that the 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), the CCG would not be able to discharge its functions in relation to the national 18-week referral to treatment target, relating to RFL. NHS England issued legal directions on this target, and licensed Barnet CCG with two authorisation conditions relating to finance and producing a finance plan.

In August 2015, the legal directions were lifted, with the review processes used by the CCG and RFL to achieve this being seen as best practice. The lessons learned have been shared nationally.

As of the date of this annual report, the Board Executive Team of Barnet CCG remains focused on removing the authorisation conditions on its licence. Further recent guidance has been given to the CCG by NHS England on this matter and there will be a review of progress in September 2016.

2.3.3 Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Barnet CCG'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 the government guidance document, *Managing Public Money*. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

2.3.4 Compliance with the UK Corporate Governance Code

This Governance Statement is intended to demonstrate how the clinical commissioning group had regard to the principles set out in the UK Corporate Governance Code considered appropriate for clinical commissioning groups for the financial year ended 31 March 2016.

2.3.5 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.

NHS Barnet CCG was established as a statutory public body in April 2013 by the NHS England under the Health and Social Care Act 2012. Barnet CCG is a membership organisation which makes clinically-led decisions that will give patients and their carers a true voice and put them at the heart of the CCG's work.

Barnet's GPs have a strong tradition of being involved in the planning and design of services for their patients and are committed to working with patient groups, local stakeholders and partners across Barnet to improve services for our local residents.

Constitution

The CCG's Constitution sets out the powers that the member practices have elected to reserve for themselves as members of the CCG; and those that they have delegated to the Governing Body of the CCG and its various committees. It describes the governing principles, rules and procedures that the member practices have established to ensure accountability and probity in the day-to-day running of the CCG.

The CCG's Constitution has been subject to a comprehensive internal review by the Executive Team and the Audit Committee. The CCG has also sought legal advice and engaged with the Barnet Local Medical Committee (LMC) to ensure that the Constitution is a fit for purpose document as the CCG is the process of entering into Joint Committee arrangements with the North Central London (NCL) CCGs for collaborative working at a strategic level, based on directions provided by NHS England. UNDER REVIEW

Annual General Meeting

The CCG held its Annual General Meeting (AGM) on Thursday 10 September 2015 at the Hundred Club, Allianz Park. The AGM was well attended by Members representing 51 out of the 64 practices in Barnet. The Annual Report and Accounts for 2014-2015 were approved by Members. A safeguarding training on Fabricated Illness was also delivered by Dr Danya Glaser, Honorary Consultant, Child and Adolescent Psychiatrist at University College London.

Governing Body

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

Barnet CCG's Governing Body is constituted of 15 members, nine of whom are elected GP members including the Chair. The following are appointed: Accountable Officer; Chief Financial Officer; Lay Member with Governance Remit; Lay Member with Patient and Public Engagement remit; Registered Nurse member; Secondary Care Doctor.

The Governing Body met eight times in 2015-2016 and all meetings were quorate.

Details of Membership and the attendance record are set out in Annex A.

The Governing Body delegated authority on a number of occasions to the Chair to take action on its behalf, and to relevant Committees to make decisions that were either time critical or were needed to robustly manage conflict of interests. These decisions were ratified at the next Governing Body meeting.

During 2015-2016, the Governing Body:

- Ratified the CCG's revised Constitution including the Scheme of Reservation and Delegation, approved by the Audit Committee;
- Ratified the Standing Financial Instructions, approved by the Audit Committee;
- Ratified the Pan London Collaborative Transformation plan, approved by the Clinical Cabinet;
- Ratified the following Chair's action:
  - Due process for NHS 111/GP Out of Hours Business case;
  - Formally sign up to the London Health and Care Collaboration Agreement;
  - Delegated authority to the Primary Care Procurement Committee to approve on behalf of the Governing Body, the NCL Integrated NHS 111/ OOH service contract award
- Ratified the Community Gynaecology Service approved by the Primary Care Procurement Committee;
- Ratified the Financial Control Environment Assessment, approved by the Audit Committee;
- Ratified the Conflict of Interest Policy approved by the Audit Committee;
- Ratified the Quality Strategy, approved by the Clinical Quality and Risk Committee;
- Received the minutes of its Committees;
- Approved the Financial Plan and Budget for 2015-2016;

- Approved the 2014-2015 Annual Report and Account as recommended by the Audit Committee;
- Approved the 2016-2017 Commissioning Intentions ;
- Undertook a deep dive on maternity services at the Royal Free London NHS Foundation Trust (RFL), following concerns raised by Commissioners about the level of severe perineal tears and emergency caesarean section rates in the maternity service at RFL;
- Undertook a deep dive on cancer services following a downward trajectory for Cancer 62 day waits;
- Introduced the Patient Story element to meetings, with the first patient attending the Governing Body meeting on 31 January 2016 to present their story.

Committees of the Governing Body

AUDIT COMMITTEE

The Audit Committee assists 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. Reasonable steps are taken to prevent and detect fraud and other irregularities.

The Audit Committee is chaired by Bernadette Conroy, Lay Member.

The Audit Committee met eight times in 2015-16 and all meetings were quorate.

Attendance of individual committee members is set out at Annex A.

During 2015/16 the Audit Committee:

- Approved the revised Conflict of Interests Policy;
- Approved the Local Counter Fraud Specialist Workplan for 2015-2016;
- Approved the Barnet CCG Anti-Fraud and Bribery Policy;
- Approved the Internal Audit Strategy for 2014-2015 and 2016-2017;
- Approved the Use of Interim Staff Policy;
- Approved the Annual Report and Accounts 2014-2015;
- Undertook a deep dive on the assurance framework;
- Approved and recommended to the Governing Body the revised Scheme of Reservation and Delegation and Standing Financial Instructions;
- Received regular updates on Local Counter Fraud and Internal Audit;
- Regularly reviewed the Governing Body Assurance Framework and Corporate Risk Register;
- Approved the governance process for the approval of the contract award for the Integrated NCL NHS 111 and GP OOH.

CLINICAL CABINET

The Clinical Cabinet assists the CCG's Governing Body to deliver its responsibilities for the conduct of public business. The Clinical Cabinet operates as an Executive Committee of Barnet CCG's Governing Body and therefore holds delegated responsibility from the Governing Body for the strategic and operational management of the CCG except where the Governing Body reserves certain powers to itself.

The Clinical Cabinet considers and gives guidance to the CCG's Executive and Clinical Leads on the development of strategies, policies, plans, and proposals relating 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.

The Clinical Cabinet is chaired by Dr Debbie Frost, Barnet CCG Chair and met 14 times in 2015-2016.

The meeting held on 20 August 2015 was inquorate and no decisions were taken at this meeting.

Attendance of individual committee members is set out at Annex A.

During 2015/16, the Clinical Cabinet:

- Reviewed, provided clinical input and where appropriate approved a number of service specifications including:
  - Community Gynaecology
  - NHS 111/OOH
  - Community Cardiology
  - Wheelchair service
- Discussed:
  - The results of the CCG's 360 stakeholder survey and action plan
  - Work on District Nursing
  - The outcome of the Care Home Pilot
- Approved:
  - The development of a primary care local commissioned service for Atrial Fibrillation
  - Options for the Finchley Memorial Hospital Transformation Project
  - Presentation of Patient Stories at Governing Body
  - Information Sharing Agreement between Barnet GP Practices and Local Named Providers
  - Overarching Children and Adult Mental Health Service Transformation Plan
  - Proposals that will form the Barnet CCG local offer for Personal Health Budgets
  - Held a workshop on the North Central London Strategic Planning

REMUNERATION COMMITTEE

The Remuneration Committee determines and approves 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.

The Remuneration Committee is chaired by Valerie Harrison, Lay Member for Public and Patient Engagement and met four times in 2015/16, with one of the meetings held virtually.

Attendance of individual committee members is set out at Annex A.

Decisions taken by the Committee in 2015/16 concerned the remuneration of the Accountable Officer.

FINANCE, PERFORMANCE AND QIPP COMMITTEE

The Finance, Performance and QIPP (Quality, Innovation, Productivity and Prevention) Committee has responsibility for financial monitoring and has oversight of the development and implementation of strategic plans including associated financial plans and oversee the delivery of QIPP, finance and performance targets and provide assurance to the Governing Body on the CCG's performance against these targets. Highlights of reports that the Committee has received reports on:

- The delivery of the financial plans and the QIPP Programme;
- The contracting process;
- Performance against strategic programmes integrated care, primary care, urgent care, and planned care;
- Local Commissioned Services.

The Finance, Performance and QIPP Committee is chaired by Dr Debbie Frost, Barnet CCG Chair and met twelve times in 2015/16.

Attendance of individual committee members is set out at Annex A.

CLINICAL QUALITY AND RISK COMMITTEE

The Clinical Quality and Risk 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. One 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.

The Clinical Quality and Risk Committee is chaired by Dr John Bentley and met four times in 2015/16.

The meeting on 23 April 2015 was inquorate.

Attendance of individual committee members is set out at Annex A.

Some of the Committee's work during 2015-2016 included:

- Discussing the Integrated Board and Performance Report at every meeting;
- Reviewing Quality Alerts;
- Discussing annual reviews and reports from Providers;
- Reviewing risks relating to clinical quality;
- Approval of the policies relating to Information Governance and recommended them to the Governing Body for ratification;
- Approval of the Adults' and Children's Safeguarding Policy; Barnet, Enfield and Haringey Mental Capacity Act Policy and Barnet CCG Prevent Policy;
- Approval of the Quality Strategy and recommended it to the Governing Body for ratification;
- Receiving regular assurance on the RFL top ten risks;
- Discussing and reviewing work on District Nursing;
- Supported the campaign to sign up for safety;
- Received minutes of Sub-Groups.

PRIMARY CARE PROCUREMENT COMMITTEE

The Primary Care Procurement Committee (PCPC) 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.

The PCPC provides a forum within the CCG governance structure for recommending the award of contracts for healthcare services that may be provided by general practice to the Governing Body and to ensure all decisions are defensible to challenge or scrutiny and ensure that procurement of such services contribute to the delivery of the CCG's strategic objectives, supporting the Commissioning Intentions.

The PCPC is chaired by Bernadette Conroy, Lay Member, and met nine times during 2015-2016.

All meetings held in 2015-16 were quorate.

Attendance of individual committee members is set out at Annex A.

Some highlights of the Committee's work during 2015-2016 includes:

- The NCL Collaborative Commissioning and Procurement Agreement prior to enable the procurement process to proceed and approved the appointment of Enfield CCG as the Coordinating Commissioner on behalf of Barnet CCG and the other NCL CCGs;
- Approval of the Community Gynaecology Service, and awarding the Community Gynaecology Service contract to the specified provider
- Approval of the Procurement of the End-to-End Pathway through local negotiation and Contract Variations;
- Approval of the recommendation to award the Integrated NCL NHS 111 and GP OOH contract to the specified provider;
- Approval of the Medicines Management Prescribing Incentive Scheme;
- Approval of Contract Extension for Audiology Services;
- Approval of the establishment of the Primary Care Working Group;
- Approval of the Referral Management Service Business Case;

- Approval of the Community ENT, Wax Removal and Audiology Procurement.

PATIENT AND PUBLIC ENGAGEMENT COMMITTEE

The Patient and Public Engagement Committee met three times this year. Up until June 2015, it was Chaired by David Riddle. Following David's resignation from the CCG, it was chaired by his successor, Valerie Harrison.

The Terms of Reference provide for the Committee to meet four times per year. Unfortunately, due to the changeover of Chairs, it was not possible to hold the meeting planned for the summer quarter, and the spring meeting was not quorate as there was no Governing Body member in attendance. The minutes of the previous meeting could not be approved, and no decisions were taken.

Members were advised that they could comment and make recommendations pertaining to each agenda item, and any decisions would be deferred to the Committee Chair for approval or for taking forward to the next meeting. So there has been significant turnover in the Committee's membership during the year.

To explore ways in which the Committee could work more effectively together in future therefore, a workshop was held to review and revise the Committee's Terms of Reference and focus on the CCG's strategic priorities.

There were two interactive sessions to discuss the CCG's statutory patient and public participation duty. These focused on CCG obligations around equalities, how engagement aligns with the CCG's strategic priorities and the role the Committee can play in in delivering effective and meaningful engagement.

A small sub-group of the Committee also met several times to identify and discuss the priorities for 2016-2017 engagement activity. The CCG, in collaboration with the local authority and Healthwatch, has identified a number of key areas for prioritisation and made some recommendations for taking engagement forward.

2.3.6 The Clinical Commissioning Group Risk Management Framework

By working closely together, the Directors and I lead the risk management process, to ensure an integrated and holistic approach to the CCG's risk management activities.

The CCG first established a corporate risk register and board assurance framework in April 2013. The principles were established then that risks should go through a regular review cycle of:

- Risk leads and Integrated Governance Managers review and update risks
- Risk owners (the Chief Officer and Directors of the CCG) review risks
- The risk register is considered by the Executive Management Team monthly
- Relevant risks are considered by these three committees:
  - Clinical Quality and Risk Committee;
  - Finance, Performance and QIPP; and
  - Audit Committee.
- The full risk register, with amendments, is approved by the Governing Body at its bi-monthly meetings.

The risk strategy applies to all members of the CCG, the CCG Governing Body, CCG Executive team and all managers, to ensure that risk management is a fundamental part of the CCG approach to governing the organisation and all its activities.

The strategy also enables the organisation to have a clear view of the risks affecting each area of its activity, how those risks are being managed, the likelihood of occurrence, and their potential impact on the successful achievement of the CCG's objectives.

All risks are linked to the CCG's key priorities and the mitigation and assurance of risks is scrutinised as part of the CCG's internal audit work plan. The CCG through the use of its committee paper front cover sheets requires all risks relating to the content in the reports to be highlighted, including an equality impact assessment and also whether there is any patient and public involvement.

In addition to this, there are a number of further mechanisms by which risks are identified. These are explained below.

- Risk leads work collaboratively with stakeholders to identify and implement mitigating controls.
- Examples include joint working with the Local Authority on managing risks around Commissioning Healthcare, or working with our Patient and Public Participation groups to manage risks around the proper handling of, and learning from, patient complaints.
- In addition our committees and Governing Body have representation on them from key stakeholders. There is at least one patient representative on each of our committees, and our Governing Body has observers from Public Health, HealthWatch Islington and the Local Authority.
- All incidents, complaints and claims are reported and managed in line with the respective policies. Any risks identified as part of these processes are managed in line with relevant policies.
- Risks identified through the development and implementation of policies are assessed and managed through the risk management process.
- A number of external assessments and audits are undertaken each year. All risks identified in relation to the requirements of an external assessment are assessed and managed through the risk management process.
- There is a process in place for managing the dissemination and implementation of relevant NICE guidance, national guidance, and safety alerts. All risks identified in relation to implementation of guidance are assessed and managed through the risk management process.
- Internal Audit provides an independent and objective opinion on the effectiveness of risk management and governance within the organisation. All risks identified through this process are assessed and managed through the risk management system.
- It is common for risks to be rated one a scale of one to five for likelihood and impact, with five being the highest. Risks rated 1-6 inclusive are green; 8-12 inclusive are amber; and those rated 15 or higher are red.
- The assessment of likelihood uses a scale from highly unlikely to almost certain. Anything that is *certain* to occur is not a risk, and should not be managed using the risk register.
- The assessment of risk impact is described in terms of clinical impact, financial impact, or reputational impact. The Governing body consider the guidance on risk impact in their assessment, noting that a clinical impact of three is defined as the minimum threshold for a risk that relates to an SI and as such a rating of five cannot be applied to anything that is not considered an SI.

For 2015, the Barnet CCG Risk Management Strategy 2015 identified the roles and responsibilities of directors, managers and staff in relation to the management of identified risk and was approved by the Governing Body in December 2014.

The 2015 is now under review, awaiting an update. This will incorporate the outcomes of an internal audit undertaken in [DATE TBC], when it was recommended that the CCG should develop a risk appetite grading that set the level of risk the CCG was prepared to accept in terms of quality, safety, compliance, finance, reputation and innovation, so risks can be rated within an acceptable threshold. A workshop was planned for April 2016 to address this when the new Accountable Officer took up their post.

Barnet CCG's Risk Management Strategy 2015 provides a standard scoring matrix for risk owners to score the level of each risk. Risks are reviewed and updated on a regular cycle by risk owners prior to Committee and Governing Body meetings. Responsible managers use various data streams to regularly assess the levels of risk they are managing and update the risk register to ensure that an accurate position is presented.

The CCG operates 4risk, an internal web-based risk register system. All risks have an identified Executive Director as risk owner, and a responsible manager to ensure appropriate accountability for the management of the risk. The risk register system holds risks that are highlighted across the CCG.

The Governing Body Assurance Framework (GBAF) and Corporate Risk Register (CRR) are standing agenda items on the Governing Body and sub committees of the Governing Body. This allows the Governing Body members to assess identified risks with any other significant developments to ensure that problems are appropriately recorded on the CRR.

During 2015-2016 the risk management process was developed throughout the CCG. The Governance and Risk Manager provided risk management training and support for CCG staff, with risk an agenda item for all team meetings.

The three levels of risk reporting in the organisation as described in the 2015 Risk Management Strategy are summarised here.

Governing Body Assurance Framework (GBAF)

The Governing Body owns and determines the content of the GBAF. The Governing Body identifies potential strategic risks to delivery of its objectives and these are monitored throughout the year. The GBAF provides a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives. It maps out the key controls to mitigate the risks and provides a mechanism to inform the Governing Body of the assurances received about the effectiveness of these controls.

The GBAF provides an effective focus on strategic and reputational risk rather than operational issues, and highlights any gaps in controls and assurances. It provides the CCG Governing Body with confidence that the systems and processes in place are operating in a way that is safe and effective. It is regularly reviewed by each Risk Owner to ensure the controls and assurances remain valid and any identified gaps are mitigated by timely implementation of clearly defined actions.

Corporate Risk Register (CRR)

The CCG Executive Directors own the risks on the CRR. The corporate risks are the highest scoring operational risks. Each corporate risk has an Accountable Director and Senior Manager aligned to it. The risk may be applicable across the CCG and the score will then be considered by an Executive Director for acceptance onto the CRR. Any operational risk with a current score of 15 (red) or above is classified as a corporate risk and will be escalated to Executive Directors, Executive Management Team, and sub committees of the Governing Body.

The Executive Management team play a major role in overseeing the active risks that are recorded on the CCG's risk management system and regularly review risks to understand the nature of those that have been highlighted by staff at all levels/scores.

Departmental Risk Registers

The departmental risk registers contain all the identified risks identified within the service monitored and reviewed at the departmental team meetings at least twice yearly. Risks identified as scoring 8 and above are escalated to the CRR.

CCG Risk Management Committee Responsibilities

THE AUDIT COMMITTEE

The Audit Committee, in line with the NHS Audit Committee Handbook, ensures Barnet CCG has an effective process in place with regard to risk management. The Audit Committee is "the Assurance Committee" and monitors the quality of the GBAF and the CRR and refers significant issues to the Governing Body.

The Committee is the central means by which the Governing Body ensures that effective internal control arrangements are in place and receives and considers the latest iteration of the Assurance Framework and Risk Register at every meeting, along with updates on significant developments.

The Audit Committee also oversees the development and maintenance of systems of internal control that enables BCCG Governing Body to achieve the requirements of the CCG's Annual Governance Statement.

FINANCE PERFORMANCE AND QIPP COMMITTEE (FPQ)

FPQ ensures that all financial risks are monitored through a robust directorate risk register and reported regularly to the Audit Committee. The committee on a monthly basis assesses financial and non-financial risks relating to the QIPP plans and ensures the CCG has in place measures and mitigation to manage risk.

CLINICAL QUALITY AND RISK COMMITTEE (CQRC)

CQRC is the overarching responsibility for clinical risk management, information governance and health and safety risks. This Committee ensures that there is a sound system of risk management and quality assurance in place across the CCG.

CQRC ensures that the Governing Body receives a report that provides assurance that quality and safety risks, including any incidents, are being managed robustly and that lessons are being learned and shared across the organisation.

2.3.7 The Clinical Commissioning Group Internal Control Framework

The Internal Control Framework is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk. It can therefore only provide reasonable and not absolute assurance of effectiveness.

2.3.8 Information Governance

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

Barnet CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG takes its Information Governance responsibilities seriously, part of which involves data security.

The CCG has reviewed and renewed all its Information Governance policies this year and has provided the associated staff awareness and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities. Information Governance training is mandatory for all staff. Compliance remains above the required target level.

The CCG undertook an assessment of its Information Governance arrangements through completion of the Information Governance Toolkit. This included a review of key factors via our internal auditors. The CCG is currently a level 2. The CCG is working towards becoming an Accredited Safe Haven (ASH). This means the CCG will provide a safe environment for the processing of information containing NHS numbers.

The CCG has a board-level officer responsible for information security and the associated management processes, and this role is known as the Senior Information Risk Owner.

The CCG has a board-level clinician responsible for ensuring that all flows of patient information are justified and secure, and this role is known as the Caldicott Guardian.

The CQRC is the subcommittee of the Governing Body and ensures that there is a sound system of information governance processes and monitors compliance with the IG toolkit.

The CCG buys expert Information Governance practitioner and advisory service from the North East London Commissioning Support Unit. Any breaches of security are managed within the CCG incident reporting policy.

During 2015-2016 there were six incidents involving data loss or confidentiality breaches reported.

Lessons learnt from an Information Governance incident during 2015

As an example of how Barnet CCG acts on any breaches to its Information Governance procedures, here are the measures which were taken when GP practices were sent patient identifiable information into the CCG Primary Care team without using nhs.uk email addresses, as is required NHS practice.

- If verification is needed at the level of individual patients, this should be by a specific audit taking place at the practice. Alternatively, if the data is required, it should only be received via an nhs.net email, and stored in a password protected folder.
- For any current schemes affected: Issue revised claim forms which do not require personal information.
- For any future schemes: Remove requests for personal information from any financial claim forms.
- A message was included in the Chair's Bulletin asking GP practices not to send patient identifiable information as part of claims, and pointing to a revised claim form.
- A lesson learned item was presented at the next All Staff meeting, to help to change practice across the organisation.
- Have an item at the next Practice Managers' Meeting, to highlight the issue, explain we are changing our practice, and encourage practices to challenge any such requests in the future, and insist upon the use of nhs.net accounts where the data transfer is justified.

2.3.9 Risk Assessment in Relation to Governance, Risk Management and Internal Control

[COPY BEING SUPPLIED]

2.3.10 Review of Economy, Efficiency and Effectiveness and the Use of Resources

The Governing Body has over-arching responsibility for ensuring the CCG carries out its activities effectively, efficiently and economically. To ensure this:

- The GB receives a report from the Chief Financial Officer at each of its meetings;
- The Audit Committee receives regular reports on financial governance, monitors the internal audit programme and reviews the draft and final annual accounts;
- The CCG has a programme of internal audits that provides assurance to the Board and Executive Team of the effectiveness of its internal processes.
- The CCG's annual accounts are reviewed by the Audit Committee and audited by our external auditors.

Following completion of the planned audit work, our external auditors issued an independent and objective opinion on the CCG's arrangements for securing economy, efficiency & effectiveness in the use of resources.

The auditors concluded that the CCG has adequate arrangements for securing economy, efficiency and effectiveness in the use of resources.

2.3.11 Feedback from Delegation Chains Regarding Business, Use of Resources and Responses to Risk

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2.3.12 Review of the Effectiveness of Governance, Risk Management and Internal Control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

Capacity to Handle Risk

The CCG received reasonable assurance from the 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 systems of internal controls are strengthened.

The 2015 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 Governing Body Assurance Framework (GBAF) through either a lead director exercising their executive discretion, or 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 GBAF and the Corporate Risk Register (CRR). The 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 Director of Quality and Governance is the lead director for risk management and retains overall responsibility for ensuring that the GBAF and CRR are updated on a regular basis. This 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 GBAF and CRR 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 of 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.

The CCG uses risk management software to 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.

Review of Effectiveness

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

As Accountable Officer, I have drawn for my review on performance information available and on comments made by the external auditors in their management letter and other reports. The GBAF 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 CCG, 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.

Head of Internal Audit Opinion – [TO FOLLOW]

DATA QUALITY

The CCG is a level 2 level compliance with the information governance toolkit assessment. There have been no Serious Incidents relating to data security breaches, including any that were reported to the Information Commissioner

2.3.12 Business Critical Models

CCG business-critical models primarily rely on activity and finance data produced by the North East London Commissioning Support Unit (NELCSU) which is assured through their own processes. The CCG reviews NELCSU 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.

2.3.13 Discharge of Statutory Functions

During establishment, the arrangements put in place by Barnet CCG 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.

2.3.14 Conclusion

There have been no significant internal control issues identified during the course of 2015-2016.

Signed:

Cathy Gritzner, Accountable Officer
Barnet Clinical Commissioning Group

2.4.1 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 31 March 2016.

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 every financial quarter and make recommendations to the Governing Body based on financial and Human Resources independent reviews.

2.4.2 Remuneration Policy for Directors and 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 directors (Chief Officer and Chief Finance Officer) on an annual basis in accordance with the CCG's constitution.

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 directors 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 directors who do not sit on the Governing Body are governed by the national Agenda for Change regulations."

Senior Managers Performance Related Pay

We operate a system of performance-related pay for those senior management posts subject to the Very Senior Managers (VSM) pay framework. There has been no payment of performance related pay during the year ending 31 March 2016.

Future performance related pay for directors 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.

2.4.5 Staff-Sharing Arrangements

To be added with the accounts

2.4.6 Accounting Officer's Statement on Attendees at Governing Body Meetings

To be added with the accounts

2.4.7 Exit packages and Off-Payroll Engagements Disclosures

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.

Off-Payroll Engagements Disclosures

Off-payroll existing engagements as of 31 March 2016, for more than £220 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2016	8
Of which, the number that have existed:	
• for less than one year at the time of reporting	4
• 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	

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

For all new off-payroll engagements between 1 April 2015 and 31 March 2016, 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 2015 and 31 March 2016	11
Number of new engagements which include contractual clauses giving NHS Barnet CCG the right to request assurance in relation to income tax and National Insurance obligations	
Number for whom assurance has been requested	9
Of which:	
• assurance has been received	6
• assurance has not been received	3
• engagements terminated as a result of assurance not being received	

[In any cases where, exceptionally, the reporting entity has engaged without including contractual clauses allowing it to seek assurance as to their tax obligations – or where assurance has been requested and not received, without a contract termination – the body should set out the reasons for this.

Instances where reporting entities are still waiting for information from the individual at the time of reporting should be reported as not received.]

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	5
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

2.4.9 Remuneration of Senior Managers for 2015/16 and 2013/14

Salaries and allowances of Senior Managers 2015/16

	NAME	TITLE	2015-16 Salary (bands of £5,000) £000	Taxable Benefits (rounded to the nearest £000	Annual Performance Related Bonuses (Bands of £5000) £000	Long -term Performance Related Bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2,500) £000	Total (Bands of £5000) £00	Dates served Commenced	Ceased
	VOTING MEMBERS									
	Executive Directors									
	Mr Rob Larkman	Interim Accountable Officer	0	0	0	0	0	0	01/08/2014	
(1)	Ms Regina Shakespeare	Interim Chief Operating Officer and Director of Clinical Commissioning	255-260	0	0	0	0	255-260	24/11/2014	27/11/2015
(2)	Mr Hugh Mc Garel-Groves	Chief Finance Officer	155-160	0	0	0	7.5-10	165-170	12/08/2013	31/12/2015
	Mr Roger Hammond	Acting Chief Finance Officer	25-30	0	0	0	5-7.5	30-35	01/12/2015	
	Lay Members									
	Mr David Riddle	Vice Chair Lay Member Engagement	5-10	0	0	0	0	5-10	01/04/2013	31/07/2015
	Ms Bernadette Conroy	Lay Member for Audit	25-30	0	0	0	0	25-30	01/04/2013	
	GP/ Clinical Members									
	Dr Jonathan Lubin	CCG GP Member	25-30	0	0	0	0	25-30	01/10/2014	
(3)	Dr Karl Marlowe	Board Secondary Care Doctor	15-20	0	0	0	0	15-20	01/04/2013	
	Mrs Helen Donovan	CCG Registered Board Nurse	10-15	0	0	0	0	10-15	01/04/2013	
	Dr Ahmer Farooqi	CCG GP Member	55-60	0	0	0	0	55-60	01/04/2013	
	Dr Deborah Frost	Chair	120-125	0	0	0	0	120-125	01/04/2013	
	Dr Clare Stephens	CCG GP Member	35-40	0	0	0	0	35-40	01/04/2013	
	Dr Barry Subel	CCG GP Member	75-80	0	0	0	0	75-80	01/07/2013	
	Dr Charlotte Benjamin	CCG GP Member	35-40	0	0	0	0	35-40	01/04/2013	
	Dr John Bentley	CCG GP Member	30-35	0	0	0	0	30-35	01/04/2013	
	Dr Swati Dholakia	CCG GP Member	35-40	0	0	0	0	35-40	01/05/2014	
	Dr Michelle Kurer	CCG GP Member	35-40	0	0	0	0	35-40	01/05/2014	
	NON VOTING MEMBERS									
	Miss Vivienne Stimpson	Director of Quality & Governance	80-85	0	0	0	5-7.5	90-95	01/04/2013	
	Ms Maria O'Dwyer	Director of Integrated Commissioning	80-85	0	0	0	7.5-10	90-95	01/04/2013	
(1)*	Mr Matthew Powls	Director of Planning and Performance / Interim Joint Chief Operating Oficer	300-305	0	0	0	0	300-305	01/04/2015	
(4)	Ms Sarah Thompson	Director of Clinical Commissioning	89-90	0	0	0	0	89-90	01/04/2015	28/08/2015
(1)*	Ms Elizabeth James	Director of Clinical Commissioning / Interim Joint Chief Operating Officer	200-205	0	0	0	0	200-205	01/09/2015	
(1)	Mr William Redlin	Director of Delivery and Operations	70-75	0	0	0	0	70-75	14/12/2015	

(1) Paid to an agency not to the individual.
(2) Includes £60k contractual payment in respect to Lieu of Notice period.
(3) Secondment from other NHS organisation.
(4) Paid to a Consultancy company

(*) Interim Joint Chief Operating Officer positions commenced 30th November 2015.

Salaries and allowances of Senior Managers 2014/15

	NAME	TITLE	2014-15 Salary (bands of £5,000) £000	Taxable Benefits (rounded to the nearest £000) £000	Annual Performance Related Bonuses (Bands of £5000) £000	Long-term Performance Related Bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2,500) £000	Total (Bands of £5000) £00	Dates served Commenced	Ceased
	VOTING MEMBERS									
	Executive Directors									
	Mr John Morton	Chief Officer	45 - 50	0	0	0	5 - 7.5	50 - 55	01/04/2013	31/07/2014
	Mr Rob Larkman	Interim Accountable Officer	0 - 5	0	0	0	0	0 - 5	01/08/2014	
(4)	Mr Peter Coles	Interim Chief Operating Officer	85 - 90	0	0	0	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	0	0	0	145 - 150	24/11/2014	
	Mr Hugh Mc Garel-Grov	Chief Finance Officer	120 - 125	0	0	0	20 - 22.5	140 - 145	12/08/2013	
	Lay Members									
	Mr David Riddle	Vice Chair Lay Member Engagement	20 - 25	0	0	0	0	20 - 25	01/04/2013	
	Ms Bernadette Conroy	Lay Member for Audit	20 - 25	0	0	0	0	20 - 25	01/04/2013	
	GP/ Clinical Members									
(2)	Dr Jonathan Lubin	CCG GP Member	10 - 15	0	0	0	0	10 - 15	01/04/2013	30/09/2014
	Dr Jonathan Lubin	CCG GP Member	10 - 15	0	0	0		10 - 15	01/10/2014	
(3)	Dr Karl Marlowe	Board Secondary Care Doctor	15 - 20	0	0	0	0	15 - 20	01/04/2013	
	Mrs Helen Donovan	CCG Registered Board Nurse	10 - 15	0	0	0	(22.5) - (20.0)	(10) - (5)	01/04/2013	
	Dr Ahmer Farooqi	CCG GP Member	30 - 35	0	0	0	0	30 - 35	01/04/2013	
	Dr Deborah Frost	Chair	80 - 85	0	0	0	0	80 - 85	01/04/2013	
	Dr Clare Stephens	CCG GP Member	25 - 30	0	0	0	0	25 -30	01/04/2013	
	Dr Barry Subel	CCG GP Member	35 - 40	0	0	0	0	35-40	01/07/2013	
	Dr Lyndon Wagman	CCG GP Member	0 - 5	0	0	0	0	0 - 5	01/04/2013	30/04/2014
	Dr Charlotte Benjamin	CCG GP Member	25 - 30	0	0	0	0	25 - 30	01/04/2013	
	Dr John Bentley	CCG GP Member	20 - 25	0	0	0	0	20 - 25	01/04/2013	
	Dr Swati Dholakia	CCG GP Member	25 - 30	0	0	0	0	25 - 30	01/05/2014	
	Dr Michelle Kurer	CCG GP Member	25 - 30	0	0	0	0	25 - 30	01/05/2014	
	NON VOTING MEMBERS									
	Miss Vivienne Stimpson	Director of Quality & Governance	80 - 85	0	0	0	37.5 - 40	120 - 125	01/04/2013	
	Ms Maria O'Dwyer	Director of Integrated	80 - 85	0	0	0	40 - 42.5	120 - 125	01/04/2013	
	Mr Andrew Harrington	Director of Clinical Commissioning	75 - 80	0	0	0	0	75 - 80	09/12/2013	31/12/2014
(1)	Ms Dianne Prescott	Director of Planning and	115 - 120	0	0	0	0	115 - 120	20/05/2014	26/09/2014
(4)	Ms Alison Alsbury	Director of Planning and	40 - 45	0	0	0	0	40 - 45	20/01/2014	27/05/2014
(1)	Mr Matthew Powls	Director of Planning and	140 - 145	0	0	0	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.

2.4.10 Pensions

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

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, and the prior year comparators, are as follows:

2.4.11 Member Contribution Rates before tax relief (gross)

Full-time pensionable pay/earnings used to determine contribution rate	2015/16
Up to £15,431.99	5.0%
£15,432.00 to £21,387.99	5.6%
£21,388.00 to £26,823.99	7.1%
£26,824.00 to £49,472.99	9.3%
£49,473.00 to £70,630.99	12.5%
£70,631.00 to £111,376.99	13.5%
£111,377.00 and over	14.5%

Full-time pensionable pay/earnings used to determine contribution rate	2016/17
Up to £15,431.99	5.0%
£15,432.00 to £21,477.99	5.6%
£21,478.00 to £26,823.99	7.1%
£26,824.00 to £47,845.99	9.3%
£47,846.00 to £70,630.99	12.5%
£70,631.00 to £111,376.99	13.5%
£111,377.00 and over	14.5%

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.

2.4.12 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.

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

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

2.4.13 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.

2.4.14 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.

2.4.15 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/Member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid Director/Member in Barnet CCG in the financial year 2015-16 was £195 - £200k (2014-15, £140-£145k). This was 4.99 times (2014-15, 2.9) the median remuneration of the workforce, which was £39k (2014-15, £48k).

In 2015-16, no (2014-15, 2) employees received remuneration in excess of the highest-paid Director/member.

Remuneration ranged from £1k to £196k (2014-15 £12k- £140k) Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. .

The 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.

2.4.16 Salary and pension entitlements of Directors and Senior Managers

The following schedules disclose further information regarding remuneration and pension entitlements:

Name	Title	Real increase /decrease in pension at retirement age (bands of 2500)	Real increase /decrease in related lump sum at retirement age (bands of £2500)	Total accrued pension at retirement age at 31 March 2016 (bands of £5000)	Total accrued related lump sum at retirement age at 31 March 2016 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31 March 2016	Cash Equivalent Transfer Value (CETV) at 31 March 2015	Real increase / decrease in Cash Equivalent Transfer Value	Employers Contribution to Partnership Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Board Members									
Mr Hugh Mc Garel-Groves	Chief Finance Officer	0 - 2.5	0	0 - 5	0	55	16	77	14
Mr Roger Hammond	Acting Chief Finance Officer	0 - 2.5	0 - 2.5	20 - 25	65 - 70	429	396	7	13
Non Voting									
Miss Vivienne Stimpson	Director of Quality & Governance	0 - 2.5	0 - 2.5	15 - 20	55 - 60	395	371	20	12
Ms Maria O'Dwyer	Director of Integrated Commissioning	0 - 2.5	2.5 - 5	15 - 20	50 - 55	359	333	21	12
Mrs Helen Donovan	CCG Registered Board Nurse	(2.5) - 0	(2.5) - 0	35 - 40	105 - 110	634	631	-4	2

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

The Pensions Related Benefits (PRB) figure is calculated using the method set out in the Finance Act 2004(1), and includes using the member's current and prior year pension and lump sum figures. Where there has been only a small increase in pension and lump sum benefits current year compared to last year, this formula can sometimes generate a negative figure. Where this is the case, Department of Health guidance states that a "zero" should be substituted for any negative figures.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

2.4.15 Compensation on Early Retirement or Loss of Office

No significant awards or payments have been made during the financial year 2015/16

2.4.16 Payments to Past Directors

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

2.4.17 Pay Multiples

See: **The Relationship between the Highest Paid Director and Median Remuneration on page 51**

2.5.1 STAFF REPORT

2.5.2 Number of Senior Staff by Band

Very Senior Manager (VSM) information
As at the 31 March 2016, there are no Senior Manager at the CCG who are on a Very Senior Manager (VSM) grade.

Senior Manager Information
At the 31 March 2016, there are three Senior Managers at the CCG who are on band 9.

2.5.3 Staff Numbers

At 31 March 2016 there are 63 employees at Barnet CCG consisting of 53 female and 10 male staff members. These figures exclude the VSM, Senior Managers and agency/contractor workers.

2.5.4 Staff Composition

Pay Group	Female	Male	Grand Total
Band 3	0	0	0
Band 4	4	1	5
Band 5	6	0	6
Band 6	6	0	6
Band 7	12	1	13
Band 8a	18	5	23
Band 8b	3	0	3
Band 8c	4	3	7
Band 8d	0	0	0
Grand Total	53	10	63

Gender breakdown of all Senior Managers including managers at Very Senior Manager grade

There is one male and two female Senior Managers (Directors)/Very Senior Managers at 31 March 2016.

Gender breakdown of Governing Body Members at 31 March 2016

GB Member Category	Male	Female
Elected	4	5
Appointed	2	3
Executive Members	4	2
Non-Voting	5	5
Total	15	15

2.5.6 Sickness Absence Data

The average sickness absence rate for 2015-2016 (01 April 2015 – 29 February 2016) was 2.76%.

2.5.7 Staff Policies Applied During the Financial Year

The CCG has published its Workforce Race Equality Standard Report (WRES) in July 2015 and the annual public sector equality duty (PSED) report in January 2016. Both of these have detailed information about workforce including recruitment, starters and leavers and training by protected characteristics. They also include equality information about the CCG's Governing Body Members.

2.5.8 Expenditure on Consultancy

To be added later from the accounts section

2.5.9 Off-Payroll Engagements

To be added later from the accounts section

2.5.10 Exit Packages

To be added later from the accounts section

Annex A: Members' Attendance at Governing Body and Committee meetings

1 Governing Body Register and 2015-16 Meeting Attendance

Governing Body Register and 2015-16 Meeting Attendance										
Elected Members - Clinical Leaders (voting rights)	**Name**	30-Apr-15	28-May-15	25-Jun-15	27-Aug-15	24-Sep-15	26-Nov-15	28-Jan-16	31-Mar-16	Cumalative Attendance
Chair - Governing Body	Dr. Debbie Frost (GP)	√	√	√		√	√	√	√	7/8
Elected Body Member	Dr. Michelle Newman (GP)	√	√	√		√	√	√	√	7/8
Elected Body Member	Dr. Charlotte Benjamin (GP)	√	√	√			√	√	√	6/8
Elected Body Member	Dr. Barry Subel (GP)	√	√	√	√	√	√		√	7/8
Elected Body Member	Dr. Clare Stephens (GP)	√	√	√		√	√	√	√	7/8
Elected Body Member	Dr. Jonathan Lubin (GP)	√	√	√	√	√	√	√	√	8/8
Elected Body Member	Dr. Ahmer Farooqi (GP)	√	√	√	√	√	√	√	√	8/8
Elected Body Member	Dr. Swati Dholakia (GP)	√	√	√	√	√	√	√		7/8
Elected Body Member	Dr. John Bentley (GP)	√	√	√		√	√	√		6/8
Appointed Members (voting rights)	**Name**	30-Apr-15	28-May-15	25-Jun-15	27-Aug-15	24-Sep-15	26-Nov-15	28-Jan-16	31-Mar-16	
Lay member - Governance	Bernadette Conroy	√	√	√	√	√		√	√	7/8
Lay member - Engagement & Patient Participation	David Riddle	√		√						2/3
Lay member - Engagement & Patient Participation	Valerie Harrison			√	√	√	√	√	√	6/6
Registered Nurse	Helen Donovan	√		√	√	√	√	√	√	7/8
Secondary Care Doctor	Dr. Karl Marlowe				√	√	√	√	√	5/5
Executive Members (voting rights)	**Name**	30-Apr-15	28-May-15	25-Jun-15	27-Aug-15	24-Sep-15	26-Nov-15	28-Jan-16	31-Mar-16	
Accountable Officer	Rob Larkman	√				√	√			3/8
Chief Operating Officer	Regina Shakespeare (interim)	√	√	√	√	√	√			6/6
Joint COO (Acting with Elizabeth James)	Matthew Powls (interim)							√		1/2
Joint COO (Acting with Matthew Powls)	Elizabeth James (interim)							√	√	2/2
Chief Finance Officer	Roger Hammond (acting)							√	√	2/2
Chief Finance Officer	Hugh McGarel-Groves	√	√	√	√	√				5/5
Other Board Members (non-voting)	**Name**	30-Apr-15	28-May-15	25-Jun-15	27-Aug-15	24-Sep-15	26-Nov-15	28-Jan-16	31-Mar-16	
Director of Quality and Governance	Vivienne Stimpson	√		√		√		√	√	5/8
Director of Integrated Commissioning	Maria O'Dwyer	√		√			√			3/6
Director of Operations and Delivery	Bill Redlin (interim)							√		1/1
Director of Performance & Planning	Matthew Powls (interim)	√		√		√				3/6
Director of Clinical Commissioning	Liz James (interim)					√	√			2/2
Director Of Clinical Commissioning	Sarah Thompson (interim)	√	√	√	√					4/4
QUORACY		YES	YES	YES	YES	YES	YES	YES	YES	
									Apologies	
									Not in post	

2. Clinical Cabinet

Clinical Cabinet	Name	02-Apr-15	14-May-15	18-Jun-15	23-Jul-16	20-Aug-16	22-Oct-16	19-Nov-16	24-Dec-16	07-Jan-16	18-Feb-16	24-Mar-16	Cumulative Attendance
Chair	Dr Debbie Frost	√	√	√	√	√	√	√	√	√	√	√	11/11
Accountable Officer (from 1 April 2016)	Cathy Gritzner										√		1/1
Vice Chair and GB Member	David Riddle	√	√	√									3/3
Clinical Lead	Dr Charlotte Benjamin	√		√	√			√	√	√	√		7/11
Clinical Lead	Dr John Bentley	√	√	√	√		√	√	√		√		8/11
Clinical Lead	Dr Barry Subel	√	√	√	√		√	√		√	√	√	9/11
Clinical Lead	Dr Swati Dholakia	√	√	√	√	√	√	√	√	√	√		10/11
Clinical Lead	Dr Jonathan Lubin	√	√	√	√	√	√	√	√	√	√		10/11
Clinical Lead	Dr Michelle Newman	√	√		√		√	√	√	√		√	8/11
Clinical Lead	Dr Ahmer Farooqi		√	√	√		√	√	√	√		√	8/11
Clinical Lead	Dr Clare Stephens				√				√		√		3/11
Secondary Care Doctor	Dr Karl Marlowe		√		√		√			√	√	√	6/11
Registered Nurse	Helen Donovan	√			√					√		√	4/11
Lay Member - Governance	Bernadette Conroy	√	√	√		√		√	√		√	√	8/11
Lay Member - Public & Patient Engagement	Valerie Harrison			√	√	√	√	√	√	√	√		8/9
Chief Finance Officer	Hugh McGarel-Groves		√	√	√	√	√	√					6/8
Chief Finance Officer	Roger Hammond (Acting)									√	√	√	3/4
Director of Integrated Commissiong	Maria O'Dwyer	√		√		√	√	√					5/7
Chief Operating Officer	Regina Shakespeare (Interim)		√	√	√	√	√	√					6/7
Joint Chief Operating Officer	Matt Powls (with Elizabeth James) - Interim									√	√		2/3
Joint Chief Operating Officer	Elizabeth James (with Matt Powls) - Interim									√	√	√	3/3
Director of Planning and Performance	Matt Powels (Interim)		√	√	√	√	√	√	√				7/8
Director of Quality and Governance	Vivienne Stimpson			√	√	√	√			√		√	6/11
Director of Clinical Commissioning	Sarah Thompson (Interim)		√	√	√	√							4/5
Director of Clinical Commissioning	Elizabeth James (Interim)						√	√	√				3/3
Director of Operations and Delivery	William Redlin (Interim)									√	√	√	3/3
Quoracy		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
												Apologies	
												Not in post	

3. Remuneration Committee

Remuneration Committee	Name	11-Jun-15	27-Oct-15	Cumulative attendance
Chair	David Riddle			0/1
Chair	Valerie Harrison		√	1/1
Lay Member (Governance)	Bernadette Conroy	√		1/2
Lay Member (Patient & Public Engagement)	Valerie Harrison	√		1/1
Health and Wellbeing Board Representative	John Hooton (Interim)	√	√	2/2
Barnet CCG Remuneration Committee Member	Dr Anthony Uzoka		√	1/2
Barnet CCG Remuneration Committee Member	Dr Sanjiv Alhuwalia	√		1/2
Quoracy		Yes	Yes	
			Apologies	
			Not in post	

4. Audit Committee

Audit Committee Attendance Register	Name	16-Apr-15	21-May-15	28-May-15	09-Jul-15	03-Sep-15	05-Nov-15	14-Jan-16	03-Mar-16	Cumulative Attendance
			Extra Ordinary							
Chair (Lay member - Governance)	Bernadette Conroy	√	√	√	√	√	√	√	√	8/8
Lay Member (Patient and Public Engagement)	David Riddle	√								1/3
Lay Member (Patient and Public Engagement)	Valerie Harrison					√	√	√	√	4/5
Clinical Leader	Dr Barry Subel		√	√	√					3/8
Clinical Leader (Quality, Clinical Risk and Safety)	Dr John Bentley	√	√	√	√	√	√	√	√	8/8
Clinical Leader	Dr Swati Dholakia					√		√	√	3/4
Quoracy		YES	YES	YES	YES	YES	YES		YES	
									Apologies	
									Not in post	

5. Finance, Performance and QIPP

Finance, Performance and QIPP Committee	Name	23-Apr	21-May-15	18-Jun-15	23-Jul-15	20-Aug-16	17-Sep-16	22-Oct-15	19-Nov-15	17-Dec-15	21-Jan-16	18-Feb-16	24-Mar-16	Cumulative Attendance
Chair	Dr Debbie Frost	√		√	√	√	√	√	√	√	√	√	√	11/12
Chief Operating Officer	Regina Shakespeare (Interim)	√		√	√	√	√	√	√					7/8
Chief Operating Officer	Elizabeth James (Interim)									√	√	√	√	4/4
Director of Clinical Commissioning	Elizabeth James (Interim)						√	√	√					3/3
Lay Board Member (Governance)	Bernadette Conroy	√	√	√		√	√		√	√	√	√	√	10/12
Lay Board Member (Patient and Public Engagement)	Dave Riddle	√	√	√										3/3
Lay Board Member (Patient and Public Engagement)	Valerie Harrison				√	√	√	√	√	√	√	√		8/8
Clinical Leader	Dr Jonathen Lubin	√	√	√	√	√	√	√	√	√	√			10/12
Clinical Vice Chair	Dr Barry Subel	√		√	√		√	√	√	√	√	√	√	9/12
Clinical Leader	Dr Ahmer Farooqi			√	√		√						√	4/12
Secondary Care Specialist	Dr Karl Marlowe		√		√		√	√			√	√	√	7/12
Chief Finance Officer	Hugh McGarel-Groves	√	√	√	√	√	√	√	√					8/8
Chief Finance Officer	Roger Hammond (Acting)										√	√	√	3/3
Deputy Chief Finance Officer	Roger Hammond	√		√			√	√	√	√				6/9
Director of Operations and Delivery	William Redlin (Interim)										√	√	√	3/3
Director of Performance and Planning	Matthew Powls (Interim)									√	√	√		3/4
Director of Integrated Commissioning	Maria O'Dwyer	√	√	√		√	√	√						6/8
Director of Clinical Commissioning	Sarah Thompson	√	√	√										3/3
Quoracy		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
													Apologies	
													Not in post	

6. Clinical Quality and Risk

Clinical Quality and Risk Committee	Name	23-Apr-15	23-Jul-15	12-Nov-15	04-Feb-16	Cumulative Attendance
Chair	Dr John Bentley	√	√	√	√	4/4
Governing Body Member, secondary care	Dr Karl Marlowe		√	√	√	3/4
GP Associate Member	Dr Rachel Mellins		√	√	√	3/4
GP Associate Member	Dr Raju Raithatha	√			√	2/4
Registered Nurse of Governing Body	Helen Donovan	√	√	√		3/4
Governing Body Lay Member (Patient and Public Engagement)	Valerie Harrison		√		√	2/4
Director of Quality and Governance	Vivienne Stimpson	√	√		√	3/4
Quoracy		Yes	Yes	Yes	Yes	
					Apologies	

7. Primary Care Procurement Committee

Primary Care Procurement Committee	Name	01-May-15	21-May-15	09-Jul-15	27-Aug-15	29-Oct-15	28-Jan-16	14-Mar-16	Cumulative Total
Chair (Lay member - Governance)	Bernadette Conroy	√	√	√	√	√	√	√	7/7
Accountable Officer	Rob Larkman								0/7
Chief Operating Officer	Regina Shakespeare (Interim)	√		√	√				3/4
Secondary Care Specialist	Dr Karl Marlowe		√	√	√		√	√	5/6
Registered Nurse (Governing Body)	Helen Donovan	√	√		√	√			4/7
Chief Finance Officer	Hugh McGarel-Groves	√	√	√	√	√			5/5
Chief Finance Officer	Roger Hammond						√	√	2/2
Lay Governing Body Member (Patient and Public Engagement)	David Riddle	√	√						2/2
Lay Governing Body Member (Patient and Public Engagment)	Valerie Harrison				√	√	√		3/4
Director of Clinical Commissioning	Elizabeth James (Interim)					√		√	2/3
Director of Integrated Commissioning	Maria O'Dwyer	√							1/1
Director of Operations	William Redlin (Interim)						√	√	2/2
Quoracy		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
								Apologies	
								Not in post	

NHS Barnet Clinical Commissioning Group – Annual Accounts 2015-16

Statement of Comprehensive Net Expenditure for the year ended 31-March-2016

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	3.1.1	7,636	7,258
Operating Expenses	4	439,710	435,336
Other operating revenue	2	(1,399)	(3,102)
Net operating expenditure before interest		**445,946**	**439,492**
Of which:			
Administration Income and Expenditure			
Employee benefits	3.1.1	4,670	4,235
Operating Expenses	4	3,896	4,936
Other operating revenue	2	2	(23)
Net administration costs before interest		**8,568**	**9,148**
Programme Income and Expenditure			
Employee benefits	3.1.1	2,966	3,022
Operating Expenses	4	435,814	430,400
Other operating revenue	2	(1,401)	(3,079)
Net programme expenditure before interest		**437,378**	**430,344**

The notes on pages 5 to 20 form part of this statement

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

NHS Barnet Clinical Commissioning Group – Annual Accounts 2015-16

Statement of Financial Position as at 31 March 2016

	Note	31st March 2016 £000	2014-15 £000
Current assets			
Trade and other receivables	7	4,333	5,567
Cash and cash equivalents	8	107	18
Total current assets		**4,440**	**5,585**
Total assets		**4,440**	**5,585**
Current liabilities			
Trade and other payables	9	(49,296)	(41,771)
Total current liabilities		**(49,296)**	**(41,771)**
Total Assets less Current Liabilities		**(44,856)**	**(36,186)**
Financed by Taxpayers' Equity			
General fund		(44,856)	(36,186)
Total taxpayers' equity:		**(44,856)**	**(36,186)**

The notes on pages 5 to 20 form part of this statement

The financial statements on pages 1 to 20 were approved by the Governing Body on [date] and signed on its behalf by:

Rob Larkman

Interim Accountable Officer

NHS Barnet CCG

NHS Barnet Clinical Commissioning Group – Annual Accounts 2015-16

Statement of Changes in Taxpayers Equity for the year ended 31 March 2016

		General Fund £000
Changes in taxpayers' equity for 2015-16		
Balance at 1 April 2015		(36,186)
Net operating expenditure for the financial year	SOCNE	(445,946)
Net Recognised Expenditure for the Financial Year		**(445,946)**
Net funding		437,276
Balance at 31 March 2016		**(44,856)**

	General Fund £000
Changes in taxpayers' equity for 2014-15	
Balance at 1 April 2014	(37,184)
Net operating *costs* for the financial year	**(439,493)**
Net funding	440,491
Balance at 31 March 2015	**(36,186)**

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 2015/16 NHS Barnet CCG received Revenue Resource Limit (RRL) funds of £444.385m (£428.473m 2014/15) and incurred expenditure of £445.946m (£439.492m 2014/15) thus resulting in a deficit for the year of £1.562m (£11.019m deficit 2014/15).

The notes on pages 5 to 20 form part of these financial statements

NHS Barnet Clinical Commissioning Group – Annual Accounts 2015-16

Statement of Cash Flows for the year ended 31 March 2016

	Note	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(445,946)	(439,492)
Finance Costs		0	(1)
(Increase)/decrease in trade & other receivables	7	1,235	(1,942)
Increase/(decrease) in trade & other payables	9	7,525	2,776
Provisions utilised	10	0	(2,000)
Net Cash Inflow (Outflow) from Operating Activities		**(437,187)**	(440,659)
Cash Flows from Financing Activities			
Net cash funding received		437,276	440,491
Net Cash Inflow (Outflow) from Financing Activities		**437,276**	440,491
Net Increase (Decrease) in Cash & Cash Equivalents	8	**89**	(168)
Cash & Cash Equivalents at the Beginning of the Financial Year		**18**	186
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**107**	18

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 £107k.

The notes on pages 5 to 20 form part of this statement

NHS Barnet Clinical Commissioning Group – Annual Accounts 2015-16

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 2015-16* 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. The Department of Health published three years resource allocations (2016-17 to 2018-19) for Barnet CCG in January 2016. As a result of this evidence Barnet CCG is considered as going concern.

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

1.2. Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3. 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.

The Barnet Clinical Commissioning Group entered into five pooled budget arrangements with the London Borough of Barnet during 2015-16.

If the clinical commissioning group is involved in a “jointly controlled assets” arrangement, in addition to the above, the clinical commissioning group recognises:

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 (v) Better Care Fund

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 2015-16, the risk-share provided financial coverage for both the transformation of healthcare services and in-year financial risks. The governance and financial arrangements for the risk-share were approved by the CCG's Governing Body. The financial statements for 2015-16 include relevant contributions and receipts relating to the risk-share for Barnet CCG. In particular, Note 19, which sets out the financial performance of the CCG in 2015-16, reflects income and expenditure relating to the risk-share.

The CCG contributed £1.2m to the risk share in 2015-16. 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 2015-16 was £14.7m. This is set out in the table below:

	£m
Primary Care Strategy	1.1
Barnet Enfield & Haringey Clinical Strategy	3.8
Royal Free/Barnet &Chase Farm Transaction Costs	9.8
	14.7

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 2015/16 is £ 3,805,838 (2014/15 was £1,648,252)

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 2015/16 is £ 8,596,397 (2014/15 was £8,018,653).

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 2015/16 is £1,944,921 (2014/15 was £1,658,878).

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 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)

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

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

1.14. 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.

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 was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning groups contribute annually to a pooled fund, which is used to settle the claims.

In 2015/16 the CCG contributed £2,707,000 (2014-15 £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 and 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.

Loans from the Department of Health are recognised at historical cost. Otherwise, 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 2015-16, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- 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 2015-16, were they applied in that year.

2. Other Operating Revenue

	2015-16 Admin £0	2015-16 Programme £000	2015-16 Total £000	2014-15 Total £000
Net operating expenditure for the financial year	0	75	75	3
Finance Costs	5	152	157	29
(Increase)/decrease in trade & other receivables	0	1,053	1,053	3,072
Increase/(decrease) in trade & other payables	(7)	121	114	(3)
Total other operating revenue	**(2)**	**1,401**	**1,399**	**3,102**

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

3.1. Employee benefits

2015-16	Total			Admin			Programme		
£000	Total	Permanent employees	Other	Total	Permanent employees	Other	Total	Permanent employees	Other
Employee Benefits									
Salaries and wages	6,845	3,990	2,855	4,206	2,098	2,109	2,638	1,893	746
Social security costs	342	342	0	206	206	0	136	136	0
Employer Contributions to NHS Pension scheme	449	449	0	258	258	0	192	192	0
Gross employee benefits expenditure	**7,636**	**4,781**	**2,855**	**4,670**	**2,561**	**2,109**	**2,966**	**2,220**	**746**
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	**7,636**	**4,781**	**2,855**	**4,670**	**2,561**	**2,109**	**2,966**	**2,220**	**746**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**7,636**	**4,781**	**2,855**	**4,670**	**2,561**	**2,109**	**2,966**	**2,220**	**746**

2014-15	Total			Admin			Programme		
£000	Total	Permanent employees	Other	Total	Permanent employees	Other	Total	Permanent employees	Other
Employee Benefits									
Salaries and wages	6,480	4,057	2,423	3,764	2,391	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	**7,258**	**4,835**	**2,423**	**4,235**	**2,863**	**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	**7,258**	**4,835**	**2,423**	**4,235**	**2,863**	**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	**7,258**	**4,835**	**2,423**	**4,235**	**2,863**	**1,372**	**3,022**	**1,972**	**1,050**

3.2. Average number of people employed

2015-16	2015-16			2014-15
	Total Number	Permanent employees	Other Number	Total Number
Total	**18**	**0**	**18**	94
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

	2015-16 Number	2015-16 Number
Total Days Lost	-	284
Total Staff Years	-	77
Average working Days Lost	**#VALUE**	**3.7**

	2015-16 Number	2015-16 Number
Number of persons retired early on ill health grounds	0	0
	£000	**£000**
Total additional Pensions liabilities accrued in the year		0

Ill health retirement costs are met by the NHS Pension Scheme

3.4. Exit packages agreed in the financial year

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 Total	
	Number	£	Number	£	Number	£
£50,001 to £100,000	0	0	1	60	1	60
Total	**0**	**0**	**1**	**60**	**1**	**60**

	2014-15 Compulsory redundancies		2014-15 Other agreed departures		2014-15 Total	
	Number	£	Number	£	Number	£
£50,001 to £100,000	0	0	1	60	1	60

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

3.5. Pension costs

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

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

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

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

3.5.1. Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at www.nhsbsa.nhs.uk/pensions.

For 2015-16, employers' contributions of £421,763 were payable to the NHS Pensions Scheme (2014-15: £338,981) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay (2014-15: 14%). The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9th June 2014.

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4. Operating expenses

	2015-16 Admin £0	2015-16 Programme £000	2015-16 Total £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	4,670	2,966	5,157	4,733
Executive governing body members	0	0	215,626	200,155
Total gross employee benefits	**4,670**	**2,966**	**107,687**	**132,100**
Other costs				
Services from other CCGs and NHS England	3,130	2,027	5,157	4,733
Services from foundation trusts	0	215,626	215,626	200,155
Services from other NHS trusts	0	107,687	107,687	132,100
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	0	52,615	52,615	43,323
Chair and Non Executive Members	297	0	297	221
Supplies and services – clinical	0	396	396	454
Supplies and services – general	32	(527)	(495)	(587)
Consultancy services	4	(185)	(181)	273
Establishment	87	1,524	1,611	1,473
Transport	1	7	8	3
Premises	64	2,609	2,673	1,330
Audit fees	86	0	86	114
Other non statutory audit expenditure			0	
• Internal audit services	0	0	0	0
• Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	0	50,682	50,682	48,640

GPMS/APMS and PCTMS	0	577	577	1,988
Other professional fees excl. audit	99	134	233	170
Education and training	97	(66)	31	356
CHC Risk Pool contributions	0	2,707	2,707	590
Other expenditure	0	0	0	0
Total other costs	**3,896**	**435,814**	**439,710**	**435,336**
Total operating expenses	**8,566**	**438,779**	**447,346**	**442,594**

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5. Payments

5.1. Better Payment Practice Code

Measure of compliance	2015-16 Number	2015-16 £000	2014-15 Number	2014-15 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	12,683	60,621	60,621	51,149
Total Non-NHS Trade Invoices paid within target	12,187	56,182	56,182	45,777
Percentage of Non-NHS Trade invoices paid within target	**96.1%**	**92.7%**	**92.7%**	**89.5%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,535	324,294	324,294	337,441
Total NHS Trade Invoices Paid within target	3,260	312,922	312,922	326,794
Percentage of NHS Trade Invoices paid within target	**92.2%**	**96.5%**	**96.5%**	**96.8%**

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

Measure of compliance	2015-16 £000	2014-15 £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 Leases

6.1. As lessee

6.1.1. Payments recognised as an expense

	Buildings £000	2015-16 Total £000	2014-15 Total £000
Payments recognised as an expense			

Minimum lease payments	2,428	**2,428**	**1,207**
Contingent rents	0	**0**	**0**
Sub-lease payments	0	**0**	**0**
Total	**2,428**	**2,428**	**1,207**

The Clinical Commissioning Group incurs void costs for properties owned and managed by Community Health Partnerships Ltd and /or NHS Property Services Ltd.

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

	Current 2015-16 £000	Current 2014-15 £000
NHS receivables: Revenue	1,205	1,156
NHS prepayments*	1,945	1,659
Non-NHS receivables: Revenue	468	18
Non-NHS prepayments	55	59
Non-NHS accrued income	0	2,511
VAT	37	43
Total Trade and other receivables	**4,333**	**5,567**
Total current and non current	**4,333**	**5,567**
Included above:		
NHS Maternity Pathway Prepayments*	1,945	1,659
Prepaid pensions contributions**	0	0

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

	2015-16 £000	2014-15 £000
By up to three months	232	226
By three to six months	365	13
By more than six months	287	908
Total	**884**	**1,147**

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

8. Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 01-April-2015	18	186
Net change in year	89	(168)
Balance at 31-March-2016	**107**	**18**
Made up of:		
Cash with the Government Banking Service	107	18
Cash and cash equivalents as in statement of financial position	**107**	**18**
Balance at 31-March-2016	**107**	**18**

9. Trade and other payables

	Current 2015-16 £000	Current 2014-15 £000
NHS payables: revenue	18,555	15,684
NHS accruals	4,953	4,467
Non-NHS payables: revenue	10,035	4,039
Non-NHS accruals	15,442	16,724
Social security costs	48	52
Tax	46	54
Other payables	218	751
Total Trade & Other Payables	**49,296**	**41,771**
Total current and non-current	**49,296**	**41,771**

Other payables include £67k outstanding pension contributions at 31 March 2016 (2014-15 £62k)

10. Provisions

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 2016 is £0.5m (£1.0m at 31st March 2015).

11. Contingencies

	31st March 2016 £000	31st March 2015 £000
Contingent liabilities		
NHS Litigation Authority	0	0
	0	**0**

11.1.

Financial instruments

11.2. Financial risk management

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

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

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

11.2.1. 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.

11.2.2. 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.

11.2.3. Credit risk

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

11.2.4. 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.Financial instruments

12.1. Financial assets – Loans and Receivables

	Total 2015-16 £000	Total 2014-15 £000
Receivables:		
● NHS	1,828	1,156
● Non-NHS	468	18
Cash at bank and in hand	107	18
Total at 31-March-2016	**2,403**	**1,197**

12.2. Financial liabilities – Payables

	Total 2015-16 £000	Total 2014-15 £000
Payables:		
● NHS	23,508	20,152
● Non-NHS	25,694	21,514
Total at 31-March-2016	**49,202**	**41,666**

13.Pooled budgets

The NHS Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2015-16 £000	2014-15 £000
Income	-	0
Expenditure – Learning Disabilities Campus Reprovision	786	723
Expenditure – Integrated Learning Disabilities Service	1,890	1,890
Expenditure – Voluntary services	732	732
Expenditure – Community Equipment Svs (Better Care Fund)	1,460	1,273
Expenditure – Frail Elderly (Better Care Fund)	508	0
Expenditure – Community Services (Better Care Fund)	10,125	0
Expenditure – Enablement (Better Care Fund)	377	0
Expenditure – Hospice Contracts (Better Care Fund)	1,245	0
Expenditure – Memory Assessment (Better Care Fund)	215	0
Expenditure – Additional Enablement (Better Care fund)	845	0
Expenditure – Funding transfer to Local Authority	5,071	0
	23,254	**4,618**

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14.Intra-government and other balances

	Current Receivables 2015-16 £000	Current Payables 2015-16 £000
Balances with:		
● Other Central Government bodies	0	94.15
● Local Authorities	281	2,112
Balances with NHS bodies:		
● NHS Trusts and Foundation Trusts	3,773	23,508
Total of balances with NHS bodies:	**3,773**	**23,508**
● Bodies external to Government	279	23,582
Total balances at 31st March 2015	**279**	**23,582**

	Current Receivables 2014-15 £000	Current Payables 2014-15 £000
Balances with:		
● Other Central Government bodies	0	105
● Local Authorities	1476	3196
Balances with NHS bodies:		
● 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	18,318
Total balances at 31st March 2015	**5,567**	**41,771**

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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 £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Abbey Ravenscroft Park Nursing Home	497	0	64	0
Ashley Lodge Nursing Home	0	0	0	0
Barndoc Healthcare Ltd	3,021	121	249	0
Candle Court Care Home	508	0	7	0
Magnolia Court Care Home	0	0	0	0
Sonesta Nursing Home Ltd	226	0	20	0
Speedwell Practice	0	0	0	0

Clinical commissioning groups are clinically led membership organisations made up of general practices. The members of a 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 £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Adler & Rosenberg	36	0	9	0
Ballards Lane Surgery	16	0	3	0
Boyne Avenue Surgery	6	0	1	0
Cherry Tree Surgery	5	0	0	0
Church House Surgery/Vale Drive Medical Practice	12	0	0	0
Claassen & Partner/Langstone Way Surgery	47	0	0	0
Cornwall House Surgery	35	0	1	0
Cricklewood Health Centre/CHC (Barndoc Healthcare Ltd)	0	0	0	0
Derwent Crescent Medical Centre	81	0	6	0
Dr Azim & Partners	29	0	2	0
Dr C Peskin	17	0	3	0
Dr Ds Monkman	12	0	2	0
Dr Fj Mckenzie East Finchley/Woodlands Medical Practice	20	0	0	0
Dr Lakhani/Temple Fortune Medical Centre	0	0	0	0
Dr Nitin Lakhani/Temple Fortune Medical Centre	10	0	0	0
Dr P Weston Practice Account/Dr P Weston & Tal Helbitz	2	0	2	0

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Dr S Samuels Hillview Surgery	5	0	1	0
Dr Sl Datoo/Watford Way Medical Centre	13	0	0	0
Dr Unh Sirisena	13	0	2	0
East Finchley Medical Practice	16	0	0	0
Everglade Medical Parctice	43	0	4	0
Finchley Practice	0	0	0	0
Ganesh & Partner/Parkview Surgery	44	0	0	0
Greenfield Medical Centre	441	0	14	0
Grimble & Partners/The Practice @ 188	50	0	6	0
Grovemead Health Partnership	0	0	0	0
Heathfields	57	0	3	0
Hendon Way Surgery	33	0	4	0
Hodford Road Surgery	26	0	2	0
Holly Park Clinic	30	0	4	0
Isaacson & Partners/Doctors Surgery	20	0	3	0
Jai Medical Centre	88	0	0	0
Keane & Partner/Mountfield Surgery	53	0	0	0
Lai Chung Fong	5	0	2	0
Lane End Medical Group	85	0	1	0
Lichfield Grove Surgery	21	0	0	0
Longrove Surgery	71	0	10	0
Mccollum & Partners/Pennine Drive Surgery	36	0	0	0
Mcelligot/The Village Surgery	21	0	0	0
Millway Medical Practice	131	0	13	0
Mk Lamba/Dr Lamba	18	0	0	0
Msm Hamid	0	0	0	0
Mulberry Medical Practice	70	0	13	0
Oak Lodge Medical Centre	143	0	10	0
Oakleigh Road Health Centre	51	0	7	0
Old Courthouse Surgery	73	0	9	0
Painter & Partners/Addington Medical Centre	51	0	5	0
Phoenix Practice London	52	0	4	0
Pinto & Partners/Penshurst Gardens	46	0	0	0
Ravenscroft Medical Centre	42	0	1	0
Rb Moman/Station Road Surgery	5	0	0	0
Squires Lane Practice	33	0	4	0
St Andrews Medical Practice	86	0	9	0
St Georges Medical Centre	86	0	14	0
St Johns Villa/Friern Barnet Medical Centre	23	0	4	0
Supreme House Surgery/Supreme Medical Centre	29	0	2	0
Team Healthcare Practice/Brunswick Park Medical Centre	10	0	0	0
Temple Fortune H Centre Dr Buckman/Temple Fortune MC	5	0	4	0
Temple Fortune Health Centre Dr Harris	2	0	0	0

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Temple Fortune Health Centre Dr Rowbury	2	0	0	0
Temple Fortune Health Centre Phgh	86	0	15	0
Torrington Park Group Practice	79	0	15	0
Torrington Speedwell Practice	85	0	8	0
Vale Drive Health Centre/Bicknoller Surgery	24	0	2	0
Vm Aziz	5	0	0	0
Wakemans Hill Surgery/The Surgery	21	0	3	0
Watling Street Surgery	92	0	9	0
Wentworth Medical Practice	40	0	4	0
Woodcroft Medical Centre - Dr Makanji	7	0	3	0
Woodcroft Medical Centre - Dr Moodaley	0	0	0	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	2,699	701	41	611
NHS Lambeth CCG	249	0	0	0
NHS North & East London CSU	5,385	0	518	0
Barnet, Enfield & Haringey Mental Health NHS Trust	28,699	0	1,588	0
Barts Health NHS Trust	2,890	0	632	0
Central London Community Healthcare NHS Trust	30,802	0	1,185	0
East & North Hertfordshire NHS Trust	485	0	259	0
Imperial College Healthcare NHS Trust	3,712	0	555	0
London Ambulance Service NHS Trust	11,485	0	271	0
London North West Healthcare NHS Trust	9,765	0	808	49
North Middlesex University Hospital NHS Trust	1,751	0	151	0
Royal National Orthopaedic Hospital NHS Trust	5,012	0	95	0
The Whittington Hospital NHS Trust	9,083	0	625	210
West Hertfordshire Hospitals NHS Trust	917	0	172	0
Camden & Islington NHS Foundation Trust	614	0	67	0
Central & North West London NHS Foundation Trust	1,401	0	84	0
Chelsea And Westminster Hospital NHS Foundation Trust	593	0	0	282
East London NHS Foundation Trust	2,258	0	227	0
Great Ormond Street Hospital for Children NHS Foundation Trust	930	0	0	96
Guy's & St Thomas' NHS Foundation Trust	2,761	0	96	0
Homerton University Hospital NHS Foundation Trust	233	0	49	0
King's College Hospital NHS Foundation Trust	291	0	175	0
Moorfields Eye Hospital NHS Foundation Trust	3,962	0	344	0
North East London NHS Foundation Trust	185	0	160	0

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Royal Brompton & Harefield NHS Foundation Trust	870	0	248	0
Royal Free London NHS Foundation Trust	175,210	0	11,549	1,631
St George's University Hospitals NHS Foundation Trust	283	0	29	0
Surrey & Borders Partnership NHS Foundation Trust	1,591	0	335	0
Tavistock & Portman NHS Foundation Trust	558	0	0	0
The Hillingdon Hospitals NHS Foundation Trust	247	0	211	0
University College London Hospitals NHS Foundation Trust	22,068	0	1,693	521
NHS Property Services	1,204	0	1,674	0
Community Health Partnerships	0	0	201	0
National Health Service Pension Scheme	450	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 £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
HM Revenue and Customs Trust Statement	342	0	0	0
Barnet London Borough Council	12,223	349	2,112	281

16.Events after the end of the reporting period

[For each non-adjusting event after the reporting period (e.g. major purchases, classifications of an asset as held for sale or announcement or commencement of a major restructuring, refinancing or renegotiation of financing terms) disclose:

- The nature of the event; and,
- An estimate of the financial effect or state that an estimate can't be made.

17.Losses and special payments

There were no losses and special payments in 2015-16 (2014-15 nil).

18.Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

The Clinical Commissioning Group performance against those duties was as follows:

	2015-16 Target Performance £000	2015-16 Actual Performance £000	2015-16 Surplus/ (Deficit)£000	2015-16 Duty Achieved Yes/No
Expenditure not to exceed income	445,784	447,345	(1,561)	No
Capital resource use does not exceed the amount specified in Directions	0	0	0	Yes
Revenue resource use does not exceed the amount specified in Directions	444,385	445,946	(1,561)	No
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	8,974	8,568	406	Yes

	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	0	0		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	0	0		Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0		Yes
Revenue administration resource use does not exceed the amount specified in Directions	10,120	9,109	1,011	Yes

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