NHS City and Hackney Clinical Commissioning Group

Annual Report and Accounts 2014/15

City and Hackney
Clinical Commissioning Group

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Member practices introduction

We are proud to have had such a successful second year as NHS City and Hackney Clinical Commissioning Group (CCG). We have maintained a healthy financial position and have been lucky enough to have been able to invest £32million in a huge range of exciting, albeit non recurrent, projects to improve health care locally for our patients and support our local providers including the voluntary and statutory sectors.

Our main acute provider, the Homerton University Hospital NHS Foundation Trust has been rated as good by the Care Quality Commission and has also maintained financial balance, and East London Foundation Trust, our main mental health provider, has been similarly rated good and in balance. We have a new provider – the GP Confederation, formed this year – which is moving rapidly to support all City and Hackney practices to deliver good primary care across a wide range of areas. For example, all practices now run a duty doctor service so patients can access advice very fast. All of our practices score above the London average on a basket of national indicators.

We have done exceptionally well in helping people to manage their long term conditions, ranking top in England for many measures, which is fantastic given the deprivation levels of our population. The Homerton was one of only six Trusts in London to maintain its four-hour Accident & Emergency target last winter, and the Accident & Emergency department was ranked as outstanding for quality by the Care Quality Commission, a wonderful double achievement. We hit our Increased Access to Psychological Therapies access and dementia prevalence targets, and we are at the forefront of innovation in mental health services.

Why and how are we able to achieve great services and stay in financial balance, given that this is now really unusual?

We ask all our GPs to help commission services and feed in their good ideas, always thinking about how to run services that save patients time. We aim to upskill and resource all practices to offer services such as diagnostic tests and treatment there and then without needing to be referred anywhere else, backed up by best practice clinical pathways, multidisciplinary teams, and consultant advice by phone or email. Practices can access, for example in mental health, psychology, primary care psychotherapy, liaison psychiatrists and community psychiatric nurses, social prescribing, and benefits advice directly within their own or a neighbouring practice. All of this has led to increased job satisfaction for GPs as well, so in general we attract and retain excellent primary care staff.

We continue to promote integration and collaboration, and have been doing so for years, even though we are not taking part in the national vanguard programme. For example, we initiated the One Hackney system for multi-organisational support for frail housebound people, and are using alliance contracting for this and four mental health areas. We are lucky that One Hackney includes a vibrant and responsive voluntary sector, a small and flexible acute hospital, a GP provider organisation, a forward looking mental health trust, and social services and we have been able to enhance all of their services.

Finally, our commissioning and finance teams are lean, yet continue to be highly effective. We are very unusual, in that we underspend our management allowance, meaning that we can invest £2m more in services for our patients, rather than in management overheads.

We try to make clinical commissioning a reality, avoid bureaucracy where we can, and keep focused on where we can improve the design of clinical pathways, outcomes for patients and quality of services.

My thanks go to all across City and Hackney and to local NHS staff for delivering such great services to our patients.

Clare Highton

Chair

Strategic report

Background information

Formally established in April 2013, the City and Hackney Clinical Commissioning Group covers an area of North Central and East London incorporating the City of London and the London Borough of Hackney. We operate in a predominantly contained local health economy, with a significant amount of our total contract value represented by local providers and with relatively small numbers of patients coming in for treatment from other CCG areas and small outflows of our patients into other areas. We work with two Health and Wellbeing Boards – one for the Corporation of the City of London and one for the London Borough of Hackney.

80% of acute care services are commissioned from Homerton University Hospital Trust, located in south Hackney, which also provides community health services. GP out of hours services are provided by a City and Hackney-only GP led social enterprise (CHUHSE) and, in 2014, a GP Confederation was established that supports all 43 practices in the area.

Mental health services are provided by East London Foundation Trust, and we work closely with Newham and Tower Hamlets CCGs to commission effective, responsive mental health services for our patient populations.

Our key service provider relationships are:

- Homerton University Hospital NHS Foundation Trust – acute and community health services;
- Whittington Health – acute services;
- University College Hospital London – acute services;
- Barts Health – acute services;
- East London Foundation Trust – mental health services;
- Tavistock and Portman NHS Foundation Trust – mental health services;
- City and Hackney Urgent Care Healthcare Social Enterprise (CHUHSE) – GP out of hours services;
- Partnership of East London Co-operatives (PELC) – 111 services;
- GP Confederation – extended primary care services.

Our commissioning work is managed through CCG Programme Boards, led by a GP with strong clinical input from local partners including public health and local authority commissioners, representatives from our patient groups, and clinicians from our main provider organisations. The Programme Boards work in a democratic and collaborative way to develop a vision for how to improve services and to establish plans to deliver these improvements through our contracts. They listen closely to the views of our patients and our member practices about the changes they would like to see, identified from their day to day experience of local services, and use benchmarked information to help pinpoint where we need to make improvements. Clinical audit of our services and pathways is critical to influencing and changing local clinical behaviour. The CCG Clinical Executive Committee, which reports to the Governing Body, brings together member practice consortia representatives and Programme Board Chairs to coordinate our plans, provide clinical challenge and ensure good consultation. The CCG Governing Body oversees the operation of the Clinical Executive and Programme Boards. We work closely with our two Health and Wellbeing Boards and other commissioners to ensure that our plans are tackling local health issues and improving local outcomes.

We have established a strong financial strategy which enables change and transformation, but also ensures we can withstand future pressures over the life of our five year plan, including a rapid move to target funding allocation were that to occur. By investing in projects with local providers, we are also seeking to ensure they are able to continue to deliver high quality, efficient and safe services to local residents. These projects are developed by each of our Programme Boards in conjunction with partners and are about making tangible improvements for our patients

We delivered a surplus of £41.5m for the year which included the surplus of £27m brought forward from 2013/14. NHS England policy didn't permit us to access the £27m so we planned a surplus of £30.8m, the increase reflecting a nationally mandated 1% surplus from the income we received.

We began the year with an allocation of 7.1% above what the national funding formula says we should receive. Our financial strategy is not to exceed the target amount on a permanent basis – that way we aren't stacking up problems, as we have no control over if and when our funding reduces to the target level. However this does give us some "headroom" which we have used to invest in a range of new services – some of which are described later in this report. All of these services are being evaluated in 2015 to see whether they have had the impact we expected and we can make them permanent

As some of the schemes took longer to get going than we had anticipated we ended the year by not spending £7.5m on our new services – so this increased our surplus for 2014/15. We were also able to release some contingency reserves of £2m which added to our surplus. NHS England has confirmed that we can use the £7.5m for our new services in 2015/16.

We continue to work closely throughout the year with neighbouring CCGs being party to various collaborative commissioning arrangements in north central and east London to work together in contracting with some Trusts; in addition, we are party to a collaborative risk share with Tower Hamlets CCG, Newham CCG and Waltham Forest CCG. We will continue this collaborative arrangement into 2015/16, although the plans of each organisation mean it is unlikely to be used.

Overall, our strong financial performance was driven by effective clinical commissioning work by all our member practices and strong patient engagement, which enabled us to benchmark favourably in London on most measures and standards and allowed us to invest in new local services.

Social, community and human rights context

Local population

The number of people registered with our 43 practices is 286,902 (source NHS England allocations) whilst the number of people living in the area is as follows:

- 7,600 (City of London);
- 257,400 (Hackney).

(Source: Office for National Statistics mid-year estimates)

The area faces significant health and wellbeing challenges, with a super-diverse and highly transient patient population. Hackney is the second-most deprived local authority area in England, with significant inequality within the borough on a ward by ward and even street by street basis. The same is true for the City of London where some wards are among the most deprived 40 per cent in the country and others are among the least deprived 20 per cent. Approximately 37 per cent of children in Hackney are affected by poverty, almost double the rate for England and significantly higher than the London average. Child poverty is also a significant issue in the City of London with a high concentration in the ward of Portsoken, at 35 per cent.

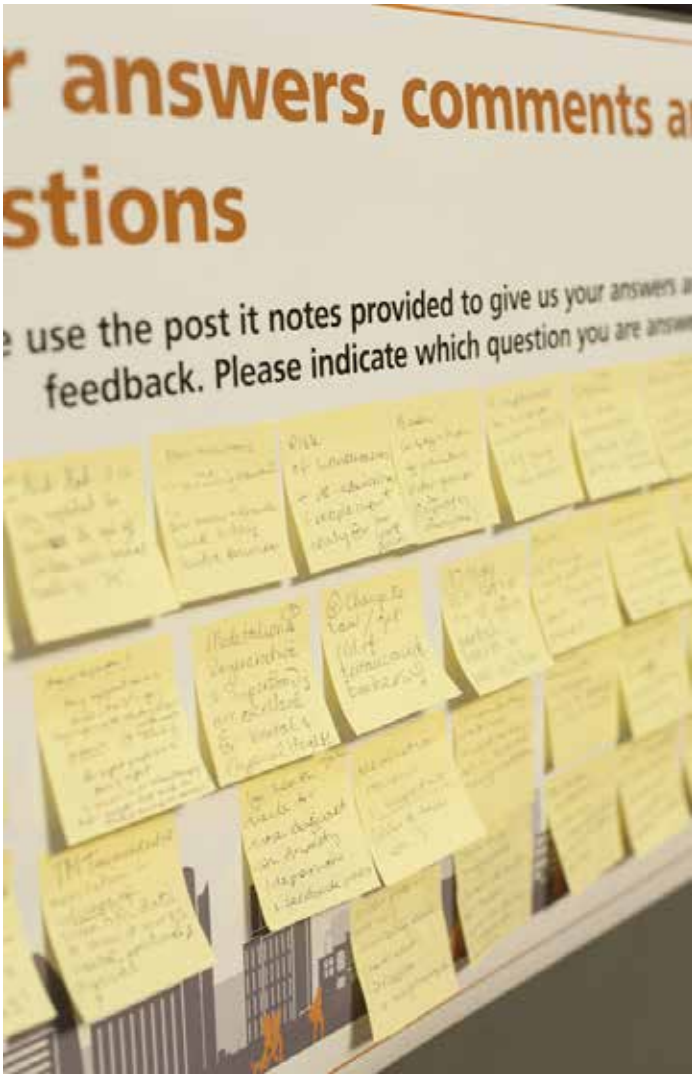
Hackney has one of the highest proportions of people living with long-term health conditions in London at 7 per cent, and one of the highest rates of smoking in the country. A 2012 report found that nearly a quarter of the City of London's working population smoked. These factors, along with prevalence of severe mental health issues, late presentation for cancer, and deaths from heart attacks and strokes, have resulted in higher levels of premature mortality than in most other areas of England.

Working with other commissioning bodies, such as NHS England and the two local authorities, City and Hackney CCG has responsibility for commissioning services to meet these health needs. We are working closely with our Health and Wellbeing Boards in both the City and in Hackney to align our plans and ensure we are collectively making a difference. We listen closely to the views of local clinicians, patient groups and other key stakeholders, and we were delighted to see so many local people at our commissioning event in October 2014, where we spent a lot of time listening to the views of our patients about the changes they would like to see. We get regular ideas and input from our member practices through our consortia and our monthly clinical commissioning forum.

We have a range of overarching health issues that we want to tackle – too many people still die from heart disease and cancer – at the same time as making sure our services can meet the diverse and specific needs of the many different communities across Hackney and the City. We believe that the best ideas come from listening to our patients and clinicians, and we are working hard together to really make sure services join up around our patients.

We have commissioned a range of services from the voluntary and statutory sectors to support and deliver the care plans that have been developed by patients in consultation with their GP. We want to ensure that these services join up effectively and seamlessly so that patients are supported and empowered to manage their conditions more effectively. This focus is a strong message from our patients and their families and carers, and demonstrates how our patient and public involvement activities have become increasingly embedded and integral to our work, meaning a stronger patient voice is heard throughout our commissioning process.

Involving our patients



We want to put our patients at the centre of everything that we do. Governing Body meetings are held in public with a strong emphasis on trying to conduct all of our business wherever possible in public. Patients and patient groups are encouraged to be involved across all our activities and representatives of City of London and Hackney Healthwatch are present at Governing Body meetings and sub committee meetings and patient representatives are on our Programme Boards. Our sub committee which considers how we invest our money meets in public and also really benefits from the input of our Healthwatch colleagues.

We work closely with the 43 practice-based patient participation groups in City and Hackney. These groups feed into our formal engagement structures through their representatives attending the Public and Patient Involvement Committee. We have commissioned Healthwatch Hackney, in partnership with Age UK Hackney, to deliver the 'NHS Community Voice' project, aimed at helping local communities shape NHS health services in City and Hackney. This has involved conducting regular open forums focussed on discussing and debating local health topics as well as wider NHS issues such as improving access to health services, the better integration of health and social care and helping people to feel more in control of their health. Guest speakers and experts attend the meetings and questions and recommendations are fed back to influence commissioning decisions.

We have listened to our patients and have commissioned all our practices to offer longer consultations when someone is first diagnosed with a long term condition or cancer and at various stages throughout their treatment. We are working with Homerton Hospital and the local authorities to improve discharge arrangements and have set up a project to make sure hospital and community services all link together in the City of London. Our patients help us to design the specifications for new services, ensuring that they address patient needs and we involve them in testing out the responses of our providers and in helping to evaluate proposals.

In 2014, in response to feedback from patients and other stakeholders, we launched the first round of an Innovation Fund. Grants of between £10,000 and

£100,000 were awarded to 11 projects that offered innovative and lasting solutions to identified healthcare challenges impacting on our local communities. Projects from this round are starting to deliver outcomes on the ground and we have made £400,000 available to deliver the fund again in 2015/16.

Business information

The CCG Governing Body oversaw a very positive second year of operation. A surplus of £27m had been delivered in 2013/14, mainly down to late resolution of funding issues following the NHS reorganisation which had led the Governing Body to hold back committing expenditure, for example the 2.5% mandatory non-recurrent investment fund. Our providers delivered high performance across a range of standards and indicators and we did not have the problems in Accident & Emergency over winter that were experienced elsewhere – with Homerton Hospital being one of the few hospitals to hit the A&E target.

In 2014/15, we agreed an original plan to deliver a surplus of 1% or £3.8m which was the nationally mandated minimum, which would increase the cumulative surplus to £30.8m from £27m. This was predicated on the CCG being able to mobilise a significant non-recurrent investment programme. During the year, the Governing Body agreed to release £2.1m contingency funds, increasing the in-year surplus to £5.9m. The major in-year risk was delivery of the individual schemes in the non-recurrent programme; these risks included delays in finalising specifications, delays in agreeing final contract terms with providers, delays in mobilising schemes, for example recruitment delays, and a shift of primary care contracts to be delivered via the new City & Hackney GP Confederation which required formal establishment and CCG due diligence. In the light of these delays we strengthened our internal resources and processes to avoid them happening again. Later in the year, the Governing Body reassessed the risk of slippage and agreed a further £7.5m increase in surplus, such that the cumulative surplus was £41.5m at year end. Whilst the CCG was not permitted by NHS England to draw on this in 2014/15, the CCG has agreement from NHS England that the £7.5m will be available to draw on in 2015/16 to support our investment programme.

	£000
Original Allocation	373,644
Running Costs Allocation	6.565
Additional Allocation in year	2,634
Total	**382,843**

The CCG Governing Body oversaw the delivery of financial, performance and quality of service delivery with all of our main providers. Quality performance is reviewed in detail on a quarterly basis by the full Governing Body and the Governing Body engages promptly and directly with Directors of organisations where concerns arise, such as issues flagged by our GPs with referrals to the Royal London Hospital operated by Barts Health NHS Trust.

As mentioned above, a major Governing Body focus was the establishment of a significant programme of one-off investments, many set up to run until 31 March 2016. In total, this represents an investment of £39.7m. Some key highlights of our investments are detailed below.

Learning Disability Nursing Service

This service works with staff across the Homerton Hospital, equipping them with the values, skills and knowledge to better support patients with learning disabilities and improve their experiences across the local NHS.

Community Sickle Cell healthcare

We have funded psychologists and a social care liaison worker to expand the existing community healthcare team caring for people with sickle cell disease and thalassemia which has many sufferers in our population. These staff have been able to work with individuals on wider issues surrounding their health and support them to access services appropriate to their needs such as counselling and benefits advice. One service user said that he "feels stronger and more confident to manage himself when in crisis".

One Hackney

This project supports a network of our local providers and the voluntary sector who are working together to keep people safely cared for in the community. It represents a new way of working, with a range of additional resources across different providers to help improve the co-ordination of care services and clinical outcomes for patients and carers in the following broad categories:

- End of Life;
- Patients identified as high risk of admission to hospital;
- Patients being cared for under the Frail Home Visiting service;
- Highly complex patients where:
  - Help is needed to coordinate the involvement of multiple teams;
  - Additional services are required to help the patient remain safely at home (e.g. support with meals, personal care, daily activities such as shopping / cleaning);
  - Additional services are required to help the patient self-care, reduce social isolation and live well independently for longer;
  - Additional services are needed in the first few days after a stay in hospital.

The project aims to let patients stay in a more comfortable and familiar environment and helps to reduce hospital activity, freeing up funds for further investment in the community. It relies on the provider organisations working together and coordinating their services to deliver the care plans set by our patients

Some of the new One Hackney services include:

- Marie Curie overnight end of life nursing care provided by registered nurses and healthcare assistants who are experienced in caring for patients with these needs. It is delivered from 10pm to 7am, any day of the week, at a patient's own home or in a care home;
- A vast range of voluntary sector services including, in-home personal and practical care (household chores, food preparation, washing / bathing, pet care, collection of prescriptions, cleaning and laundry), personal support during hospital discharges, befriending, companionship and emotional support, in-home exercise, financial and legal advocacy and support, in-home mental health assessment and intervention, out of hours telephone support, hoarding / de-cluttering service, personalised eco-therapy, health and medical equipment provision, carpentry, plumbing and home maintenance, and gas, electrical and appliance repairs. This offer will continue to grow through 2015/16, expanding to include transport, massage, yoga, meditation and relaxation, complementary therapies, additional legal and financial advocacy support, social activities, and much more;
- More district nurses to care for people in their own homes;
- More support for people with mental health problems;
- More social workers;
- A take home and settle service by Age Concern to support discharge from hospital.

Children's Community Nursing service

This service has provided extended support on 532 occasions to children in their home at weekends and bank holidays, to prevent their need to attend the Starlight children's ward or accident and emergency. These patients include children who may be well enough to be discharged from hospital, but need on-going treatment at home or children who may otherwise have attended hospital for a one off treatment. This service is providing a better patient experience and is also expected to result in a reduction in the cost of hospital services for children.

Frail Home Visiting service

The frailest patients across City and Hackney have benefited from a GP home visiting during 2014/15. 1,696 people were visited, with each patient receiving between four and five visits on average. This service has ensured that this most vulnerable group of patients receive proactive care orchestrated by a named and regular GP. It has also supported these patients through ensuring that they are referred to a range of health, social care and voluntary sector professionals to help them where necessary.

Duty Doctor service

Patients registered with a City and Hackney GP now get a same day phone consultation with a doctor from their practice if they have been unable to book a face-to-face appointment. The duty doctor system helps patients who may not be sure if they need to see a GP or when there are no same day appointments left at their surgery. A qualified GP will call patients back, assess symptoms and, if safe and appropriate, advise on the best course of treatment. The service is also available to support health and social care professionals access practice GPs in urgent situations such as consultants at Homerton Hospital and the London Ambulance Service.

Local Dementia Support Service

We have invested to ensure that all patients diagnosed with dementia are notified to their registered GP within 48 hours so that a care plan is agreed with patients and carers, and then shared across other providers. This early support from our dementia advisors and GPs is improving the chances of people living more fulfilled lives with the right support in place.

This new clinical interface is supported by more accurate coding and the early recording of dementia diagnoses means that care is integrated across GP practices, East London Foundation Trust memory clinics and Homerton University Hospital. As a result, patients are no longer waiting as long for a diagnosis and we have funded a team of Dementia Care Assistants at Homerton University Hospital, who work alongside the Alzheimer's Society Dementia Advisors to ensure every patient with a diagnosis of dementia and their carers have access to advice, information and support on their diagnosis and on local support services available. We have worked closely on our dementia plans with the Local Authorities as both of our Health and Wellbeing Board chose dementia as a particular focus for 2014/15.

We play an active part in collaborative arrangements with other local CCGs. Although the City & Hackney NHS system is fairly self-contained, we have £23.5m patient activity to the east (mostly with Barts Health) and £24m to the immediate west. North East London was identified early in 2014/15 as a 'challenged health economy' by the tripartite panel of NHS England, Monitor and the Trust Development Agency. The challenges were primarily with Barts Health NHS Trust and Barking Havering and Redbridge University Hospitals NHS Trust. Whilst our contracts with these organisations are fairly peripheral (representing approximately 1.8% and 0.9% of the Trust's turnover respectively) we participated in the review process with McKinsey & Company, who had been appointed by the Tripartite to support the review. We continue to collaborate with Tower Hamlets and Newham CCGs in the commissioning of mental health services from East London Foundation Trust and in commissioning ambulance services, and 111. A risk share with these CCGs and Waltham Forest, was in place and the CCG contributed £2m of support to Waltham Forest CCG.

A key challenge during the year was the management of continuing healthcare. A very small number of new additional retrospective claims had been identified and these were resolved in 2014/15 at a cost of £141k. The CCG contributed £1.352m to a national risk pool to cover these costs nationally, although £842k was returned unutilised. The pressure on current continuing care budget presents an ongoing challenge to the local NHS as demand rises.

During 2014 NHSE offered all CCGs the chance to take responsibility for commissioning primary care services. We were very enthusiastic about the opportunity presented, working with our stakeholders

on our local priorities and developing new processes to manage the conflict of interest for our GPs if we took this role on. However, in the end we decided not to pursue our application. The offer didn't give us the freedoms to develop primary care in the way we had hoped and the Governing Body and our member practices were very concerned about the financial risk involved. Despite not taking our application forward, we have already begun a large exercise to develop a primary care strategy during 2015, using all the information about local primary care services that our application gave us. We are looking forward to working with our patients and members to develop our plans.

Our Governing Body looked at the management functions being delivered on our behalf by external organisations during 2013/14 and decided to bring a number of these back in-house from 1 April 2014, including financial management, contract management, prescribing advisors and human resource management. This increased the number of employees, but enabled more efficient and productive support to commissioning, resulting in an underspend against our running cost allocation. The Running Cost Allocation was £6.5m and the CCG expenditure for the year was £3.7m. We used this underspend to fund more direct front line patient services, and we continue to think very critically before creating any new management posts and systems to ensure that these will add real value.

The size of our CCG running cost allowance will reduce by 10% in 2015/16. We will have no problem in containing our running costs within this revised allocation, freeing up more money to spend on front line services.

We set a savings target of £5.42m to be delivered in 2014/15, known as QIPP (Quality, Innovation, Productivity & Prevention), which was slightly exceeded at £6.07m. We are planning to deliver a further £5m of QIPP savings in 2015/16, partly as a result of the planned investment programme (i.e. transformational change) and partly through more effective contracting arrangements. This isn't about cutting services but about how investing in more community services, like the sickle cell service highlighted above, enables us to reduce the money we spend on Accident & Emergency attendances and hospital admissions. All of these plans are developed and overseen by our clinicians to ensure that they are sense-checked by experts in the field and deliver real patient gains.

We were also required by NHS England to hold no more than 1.25% of our March spend as a cash balance at the year end. The CCG held £58k in its bank account as at 31 March 2015, which was well within the permitted sum. We hold no fixed assets so all transactions were processed as revenue transactions.

Note 4 to the CCG Annual Accounts covers the CCG's pension arrangements (on page 80). Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

We are required to put in place arrangements for the effective management of information governance. The NHS has a number of criteria against which this is measured, known as the 'information governance toolkit'. Measured against the toolkit criteria, we attained level 2 compliance (Satisfactory).

The Better Payment Practice Code requires us to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. We are pleased that we paid 94.7% of non-NHS invoices by value and 95.2% by volume in accordance with this requirement. Full details of compliance with the code are given in the notes to the financial statements.

In 2015/16, we are planning over £36.6m of investment. The major projects are spread across the portfolio, with investment in mental health, in primary care and acute hospital services. A major new national NHS funded initiative, the Better Care Fund (BCF) has now started, with the aim of better integrating Health and local authority commissioning and thereby hoping to reduce non-elective activity. BCFs have been put in place with the City of London and London Borough of Hackney and are overseen by our 2 local Health and Wellbeing Boards and our CCG Integrated Care Board. There is little new money in to the BCFs, but it presents an opportunity for various streams of funding to come together in a local pool to be used on a more integrated basis. Our One Hackney initiative described above is one of our BCF plans along with a range of other services we already commission and will be reviewing the impact of each of these services over the next few months as we try to align them with what the local authorities commission.

In the medium term, the key risk to the CCG is the funding formula. We are above our target allocation by 5.5% or £18.4m, (Dec 2014). The financial strategy adopted by the Governing Body is to ensure recurrent costs do not exceed the target allocation and ensure any non-recurrent expenditure is not committed without the security of the funding being in place. By investing in non-recurrent projects, it enables us to continue our excellent past performance of remaining efficient, productive and effective as a health economy, with high performing and financially secure providers. Whilst not of significant financial importance to the CCG, Barts Health NHS Trust continues to be challenged financially and a recent CQC inspection impact rated services as inadequate. The CCG is seeking to invest £500k non-recurrently to fix problems our patients are experiencing with treatment at this provider and we work with other local CCGs to ensure that any plans by the Trust to save money don't adversely impact on City and Hackney. Finally, we are at risk from external policy changes and decisions made by other bodies. Whilst we have sufficient financial capacity to remain resilient, it has the potential to undermine the direction of travel we are taking to meet the needs of the local population.

The key risks we face are as follows:

- Changes in the national funding formula and a move to target funding over a short period. The CCG will be 5.5% over target at the end of 2015/16;
- Decisions made by other commissioners/ national policy changes. We are working with other commissioners to influence the impact of decisions on care pathways we are responsible for and ensure demand is managed and contained;
- The impact of Barts Health NHS Trust's financial and operational recovery plans. Although a small commissioner of Barts Health, the impact should the Trust not succeed in its recovery will ripple across east and north London.

Key service improvements delivered 2014/2015

We are really proud of all these new services we've now put in place.

Children

- Offered Personal Health Budgets to all children and young people who receive a continuing care package, giving patients and their carers greater choice and control over their care and treatment.
- Provided emotional and wellbeing support to children and their families through a social prescribing pilot in a number of primary schools.
- Established a Children's Disability Forum to ensure that patient and carer feedback is heard and is able to play a key role in commissioning decisions.

Integrated care

- Supported elderly and frail patients identified as being at risk of hospital admission to stay in their own homes for longer through 'One Hackney', Nearly 1,800 service users now have joined-up care plans alongside a dedicated emergency contact.
- Further enhanced out-of-hospital care for frail, vulnerable people through the development of the Community Reablement and Intermediate Care Service.

- Established an Integrated Care Programme Board to coordinate effective multi-agency approaches and ensure plans are joined up more effectively.

Long term conditions

- Significantly improved outcomes for sickle cell patients, including reduced use of urgent and emergency care, by investing in an expanded multi-disciplinary team. Similarly, a self-management programme for people with epilepsy in City and Hackney has helped people with the condition achieve greater independence and improved confidence.
- Gave patients with existing long term conditions more time to talk to their GP, and patients newly diagnosed with a chronic condition greater support from their GP practice.
- Achieved some of the best results in the whole country for aspects of chronic disease management such as blood pressure control in people who have had a stroke, or who have peripheral arterial disease or kidney disease.

Maternity

- Focussed on improving women's satisfaction and experience of labour and childbirth by improving postnatal care; developing the communication skills of midwives and breastfeeding support staff, and agreeing changes to the physical environment at Homerton University Hospital's maternity unit.
- Increased and improved continuity of care for pregnant women through a new community midwifery service with a focus on high quality care based in the community.
- Improved access to tongue-tie services following feedback from parents. The service now has a single point of contact which is promoted to GPs and to parents and carers wishing to self-refer.

Mental Health

- Supported mental health patients coming into A&E by commissioning a round-the-clock psychiatric liaison team at Homerton University Hospital. The team is also responsible for mental health awareness training for staff and for providing expert input for patients with dementia.
- Commissioned the Alzheimer's Society to provide dementia care advisors who see every patient with a new diagnosis, and support patients and GPs in the community to manage dementia well.
- Improved our dementia prevalence figures from 50% to 67%, putting us in the top three highest performing CCGs in London for this target.

Planned care

- Implemented a direct access colonoscopy service meaning that patients with worrying bowel symptoms can now be referred for testing directly without having to see a consultant.
- Listened to patient feedback and commissioned a new lymphedema service.
- Increased the provision of chronic pain services meaning patients now have access to a greater level of multi-disciplinary treatment and support.

Prescribing

- Supported patients to better manage chronic conditions and diseases, such as cardiovascular disease and hypertension, through improved prescribing by our GPs.
- Ran a pilot scheme aimed at delivering improved prescribing for mental health patients through the provision of a mental health specialist pharmacist who works with GPs and other care staff to develop a better understanding and build clinical knowledge and skills.
- Were recognised as being in the top 10 of CCGs in London for cost effective prescribing practice by our GPs.

Primary Care Quality (GP services)

- Helped patients to receive as much appropriate care as possible at their own GP surgery by giving extra support to practices, including better access to consultant advice services and clearer local guidelines and pathways for care and treatment.
- Encouraged patients to return their NHS GP Patient Survey so that we can use the results to improve local services based on patient feedback.
- Developed our own approach to getting a better understanding of what 'quality' GP services really mean. We worked in partnership with the local Public Health team to create a system that takes into account local issues such as patient demographic and environmental factors, giving us a better overall picture.

Urgent care

- Gave all our registered patients greater access to same-day GP services through the Duty Doctor scheme, meaning everyone has access to a phone consultation and follow up face-to-face appointment where needed.
- Treated more patients with urgent care needs outside of hospital by working with London Ambulance Service and the out-of-hours GP service to continue the highly successful ParaDoc scheme (where a GP and Paramedic respond to some 999 calls to care for people at home and avoid taking them to hospital).
- Worked with the GP Confederation to begin the introduction of an Extended Hours Service, giving patients greater access to their GP, and a wider choice of appointment times.

Looking forward – what we will deliver in 2015/16

We have agreed a further set of clinical ambitions that outline the changes we still want to make locally to deliver improved outcomes for our patients.

Our priorities can be grouped into broad categories. Below, we have outlined these themes and here we give you an overview of just some of the key activities aligned to each one which we have agreed with our Health and Wellbeing Boards:

Increase life expectancy and reduce premature mortality

- Give patients better access to tests that support the early detection of cancer.
- Offer further support to patients with asthma and Chronic Obstructive Pulmonary Disease by working with specialist respiratory pharmacists based in GP practices.
- Support children who are vulnerable and who have long term conditions and disabilities by commissioning new services that will be delivered from GP practices.

Reduce emergency admissions and improve community services

- Continue to develop the One Hackney provider network to join up community services and undertake clinical reviews to see how we need to improve some aspects of some services
- Use feedback from the Primary Urgent Care Centre patient, partner and stakeholder workshops to align services more clearly with patient need
- Develop care plans across our local providers for a small number of our patients who are frequent attenders at A&E.

Reduce inequalities

- Launch a second round of the Innovation Fund, asking for innovative and specific solutions to meet the needs of vulnerable and hard to reach groups.
- Ensure all residents with a learning disability have an annual care plan developed with a qualified social worker.
- Support vulnerable new mothers through the 'Bonding with Baby' initiative

Improve patient satisfaction and recovery

- Support people with wellbeing and mental health needs by investing in East London NHS Foundation Trust to deliver a mental health reablement pilot scheme, and in Off Centre to deliver support to young people.
- Provide a high-quality and intensive GP-led service for the frailest patients through a dedicated home visiting scheme.
- Improve patient satisfaction and quality of services by agreeing a cross-cutting programme of quality improvement initiatives with Homerton University Hospital.

Improve patient safety and reduce harm

- Identify patients with kidney disease who are at risk of deteriorating earlier, and offer appropriate care to avoid complications.
- Ensure the highest levels of children's safeguarding through the close, ongoing monitoring of safeguarding training, both within the CCG and across commissioned provider organisations.
- Work with Homerton Hospital's maternity department to increase the presence of senior midwives and supervisors.

Ensure equal emphasis on mental and physical health

- Support mental health patients to give up smoking, maintain a healthy weight and improve their physical health through targeted investment in GP services.
- Offer extended GP consultations for people with dementia through a 'time to talk' scheme.
- Invest in MIND to deliver a 'recovery college' for mental health patients.

Wider availability of seven day services

- Support older patients who are discharged from hospital by commissioning Age UK to deliver a seven-day-a-week Take Home and Settle service.
- Ensure patients with sickle cell disease have access to specialist care outside of usual clinical hours.
- Reduce the need for patients to travel to hospital through the development of a community post-operative wound care service.

Our five year strategy

We developed our strategic plan with our Programme Boards, our two Health and Wellbeing Boards, our patients, our providers and our members. As a result, it has the strong local support needed for effective delivery.

A summary of our five year plan is available on the following page, with a full version of the document online at **http://www.cityandhackneyccg.nhs.uk/ONELCityHackney/Pages/about-us/our-plans.htm**

1 SUMMARY

Our vision for the City and Hackney health economy is:

- Patients in control of their health and wellbeing;
- A joined-up system which is safe, affordable, of high quality, easy to access, saves patients' time and improves patient experience;
- Everyone working together to reduce health inequalities and premature mortality and improve patient outcomes;
- Getting the best outcomes for every £ we invest through an equitable balance between good preventative services, strong primary and community services and effective hospital and mental health services which are wrapped around patient needs;
- Services working efficiently and effectively together to deliver patient and clinical outcomes and providers in financial balance.

2 BIG THEMES:	3 PLANS:
Reduce premature mortality	Focusing on cardiovascular & respiratory diseases, people with mental health problems and people with cancer, commission our providers to deliver: • Earlier diagnosis and treatment; • Social prescribing and integrated preventative services; • Patients supported and empowered to embrace lifestyle changes which will impact on their health.
Manage demand	• Use the Better Care Fund to ensure services and providers are working in unison to deliver patients' care plans and the system-wide metrics we have set; • Commission better support and quality of life for people with long term conditions and mental health problems; • Ensure practices have the capacity & time to support & care for people in the community given the increasing demands they are facing.
Develop primary care and community services	• Commission the GP Confederation to deliver population coverage, uniform high quality standards & outcomes in primary care; • Commission One Hackney providers including the voluntary sector to join up their services & work more closely with practices and patients& explore whether an Accountable Care Organisation would be a robust future delivery model; • Ensure patients see primary care as their first port of call in and out of hours; • Maintain our demand management & audit work with Homerton to align clinical behaviours. • Work with our partners to develop an integrated offer for early years which supports everyone to get the best possible start in life.
Safe high-quality hospital services	Support Homerton Hospital to deliver: • Strong 7 day DGH services, meeting fair, benchmarked performance standards and achieving good outcomes; • Services aligned to patient pathways across primary care & specialist services, ensuring minimal impact on local DGH services, patient access and outcomes from redesigned service models; • Improved patient experience, satisfaction and information & join up our IT systems.
Address mental health needs	• Commission access to fast professional care and support to maintain recovery and independence; • Support primary care development and education to deliver more community based provision and parity of esteem.

4 Overseen by:

- Our CCG Board & 2 HWBBs debating & making decisions which affect City & Hackney transparently & in public;
- Our Programme Boards working with patients & clinicians to affect change on the ground in line with our constitution;
- Closer collaboration with Public Health commissioners in the Local Authorities;
- Our providers working in unison under "One Hackney" aligning individual organisational and service responsibilities to deliver shared outcomes;
- Our clinical senate generating ideas & debating & influencing clinical behaviours;
- Co-commissioning with NHSE & other CCGs;
- Organisation leaders meeting & working together for the good of City & Hackney.

5 Measured by:

- User, clinical & process outcomes for each service, contributing to & delivering system outcomes;
- KPIs across aligned contracts & tracking system-wide changes in activity & spend;
- Financial balance maintained & all providers remain viable & without significant performance concerns.

Performance against KPIs

89% of our patients waited less than 18 weeks for the start of their treatment via a hospital admission (RTT Admitted standard) during 2014/15. This is under the target of 90%, but we have achieved the target since November 2014 (91% since then). For our patients at the Homerton, 93% waited less than 18 weeks (2014/15). The target is not being achieved for City and Hackney patients attending Barts (Barts have also suspended RTT reporting since September 2014 due to data issues), Moorfields or UCLH where we work with other CCGs to improve this.

96% of our patients waited less than 18 weeks for the start of their treatment (no admission needed; RTT Non-Admitted standard) during 2014/15 (over the target of 95%). 97% of our patients attending Homerton, Royal Free and Moorfields waited less than 18 weeks, but less than 95% of patients waited less than 18 weeks a Barts and UCLH.

94% of our patients waited less than 18 weeks for the start of their treatment (patients with incomplete pathways; RTT Incomplete standard) during 2014/15 (over the target of 92%). More than 92% of our patients attending the Homerton, Moorfields and Royal Free started treatment within 18 weeks (less than 92% of patients attending Barts or UCLH did).

Homerton have achieved all of the RTT performance standards for every month of 2014/15.

There were less than 1% of patients waiting over 6 weeks for a diagnostic test during 2014/15 (target: less than 1%).

95% of our patients waited for less than 4 hours to be admitted, transferred or discharged from their arrival at an A&E department (above the target of 95%). The target was only missed in November, December and February. The Homerton achieved the 95% of patients being admitted, transferred or discharged within 4 hours across 2014/15, which few other trusts in London did.

Data on ambulance and cancer targets for quarter four (March 2015) was unavailable at time of going to press, so data on quarter four is not included in the tables below. Available data for quarters one to three is included in this report.

Indicator	Operational Standard	Quarter One	Quarter Two	Quarter Three	Quarter Four
Referral to treatment waiting times for non-urgent consultant led treatment					
Admitted patients to start treatment within a max of 18 weeks from referral	90%	86.5%	90.1%	90.7%	91.2%
Non-admitted patients to start treatment within a max of 18 weeks from referral	95%	95.6%	95.5%	96.7%	97.2%
Patients on incomplete non-emergency pathways should have been waiting no more than 18 weeks from referral	92%	92.2%	92.3%	94.9%	95.1%
Number of patients waiting more than 52 weeks	0	88	53	5	6
Diagnostic test waiting times					
% of patients waiting 6 weeks or more for a diagnostic test	99%	99.4%	99.6%	99.4%	99.2
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	95.6%	95.7%	94.9%	94.8
Cancer patients – 2 week wait					
Maximum 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93	94.5	95.2	96.5	
Maximum 2 week wait for first outpatient appt for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93	94.7	94.6	97.5	
Cancer waits – 31 days					
Maximum 31 days wait from diagnostics to first definitive treatment for all cancers	96	97.6	96.5	98.9	
Maximum 31 days wait for subsequent treatment where that treatment is surgery	94	100	100	100	
Maximum 31 day wait for subsequent treatment where the treatment is an anti-cancer drug regime	98	97.8	100	100	
Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	94	97	97.6	98.8	

Indicator	Operational Standard	Quarter One	Quarter Two	Quarter Three	Quarter Four
Cancer waits – 62 days					
Maximum 62 day wait from urgent GP referral to first definitive treatment for cancer	85	83.6	79.6	87.5	
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90	100	90	77.8	
Maximum 62 day wait for first definitive treatment following a consultants decision to upgrade the priority of the patient	N/A	81.4	89.5	92.7	
Category A ambulance calls					
Cat A calls resulting in an emergency response arriving within 8 minutes (Red 1)	75	73.3	67	62.6	
Cat A calls resulting in an emergency response within 8 minutes (Red 2)	75	68	58.7	53.4	
Cat A calls resulting in an ambulance arriving at the scene within 19 minutes	95	95.6	92.6	88.5	

Statutory Basis

The CCG made an application under section 14B of the NHS Act 2006 to be established as a Clinical Commissioning Group (CCG) in 2012 and was authorised to establish City and Hackney CCG under section 14C of the NHS Act 2006 from 15 February 2013.

Authorisation was initially granted with the following conditions:

- Criteria 3.1.1 B – CCG must have a clear and credible integrated plan that meets authorisation requirements;
- Criteria 5.1 A – provide evidence that the CCG has written arrangements in place detailing the scope of collaboration with other CCGs, with clear lines of accountability and decision making processes.

NHS City and Hackney CCG worked closely with our regional NHS England colleagues, and had both conditions removed as part of the formal June 2013 conditions review, as we were able to provide assurance that we had satisfied the criteria requirements. Since that point we have been operating as a fully authorised CCG.

Equality report

We are committed to promoting equality, diversity and human rights for our patients and staff. We recognise that everyone is different, and want to make sure that the services we commission and our employment practices respect, promote and celebrate these differences.

We will protect people from unlawful discrimination, victimisation, bullying or harassment on the grounds of age, disability, gender reassignment, marriage, race, religion or belief (this includes lack of belief) sex (male and female) or sexual orientation. These are the "protected characteristics" identified by the 2010 Equality Act.

We acknowledge and respect the fundamental human right of every person not to be discriminated against on the grounds of perceived difference. Direct and/or indirect discrimination, harassment or victimisation will not be tolerated within the workplace, or in the way we carry out our commissioning business, functions and duties. We are committed to promoting equality of opportunity, eliminating unlawful discrimination and promoting community cohesion. We will seek to protect the right of everyone not to be discriminated against and work to ensure equality of opportunity for all, so that each person can reach their potential.

We welcome applications to work with us from disabled people, who are an under represented group in the workforce of the NHS. We will make reasonable adjustments to make sure disabled workers are not disadvantaged when doing their jobs.

The table below provides a breakdown of staff by gender at the end of the financial year:

	Male	Female
Governing Body	4	4
Employees of the CCG	22	19

In February 2014, we adopted an Equality and Diversity Policy Statement and set the following equality objectives for 2013-17:

- Reduce mental health inequalities amongst communities in east London;
- Reduce mortality from cardiovascular disease and respiratory disease;
- Ensure equitable access to services for residents of City of London;
- Implement the Equality Delivery System.

Additionally, we have reviewed and refined the equalities impact assessment tool and will be utilising the new version to support evaluating the impact of our service specifications.

We are currently finalising a Sustainable Development Management Plan, in which equalities is firmly embedded. This means that by the end of 2015/16, equality, social inclusion and community cohesion issues will be considered at every stage of our commissioning activity, from planning and specifying services through to reviewing the impact and outcomes. More details of our approach to sustainability to follow on page 20.

The 2014 Fund for Health was a joint funding programme by Healthwatch Hackney and ourselves to enable the voices of those who are often not heard directly to be taken into consideration by policy makers and health service providers.

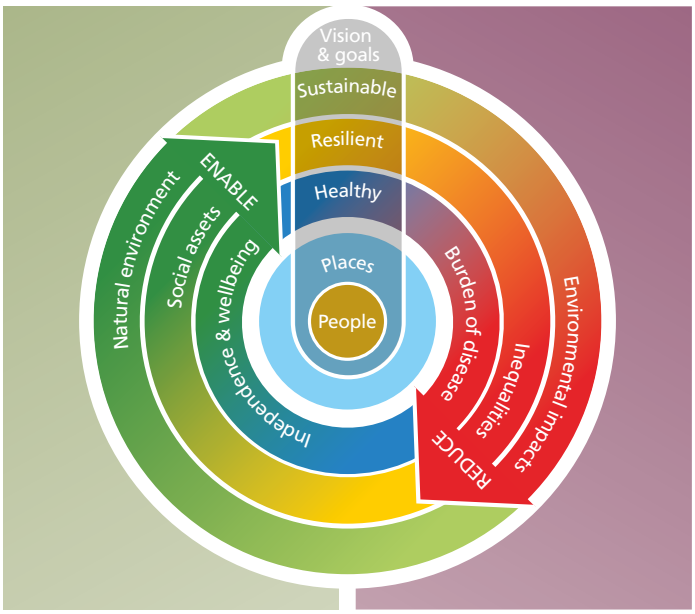
Twenty-three community research projects received funding in order to find out more about how people experience using health services. The aim was to hear from people who don't speak English as their first language, young people, homeless, people with mental health issue and those with learning difficulties or low literacy skills as well as other excluded groups. We also wanted to gather the views of people who use wide range of health services or use them more often than others, such as patients with long term conditions and those caring for others.

The findings and recommendations from the research projects have been shared with commissioners, policy teams and decision makers including not just ourselves but also, London Borough of Hackney and NHS England. They will also inform the criteria for our Innovation Fund 2015.

Sustainability report

Overview

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



The National Sustainability Strategy for Health and Care 2014-2020 sets outs its requirements on the health and care system to incorporate sustainable development into its ethos. Health and wellbeing themselves are both elements of a sustainable society.

Sustainability has to be about reducing the negatives (such as CO2 emissions and poor air quality), but at the same time we must seek and act upon opportunities to enhance positive activity too. We can do this by: supporting local employment and training opportunities, buying locally and ethically, embracing new technology for efficient care pathways, and ensuring we have equality at the heart of our commissioning activity.

Other legislation too has increasing influence on how we design and shape services, including the recently reviewed Social Value Act, which requires social and environmental value to be considered alongside the financial impact when making procurement decisions, and the Climate Change Act, which has legally binding CO2 reduction targets across the UK and the Public Sector Equality Duty, which requires the integration and consideration of equalities and good community relations into our day-to-day work.

To meet these requirements we endeavour to:

- Reduce our own carbon footprint, and that of our supply chain;
- Maximise local and social value in how we commission and procure services; and how we influence our providers and our communities.
- Improve local air quality and improve the health of our community by promoting active travel – to our staff, through our providers and to the patients and public that use the services we commission
- Prepare and prevent from the negative health impacts felt by the changing climate (e.g. heatwaves) and reducing resources (e.g. fuel poverty).
- Tackle the root causes of health issues that are brought on by social factors.
- Improve equality and diversity through the service we commission.
- Working in partnership with providers, the local authority and other CCGs to reduce duplication optimise outputs.

This way of working will not only help us to meet our legislative requirements but, when embedded into our organisation, this sustainable activity will help us to meet the objectives in our five year plan and our core vision as a commissioning organisation.

Our Priorities in 2014/15

At the beginning of the year we set out to:

1) Develop a more detailed local understanding our performance through systematic measurement of environmental impacts across our providers.

How we have achieved this: We have collated data from across our core large providers, and have engaged with a range of providers on their sustainable development goals and ambitions. We are now developing a system to annually monitor and report on their progress against sustainable development targets

2) Exploit the synergies between environmental sustainability and other organisational objectives

How we have achieved this: we have endorsed the Royal College of General Practitioners (RCGP) Foundations for Effective Healthcare Commissioning, which recognises the environmental and health co-benefits of services and health advice which: promote active travel, support the reduction of fuel poverty though more efficient housing, and making best use of the local natural environment.

3) Be active partners in the commissioning of preventive approaches to reduce demand for formal care

How we have achieved this: we have commissioned a social prescribing pilot across half of our member GP Practices that will assess the impact of preventive social approaches to health complaints that aim to target the root cause of the issue (e.g. depression relating to financial stress). We are also working closely with our local authority Public Health colleagues who are responsible for commissioning prevention to ensure our plans are aligned.

4) Exploit the opportunities presented by applying sustainability to procurement policies and embedding performance management approaches to providers.

How we have achieved this: we have developed a process which will commit our core large providers to align to our sustainable ambitions through the contracting process, and in line with the standard NHS Service Conditions. We are currently testing this approach before our planned implementation within the 2015/16 commissioning intentions and in our procurement policy.

5) Improve medicines management and prescribing practice to reduce inefficient or wasteful use of pharmaceuticals

How we have achieved this: we have delivered a research programme into the extent of medicines wastage in City & Hackney, and have delivered a three month campaign to highlight the issue among residents.

Case Studies of 2014/15

Case Study: Social Prescribing

In early 2014 we commissioned a Social Prescribing service that links into 50% of our GP practices. Where a patient's health concern is linked to, or related to, a social factor (for example, isolation, debt, anxiety, low self-esteem, long term unemployed) they are referred to a 'wellbeing coordinator' who help them to identify and access the right support to meet their needs.

Over 80 third sector and statutory organisations are linked to the service who provide a ranges of support including; debt or housing advice, Improving Access to Psychological Therapies (IAPT) services and support to get active. They also offer a number of volunteering opportunities to help service users gain skills and re-gain lost confidence.

The wellbeing coordinator is supported by 20 Social Prescribing volunteers who are often assigned to service users to provide additional support.

Project evaluation will begin later in the year, but to date the service has seen over 400 users and early evidence suggests its impact is creating positive waves in the community. Not only are the service users anecdotally reporting improved health and social outcomes; the service itself is placing much needed volunteers into City & Hackneys communities – with several becoming a second cohort of Social Prescribing volunteers for the service itself.

Case Study: Provider Engagement

Over 99.99% of our environmental impact (CO_2 emissions) sits within our supply chain. Although yet unmeasured we believe that this figure will be similar for our social impact too. Our providers, therefore, must be an integral part of our Sustainable Development Management Plan if we are to make a positive difference.

As part of the Plans development we reached out into our supply chain and engaged with five of our key providers to learn more about sustainability from their perspective, and how they can help us to meet our objectives. We needed to understand:

- What are their challenges, goals and ambitions?
- How does their sustainability agenda align with ours?
- What level of requirement is contractually appropriate from a CCG (what is being asked elsewhere?), and
- What support might they need in to help us all reach our end goal?

To keep the engagement honest and impartial we used an independent sustainability advisor to begin the discussions, and to dig deep into the possibilities of what we might be able to achieve. This engagement exercise has developed into a 'Provider Engagement' work stream within our SDMP where we will continue to engage with our large and small providers and also have plans to discuss how our Commissioning Support Unit can engage with this agenda.

Resources

The National Sustainability Strategy incorporates our obligation to the UKs Climate Change Act (2008). As of March 2015, our two key providers; Homerton University Hospitals and East London Foundation Trust report that they are on track to meet their 10% reduction targets in energy and resource use by the end of March 2015 and continue to develop and improve their Sustainable Development Management Plans.

Organisation Name	Do you have an SDMP?	On track for 10% CO_2 Reduction?
Homerton UHF Trust	Yes	Yes
East London NHS Foundation Trust	Yes	Yes

The next target date is 2020 by which all UK organisations should achieve a 34% reduction (the 2015 target was an NHS-only interim measure). Through our contractual arrangements with providers we plan, in 2015/16, to request solid plans to be in place for providers to meet this target, and we will agree clear milestones over the next five years.

While our own energy and resource use is dwarfed by that of our providers, it is important that we do not think we are 'too small' to matter.

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and CO_2 reductions. We support a culture for active travel, with only a tiny amount of our business travel occurring by car or taxi.

All of our senior team have electronic tablets to enable paperless meetings which reduces our paper use and any unnecessary printing.

Our own resource use for utilities comparing 2013/14 and 2014/15 is shown in the table below – an overall 6% reduction of CO_2.

Resource	2013/14		2014/15	
	Use (kWh)	CO_2 (t)	Use (kWh)	CO_2 (t)
Electricity	49350	27.6	44,404	27.5
Gas	43075	9.1	34035	7.1
Water	350	0.4	358	0.4
Total CO_2		37.1		35

How will we work in 2015/16

Our Sustainable Development Management Plan draws from three 'Value' areas that all support the delivery of our operational plans. We refrain from using the term some might call 'added value'; we feel that 'intrinsic value' is more appropriate for what it can achieve. Our 'value' areas are:

Local: Strengthening and supporting local communities and the local economy, enhancing opportunities for jobs, training and skills.

Equal: Delivering beyond our Equality and Diversity obligations, striving for equal access to services among our communities, reducing isolation and narrowing the gap

Green: reducing CO_2, improving air quality, increasing access to and use of green spaces, active travel, eating well and growing food.

Our challenge this year is to both consider how we can cultivate these values into our operational processes and embed this way of working into 'how we do things around here.'

We will do this in the way we…

…Work with providers

We need our providers to help us to deliver our environmental and social ambitions, and we are proud to say that there is that willing across the board for this agenda. However, our expectations on providers must be both proportional and fair to the level of service and size of organisation.

For our larger providers we will require a continually improved Sustainable Development Management Plan which includes:

- Carbon reduction plans to meet 2020 targets
- Use and benchmarking of the Good Corporate Citizen Tool
- Procurement for carbon reduction and social value

We will offer support by providing guidance on procuring for environmental and social value, and supporting a forums for all providers to engage on the sustainability agenda.

Sustainable Guidance

We are developing a sustainability framework that focusses on, among other elements: CO_2 reduction, social value, sustainable procurement, adapting to climate change, innovation and prevention.

For our smaller providers we will require them to embrace activity from the framework and suggest their own targets; but we will challenge them to be achievable yet stretching.

…Embed Equality & Diversity

By the end of 2015/16, equality, social inclusion and community cohesion issues shall be considered at every stage of our commissioning activity, from planning and specifying services through to reviewing the impact and outcomes.

We have recognised a significant overlap between the Equality Agenda and with many aspects of social value and wider sustainability. We have brought the Equality and Diversity work stream into our Sustainable Development Management Plan to help our staff and stakeholders understand this important stream in the wider context of sustainability, and also to avoid duplication. We are conscious in this action not to dilute the importance of Equality and have planned three training sessions with: Programme Directors, Clinical Leads and our Patient and Public Engagement Forum to upskill our staff and stakeholders and develop an approach to implement our Equality Delivery System.

…Design our services

The biggest efficiencies and impact are often found with design; and commissioning is no different. In 2015/16 we will review the processes within our Business Case Template to identify where improvements may result in more sustainable care pathways.

While this will incorporate an Equalities Impact Assessment, we will also consider how certain factors can be improved, including: CO_2 impact from building energy or travel, patient impact on expectation and level of self-management, time spent accessing a service for patients and carers, local opportunities for employment or training, the use of technology and innovation and assessing the likely impact of climate change on the service

…Improve our Patient and Public forums

We already gather feedback from Patient and Public Forums, from provider evaluations and from organisations such as Healthwatch. Rather than create a whole new criteria for which we shall measure and evaluate sustainable achievement we will work with these outlets to identify the best way to utilise these forums to gather feedback and intelligence and help us to analyse our impact and improve outcomes.

…Collaborate with wider stakeholders

Our GP members, our local authorities, other local CCGs (especially those with which we share our providers) the police, fire brigade, and ambulance services, and private sector businesses both in the local area, and those who contract to us or within our supply chain. All the above and more are potential partners in our Sustainability Strategy for City and Hackney CCG and throughout the year must engage, understand, and align and support priorities as appropriate too.

Accountable Officer self-certification

I certify that the clinical commissioning group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

This Strategic Report has been approved by City and Hackney's CCG's Governing Body.

Paul Haigh
Accountable Officer
Thursday 28 May 2015

Members report

The tables below provide details of our Member Practices and which consortium they work within:

Klear Consortium

Abney House Medical Centre
Brooke Road Surgery
The Dalston Practice
Healy Medical Centre
Kingsmead Health Centre
Latimer Health Centre
The Lea Surgery
Richmond Road Medical Centre
Riverside Surgery
Tollgate Lodge Primary Care Centre

South West Consortium

DeBeauvoir Practice
Hoxton Surgery
The Lawson Practice
Neaman Surgery
Queensbridge Group Practice
Shoreditch Park Surgery

North West Hackney Consortium

Barton House Health Centre
Cedar Practice
Cranwich Road Surgery
Heron Practice
Springfield Medical Centre
Statham Grove Surgery

Rainbow and Sunshine Consortium

Athena Medical Centre
Beechwood Medical Centre
Clapton Surgery
Gadhvi Practice
Rosewood Practice
Sandringham Practice
Southgate Road Practice

North East Hackney Consortium

Allerton Road Surgery
Barretts Grove Surgery
Elm Practice
Nightingale Practice
Somerford Grove Practice
Stamford Hill Group Practice

Well Consortium

Elsdale Street Surgery
Green House Health
London Fields Medical Centre
Lower Clapton Health Centre
Sorsby Health Centre
Trowbridge Practice
Well Street Surgery
Wick Health Centre

Members of the Governing Body

During the period, the following individuals remained in post throughout the year and up to the signing of the annual report and accounts:

Governing Body Role	Name
Chair	Clare Highton
Accountable Officer	Paul Haigh
Chief Finance Officer	Philippa Lowe
General Practitioner	Haren Patel
General Practitioner	Gary Marlowe
Governance Lay Member	Mariette Davis
Secondary Care Consultant	Christine Blanchard
Independent Nurse	Siobhan Clarke

In addition, the following members of the Governing Body were also in post throughout the periods indicated below:

Governing Body Role	Name	Dates
Public and Patient Involvement Lay Member	Jaime Bishop	April 2014 to September 2014
Public and Patient Involvement Lay Member	Catherine Macadam	September 2014 to present

Members of the Audit Committee

During the period, the following individuals remained in post throughout the year and up to the signing of the annual report and accounts:

Audit Committee Role	Name	Dates
Audit Committee Chair	Mariette Davis	April 2014 to present
Audit Committee Member	Honor Rhodes	April 2014 to present
Audit Committee Member	Jaime Bishop	April 2014 to September 2014
Public and Patient Involvement Lay Member	Catherine Macadam	September 2014 to present

The following individuals or organisations have regularly attended the Audit Committee:

Audit Committee Role	Name
CCG Accountable Officer	Paul Haigh
CCG Chief Finance Officer	Philippa Lowe
CCG Head of Corporate Services	Karl Thompson
Internal Auditors	Baker Tilly
External Auditors	KPMG

Please refer to the profiles section below for conflict of interest declarations and the Governance Statement on page 47 for details of other committees and sub-committees.

Governing Body Profiles

Dr Clare Highton

Job Title	CCG Chair
Member of the Governing Body from/to	1 April 2013 – current

Profile

Dr Highton is passionate about clinical commissioning and how it can bring patient benefit if we work with our provider colleagues and patients. She was a Professional Executive Committee Co-Chair with the NHS City and Hackney Primary Care Trust but stepped down to set up East London Integrated Care (ELIC). She believes in a flat and democratic structure for CCGs and that we need to continue to trust rather than instruct clinicians to deliver cost-effective care.

Member of bodies & committees

- Chair of the CCG Governing Body, 1 April 2013 – current
- Chair of the Finance and Performance Committee, 1 April 2013 – current
- Chair of the Clinical Commissioning Forum, 1 April 2013 – current
- Chair of the Long Term Conditions Programme Board, 1 April 2013 – current
- Co-Chair of the Integrated Care Programme Board, 1 April 2014 – current
- Member of the Clinical Executive Committee, 1 April 2013 – current
- Member of the Safeguarding Group, 1 April 2013 – current
- Member of the Prioritisation and Investment Committee, 1 April 2014 – current
- Member of the Remuneration Committee, 1 April 2013 – current
- Member of the Children's Services Programme Board, 1 April 2013 – current

Declared interests and conflicts

"Principal GP and partner at Lower Clapton Group Practice, our practice now provides a CCG Commissioned community ENT clinic run by my GP partner Dominic Roberts with an ENT consultant. Practice provides GMS and APMS. The practice also employs 3 Heart Failure nurses and their HCA.

Lower Clapton is a research associate practice, so does not hold grants but does participate in research that is funded."

"Rob Senior, the Medical Director at the Tavistock and Portman NHS Trust is my husband."

"Daughter is a trainee Psychiatrist in East London."

"Practice is a member of City and Hackney Urgent Healthcare Social Enterprise."

"Practice is a member of the City and Hackney GP Confederation."

"Practice Partner is a member of the LMC."

"Daughter-in-law works for Body and Soul, HIV Charity"

"Extended Family live locally, and use local services."

Dr Haren Patel

Job Title	CCG Clinical Vice Chair
Member of the Governing Body from/to	1 April 2013 – current
Profile	Dr Patel has been a GP in City and Hackney for 22 years, with a special interest in mental health, intermediate care and nursing home services. He was a board member for City & Hackney Primary Care Trust for 12 years. He currently leads the CCG prescribing Programme Board. He is passionate about the NHS and strongly believes the new changes will increase the number of services and choice for patients, making it a truly patient-led service.
Member of bodies & committees	• Member of the CCG Governing Body, 1 April 2013 – current • Chair of the Clinical Executive Committee, 1 April 2013 – current • Chair of the Prescribing Programme Board, 1 April 2013 – current • Chair of Klear Consortia, 1 April 2013 – current • Member of the Prioritisation and Investment Committee, 1 April 2014 – current
Declared interests and conflicts	"Senior Clinician and Management Lead for Project and Intermediate/Secondary Mental Health Service Provision. Interest in mental health services at the Latimer PMS Plus Practice. Partner, Dr Geeta Patel clinician with special interest." "Part owner of pharmacy with daughter and son-in-law in Brent." "Member and Co-Chair of North East London Medicine Management Committee." "Member of East London Medical Committee" "Member of the City and Hackney Local Medical Committee (the representative body for GPs)." "Member of City & Hackney GP Confederation as one of the GPs in City & Hackney. This organisation provides services on nhs contracts from City & Hackney CCG." "Lead Clinician providing NHS GMS and Enhanced Services under Nursing Home LES to the Acorn Lodge Nursing Home. Interest in intermediate care and community services under PMS contract."

Dr Gary Marlowe

Job Title	CCG Board GP
Member of the Governing Body from/to	1 April 2013 – current
Profile	Dr Marlowe trained at St Bartholomew's Medical School and has been a GP in City and Hackney for the last 23 years apart from a brief hiatus in Wales and Gloucester which helped broaden his perspective. He was a Clinical Lecturer at St Bartholomew's Department of General Practice and maintains a keen interest in evidence based medicine. He is Chair of the London regional Council of the BMA and actively campaigns for an NHS that holds true to its founding principles. He is the clinical lead for the Planned Care Programme Board and believes that collaboration and trust in the professionalism of the health service across primary and secondary care focusing on the patient respecting their opinion will deliver the best care which also happens to be cost-effective care.
Member of bodies & committees	• Member of the CCG Governing Body, 1 April 2013 – current • Member of the Clinical Executive Committee, 1 April 2013 – current • Chair of the Planned Care Programme Board, 1 April 2013 – current • Joint Chair of South West Hackney Consortia, 1 April 2013 – current • Member of the Prioritisation and Investment Committee, 1 April 2014 – current
Declared interests and conflicts	"Lead GP at De Beauvoir Surgery." "Member of City and Hackney Urgent Health Care Social Enterprise (CHUHSE)." "British Medical Association London Regional Council Chair." "City and Hackney Local Medical Committee (LMC) member." "Practice is a member of CHUHSE." "Practice is a member of the City and Hackney GP Confederation."

Paul Haigh

Job Title	CCG Chief Officer
Member of the Governing Body from/to	1 April 2013 – current
Profile	Paul has worked in the NHS since 1978. He has worked with Hackney GPs since 2005 and helped them set up East London Integrated Care (ELIC) a social enterprise to deliver practice based commissioning. He led the CCG Pathfinder work and has previous experience as a PCG and PCT CEO in London as well as hospital management experience alongside extensive NHS commissioning work. Paul's passion is to make very tangible differences for our patients and to help our clinicians realise their ambitions.
Member of bodies & committees	• Member of the CCG Governing Body, 1 April 2013 – current • Member of the Finance and Performance Committee, 1 April 2013 – current • Member of the Clinical Executive Committee, 1 April 2013 – current • Member of the Safeguarding Group, 1 April 2013 – current • Member of the Prioritisation and Investment Committee, 1 April 2014 – current • Member of the Contracts Committee, 1 April 2014 – current
Declared interests and conflicts	"Chief Executive of ELIC (East London Integrated Care).Dormant practice based commissioning organisation which has ceased operating and will close in 2015." "Partner – Helen Bullers is Regional Director of HR and Organisational Development (London), NHS England."

Philippa Lowe

Job Title	CCG Chief Financial Officer
Member of the Governing Body from/to	1 April 2013 – current
Profile	Philippa is a member of the Chartered Institute for Public Finance & Accountancy. She has held a number of senior roles in the NHS, Local Government, and other public bodies, such as Chief Executive of a Community Health Trust and Finance Director of an Acute Hospital. She has a passion for delivering excellence in public services and making the best use of resources to improve peoples' lives.
Member of bodies & committees	• Member of the CCG Governing Body, 1 April 2013 – current • Member of the Finance and Performance Committee, 1 April 2013 – current • Member of the Clinical Executive Committee, 1 April 2013 – current • Member of the Prioritisation and Investment Committee, 1 April 2014 – current • Member of the Contracts Committee, 1 April 2014 – current
Declared interests and conflicts	"Director at PIQAS Ltd, dormant company." "Group Audit Chair and Development Committee member for GreenSquare Group, a group of housing associations. "

Jaime Bishop

Job Title	CCG Public and Patient Involvement Lay Member – 1 April 2013 to 31 August 2014 Associate Lay Member – 1 September 2014 to current
Member of the Governing Body from/to	1 April 2013 – current

Profile

Jaime is an architect by profession, and is a director of a practice based in East London. Between 2006 and 2014 he sat on the executive committee of Architects for Health and now is a lecturer in undergraduate design at London South Bank University. He sat on the board of Governors for Homerton NHS Foundation Trust Hospital between 2009 and 2012.This role led towards his involvement in the East London Integrated Care (ELIC) society and latterly the City and Hackney CCG. He is actively involved in both a governance and Public and Patient Involvement (PPI) role contributing and advocating for the lay voice in the CCG.

Member of bodies & committees

- Chair of the Public and Patient Involvement (PPI) Committee, 1 April 2013 – 31 August 2014
- Chair of the Prioritisation and Investment Committee, 1 April 2014 – 31 August 2014
- Chair of the Contracts Committee, 1 April 2014 – current
- Member of the Clinical Executive Committee, 1 April 2013 – 31 August 2014
- Member of the Audit Committee, 1 April 2013 – 31 August 2014
- Member of the Remuneration Committee, 1 April 2013 – 31 August 2014
- Member of the CCG Governing Body, 1 April 2013 – 31 August 2014
- Non-voting Member of the CCG Governing Body , 1 September 2014 – current

Declared interests and conflicts

"Director of Fleet Architects LTD, a company working on socially valuable buildings. We do not currently have any involvement in the City and Hackney area. 50% shareholder in Fleet Architects. Fleet have been appointed in 2013 to advise on the reconfiguring of property in Newham (The Centre Manor Park) which involves liaising with tenants including the CHS arm of the East London Foundation Trust (ELFT).

"Architects" own 33% of HealthPorts LTD, a (as yet not trading at all) company established to design accessible sustainable modern health centres. Fleet provide design services. There are currently no projects although in the course of researching new projects HealthPorts has contact both with the NHS, GPs and other health providers outside of the City and Hackney Area."

"Executive Board Member and Head of Education at Architects for Health. I run annual Student Design Competitions in conjunction with other healthcare stakeholders including NHS Trusts. 2011 and 2012 were in conjunction with Guys and St Thomas NHS FT."

"Patient at a Hackney General Practice, Barretts Grove."

"Member of the ELIC (East London Integrated Care) LTD (a Practice Based Commissioning body) Audit Committee that is overseeing the wind up of the dormant social enterprise. ELIC is now defunct save some final legal winding up proceedings underway."

"Member of Healthwatch Hackney."

Catherine Macadam

Job Title	CCG Public and Patient Involvement Lay Member
Member of the Governing Body from/to	September 2014 – present
Profile	Catherine has lived in Hackney for nearly 30 years. She works as a coach/mentor and consultant for public and voluntary sector organisations, having worked for 23 years in local government. As a former carer and someone with a disability, she is interested in supporting unpaid carers and people with disabilities. Catherine is a volunteer life coach at City and Hackney Carers Centre, helping carers to develop greater confidence and resilience. Catherine has been a member of the British Medical Association's Patient Liaison Group since 2010, and its chair since 2013. She is a member of UK Council of the BMA and the patient representative on the General Practitioners Committee.
Member of bodies & committees	• Chair of the Public and Patient Involvement (PPI) Committee, 1 September 2014 – current • Chair of the Prioritisation and Investment Committee, 1 September 2014 – current • Member of the CCG Governing Body, 1 September 2014 – current • Member of the Clinical Executive Committee, 1 September 2014 – current • Member of the Audit Committee, 1 September 2014 – current • Member of the Remuneration Committee, 1 September 2014 – current
Declared interests and conflicts	"Chair of the British Medical Association Patient Liaison Group, also Council Member." "Owner/Sole Trader, Catherine Macadam, Coaching/Mentoring and Consulting." "Volunteer and Occasional Sessional Worker, City and Hackney Carers Centre." "Associate Consultant, People Opportunities Ltd." "Family members and myself are registered with Nightingale Practice (CCG Member Practice)." "Lambeth Living, husband is a Director."

Mariette Davis

Job Title	CCG Governance Lay Member
Member of the Governing Body from/to	1 April 2013 – current
Profile	Mariette is a Fellow of the Institute of Chartered Accountants in England and Wales and has thirty six years executive experience. She has held senior positions in a Professional Accountancy Firm and also in the Financial Services industry. Mariette was a Partner in Grant Thornton, a Director of Strategy in NM Rothschild & Sons Asset Management and Finance Director of Legal and General Ventures. She has worked in a non-executive capacity for the NHS since April 2010, including the position of Audit Chair of Tower Hamlets PCT and City and Hackney PCT. Currently, in addition to roles as Lay Member for Governance for City and Hackney CCG and Tower Hamlets CCGs, Mariette operates as a consultant, providing services to the private equity sector.
Member of bodies & committees	• Member of the CCG Governing Body, 1 April 2013 – current • Member of the Finance and Performance Committee, 1 April 2013 – current • Chair of the Audit Committee, 1 April 2013 – current • Chair of the Remuneration Committee, 1 April 2013 – current
Declared interests and conflicts	"Lay Member for Governance for Tower Hamlets CCG." "Advisor, Acanthus Advisers Private Equity Limited."

Honor Rhodes

Job Title	CCG Associate Lay Member
Member of the Governing Body from/to	1 April 2013 – current
Profile	Honor's key area of responsibility is child and adult safeguarding. She has expertise in developing partnerships and in early intervention and is currently Director of Strategy at the Tavistock Centre for Couple Relationships. Honor is particularly interested in effective interventions with hard to help families affected by very poor health. She writes short guides for practitioners and was awarded an OBE in July 2010 for her work with children and families.
Member of bodies & committees	• Non voting member of the CCG Governing Body, 1 April 2013 – current • Chair of the Safeguarding Group, 1 April 2013 – current • Member of the Audit Committee, 1 April 2013 – current • Member of the Remuneration Committee, 1 April 2013 – current
Declared interests and conflicts	"I, partner and one child are patients at Barton House Practice (CCG Member Practice)." "Employed as Director at Tavistock Centre for Couple Relationships." "Non-Executive Director, Children and Family Courts Advisory and Support Service (CAFCASS)." "Trustee and Company Secretary of Early Intervention Foundation." "Mentor to CEO of The Institute of Wellbeing." "Partner is Consultant Family Therapist at Oxleas CAMHS."

Siobhan Clarke

Job Title	CCG Governing Body Nurse
Member of the Governing Body from/to	1 April 2013 – current
Profile	Siobhan is a Registered Nurse, District Nurse and Practice Teacher with 36 years' experience in health and social care. She has held a number of senior nurse manager and leadership roles across a number of environments – acute, primary care, community, health authority, local authority, third and independent sectors. She is currently the Managing Director of Your Healthcare Community Interest Company. Prior to this she was the Chief Nurse and Executive Director of Operational Services at Hillingdon Primary Care Trust which included responsibility for a range of joint commissioning portfolios. Siobhan is a founding Director of Albion Care Alliance CIC, and the related group of companies, who have just been involved in the delivery of the Department of Health/Cabinet Office Mutuals in Health programme.
Member of bodies & committees	• Member of the CCG Governing Body, 1 April 2013 – current
Declared interests and conflicts	"Managing Director at Your Healthcare CIC." "Director of Albion Care Alliance CIC." "Director of Albion Healthcare Alliance LTD."

Christine Blanshard

Job Title	CCG Governing Body Consultant
Member of the Governing Body from/to	1 April 2013 – current
Profile	Christine graduated in Medicine from Cambridge University in 1986 and has almost 30 years NHS experience. She trained in East Anglia and London and became a consultant gastroenterologist and general physician in 1998, working at the Homerton hospital for 13 years. She has undertaken a variety of managerial roles alongside her clinical work. She is currently the Medical Director at Salisbury Hospital NHS Foundation Trust, where she has overall responsibility for delivering high quality clinical care to its patients.
Member of bodies & committees	• Member of the CCG Governing Body, 1 April 2013 – current • Member of the Prioritisation and Investment Committee, 1 April 2014 – current • Member of the Contracts Committee, 1 April 2014 – current
Declared interests and conflicts	"Medical Director at Salisbury Hospital NHS Foundation Trust that does not hold any contracts with the CCG."

The details provide above are correct for 2014/15 financial year. The latest register of interests can be found on our website **2015/16 register of Interests**

Statement as to disclosure to auditors

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

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

Pension liabilities

For details of how pension liabilities are treated in the accounts, please refer to the accounting policy note in the financial statements (page 75) and the pensions section of the Remuneration Report (page 40).

Member's interests

The interests of the members of the Governing Body are included in their profiles on page 29. A register of interests of all regular attendees at any CCG meeting is updated monthly and is available to view on our website **http://www.cityandhackneyccg.nhs.uk/**. We have undertaken a thorough review of members' interests, the register and handling conflicts of interest this year.

External auditor's remuneration

The appointed external auditor for NHS City & Hackney CCG is KPMG, and they are appointed by the Audit Commission. The fee for the statutory audit for the 2014/15 financial year is £95,400 (including VAT, which is not recoverable). This single fee is inclusive of the statutory audit, other statutory activities under the Code of Practice (value for money work) and the Whole of Government Accounts Group Reporting requirements.

KPMG provided no other services to the CCG in 2014/15.

Sickness absence data

For information on sickness absence within the CCG, please see the employee benefits note to the Financial Statements (page 81)

Cost allocation and charges for information

We certify that the clinical commissioning group has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

Disclosure of personal data related incidents

There have been no serious untoward incidents involving data loss or confidentiality breaches.

Employee consultation

We established in 2013, a very active Staff Council which all CCG staff are invited to attend. The Staff Council is chaired by one of our Programme Directors and is a forum where any matters relating to or impacting on staff is discussed. All staff members work together to develop and approve CCG employment and other policies and it is a key element of employee consultation and how we work together. It helps ensure we avoid being a 'top down' organisation and helps empower all our staff to contribute to how we work and so to our collective success.

Equality disclosure

Disabled employees

We are committed to promoting equality, diversity and human rights for our residents and staff. We recognise that everyone is different, and want to make sure our services and employment practices respect, promote and celebrate these differences.

Equal opportunities

We are all about making a real difference to the lives of people in Hackney and the City of London. We are a membership organisation where every decision is led by our patients and their GPs. We aim to be relaxed, informal, non-bureaucratic but firmly focussed on delivering great care as efficiently as possible. We are a small organisation so individual contributions really matter – people work hard and flexibly here but they feel valued and they are able to do great work.

We serve a very diverse population and we like diversity in our workforce – we don't care how people look, get around or run their lives – we just need their talents, ideas and commitment. We invest in our people and we want to see them grow and develop here.

Health and Safety

We recognise that the maintenance of a safe place of work and safe working environment is critical to our continued success and accordingly, we view our responsibilities for health, safety and welfare as really important.

We require all our staff to equally accept their responsibilities as part of the development of a true safety culture. We aim to ensure the achievement of high standards in relation to the provision of health and safety arrangements and the continued development of the safety culture and the well-being of our staff.

The nature of our activities means that a wide range of risks exist, but through the implementation of related policies, we continue to ensure that all significant risks to health are reduced so as far as is reasonably practicable.

We are committed to the continuing development of arrangements to support health, safety and wellbeing including risk management and fire safety, and to promote a proactive safety culture. We continue to ensure that sufficient resources are available to fulfil these objectives including the provision of relevant training, information and supervision.

Fraud

We have continued to engage Baker Tilly as our Local Counter Fraud Specialist (LCFS) in 2014/15. The LCFS has an annual plan agreed by the CCG Audit Committee, undertaking training, advice and review to support us in countering fraud. During the year the LCFS undertook fraud and bribery awareness training sessions for staff groups and also the CCG Governing Body; reviewed our procurement policies and practices, supported us in the National Fraud Initiative and reviewed progress with actions from the Fraud Risk Assessment undertaken in 2013/14. No items of fraud or bribery came to the attention of the CCG Audit Committee or Governing Body in 2014/15.

Better Payments Practice Code

The Better Payment Practice Code requires the clinical commissioning group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. We paid 94.7% of non-NHS invoices by value and 95.2% by volume in accordance with this requirement. Full details of compliance with the code are given in the notes to the financial statements on page 84.

Prompt Payments Code

We have not as yet signed up to the prompt payment code, but we are working towards doing so.

Emergency preparedness

A major incident or emergency is usually defined as any event which causes threat, injury, death, damage to property or the environment or disruption to the community where the impact cannot be handled within routine service arrangements.

We work with local partners across City and Hackney with the Chief Officer responsible for the Emergency Planning Resilience and Response (EPRR) provision for our organisation. Senior staff are part of an on-call rota across inner north east London.

We certify that we have incident response plans in place, which are fully compliant with the NHS England Emergency Preparedness Framework 2013. We regularly review and make improvements to our major incident plan and have a programme for regularly testing this plan.

Principles for remedy

We have a complaints policy, which is administered by the North East London Commissioning Support Unit on our behalf. Complaints handling aims to represent best practice at all times and takes account of the principles set out in the May 2010 Parliamentary and Health Service Ombudsmen 'Principles for Remedy'.

Exit packages and severance payments

There were no exit packages or severance payments paid by the CCG in 2014/15

Off-payroll engagements

Table 1

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

	Number
Number of existing engagements as of 31 March 2015	3
Of which, the number that have existed:	
• for less than one year at the time of reporting	3
• for between one and two years at the time of reporting	0
• for between 2 and 3 years at the time of reporting	0
• for between 3 and 4 years at the time of reporting	0
• for 4 or more years at the time of reporting	0

We confirm 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, assurance has been sought.

Table 2

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

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	3
Of which, the number that have existed:	
Number of new engagements which include contractual clauses giving NHS City and Hackney CCG the right to request assurance in relation to income tax and NI obligations	3
Number for whom assurance has been requested	0
• assurance has been received	0
• assurance has not been received	0
• engagements terminated as result of assurance not being received	0

Table 3

	Number
Number of off-payroll engagements of board members and/or senior officers with significant financial responsibility during the year	0
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	5

Paul Haigh
Accountable Officer
Thursday 28 May 2015

Remuneration report

Remuneration and terms of service 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.

One meeting was held on Friday 15 July 2014, attended by the following:

CCG Role	Name
Chair	Clare Highton
Governance Lay Member	Mariette Davis
Public and Patient Involvement Lay Member	Jaime Bishop

Remuneration

There has been no payment of performance-related pay during the year ending 31 March 2015. Any 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.

Contractual arrangements

The Chair and other GP members are elected by the membership and the lay membership appointed by the CCG Governing Body. The details of terms of appointment and length of office for all Board posts are contained in our constitution which is accessible on our website or on request.

The Chief Officer and the Chief Financial Officer are on permanent contracts.

Salaries and Allowances

The table below shows the Salaries and Allowances of Senior Managers in 2014/15: These are reflected in the Statement of Comprehensive Net Expenditure on page 81.

			2014-15						Dates served	
NOTE	NAME	TITLE	Salary (bands of £5,000) £000	Expense Payments (taxable) (to the nearest £100) £00	Performance pay and Bonuses (bands of £5,000) £000	Long-term Performance pay and bonuses (bands of £5000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000	Date Started	Date Ended (if applic)
	Executive Directors									
1	Paul Haigh	Chief Officer	115 – 120	0	0	0	0	115 – 120		
	Philippa Lowe	Chief Financial Officer	110 – 115	0	0	0	67.5 – 70	180 – 185		
	Non Executive Directors									
	Clare Highton	Chair	65 – 70	0	0	0	0	65 – 70		
	Gary Marlowe	Board GP	15 – 20	0	0	0	0	15 – 20		
	Haren Patel	Clinical Vice Chair	10 – 15	0	0	0	0	10 – 15		
	Siobhan Clarke	Board Nurse	5 – 10	0	0	0	0	5 – 10		
	Christine Blanshard	Board Consultant	5 – 10	0	0	0	0	5 – 10		
	Jaime Bishop	Associate Lay Member	5 – 10	0	0	0	0	5 – 10		31/08 2014
	Catherine MacAdam	Public & Patient Involvement Lay Member	10 – 15	0	0	0	0	10 – 15	01/09 2014	
	Mariette Davis	Governance Lay Member	10 – 15	0	0	0	0	10 – 15		
	Honor Rhodes	Associate Lay Member	10 – 15	0	0	0	0	10 – 15		

Notes
1 Member opted out of the NHS Pension Scheme from 1st April 2014.

Explanatory notes relating to new guidance issued by the Department of Health relating to GP Governing Body members are below:

- GPs who have a contract for service are not classed as employees of the CCG, and are considered to be "off-payroll". This is notwithstanding that, under Her Majesty's Revenue and Custom's (HMRC) rules, the CCG is required to deduct income tax and national insurance at source for these individuals;
- For those GPs with a contract for service, the 2014/15 "Salary" figures now include employer pension contributions.

In accordance with this guidance, the 2013/14 salary figures now include the employer's pension contributions, as indicated in Note 1 below, to ensure a meaningful comparison year on year.

			2013-14						Dates served	
			Salary & Fees	Taxable Benefits	Annual Performance Bonuses	Long-term Performance Bonuses	All Pension Related Benefits	Total	Com-menced	Ceased
			(Bands of £5,000)	Rounded to the nearest £00	(Bands of £5,000)	(Bands of £5000)	(Bands of £2,500)	(Bands of £5,000)		
NOTE	NAME	TITLE	£000	£00	£000	£000	£000	£000		
	VOTING MEMBERS									
	Executive Directors									
	Paul Haigh	Chief Officer	115 – 120	0	0	0	212.5 – 215	325 – 335	01/04/2013	
	Philippa Lowe	Chief Financial Officer	110 – 115	0	0	0	12.5 – 70	120 – 135	01/04/2013	
	Non Executive Directors									
1	Clare Highton	Chair	65 – 70	0	0	0	0	65 – 70	01/04/2013	
1	Gary Marlowe	Board GP	15 – 20	0	0	0	0	15 – 20	01/04/2013	
	Haren Patel	Clinical Vice Chair	10 – 15	0	0	0	0	10 – 15	01/04/2013	
	Siobhan Clarke	Board Nurse	0 – 5	0	0	0	0	0 – 5	01/04/2013	
	Christine Blanshard	Board Consultant	5 – 10	0	0	0	0	5 – 10	01/04/2013	
	Jaime Bishop	Associate Lay Member	5 – 10	0	0	0	0	10 – 15	01/04/2013	
	Mariette Davis	Governance Lay Member	15 – 20	0	0	0	0	10 – 20	01/04/2013	
	Honor Rhodes	Associate Lay Member	10 – 15	0	0	0	0	10 – 15	01/04/2013	

No prior year comparison figures are included as the CCG was created on 1st April 2013

1 In 2014/15, pension disclosures are not required for GP Governing Body members who have a contract for services. In accordance with Department of Health guidance, the 2013/14 figures have been re-stated to ensure meaningful year comparisons, namely:
– Salary figures now include employer pension contributions: and
– Pension Related Benefits figures have been removed as pensions disclosures are not required

Pension Benefits

The table below shows the Pension Benefits of Senior Managers in 2014/15:

			2014-15							
			Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31st March 2015	Lump sum at age 60 related to accrued pension at 31st March 2015	Cash equivalent transfer value at 1st April 2014	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31st March 2014	Employers contrib-utation to stakeholder pension
			(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5000)	(to nearest £1,000)	(to nearest £1,000)	(to nearest £1,000)	(to nearest £1,000)
NOTE	NAME	TITLE	£000	£00	£000	£000	£000	£000	£000	£000
	Philippa Lowe	Chief Financial Officer	2.5 – 5	10 – 12.5	45 – 50	135 – 140	799	99	920	0

Certain individuals disclosed in the Salary and Allowances table are not included in the Pension Benefits table. The reasons for this include:

- Some non-executive members do not receive pensionable remuneration; or
- An executive director may have opted out of the pension scheme; or
- Pension disclosures are not required for GP Governing Body members who have a contract for service. This is a change from last year's Department of Health guidance.

The table below shows the Pension Benefits of Senior Managers in 2013/14. In line with Department of Health guidance, this excludes a GP member who had a contract for service in 2013/14, which had been disclosed last year.

2013-14									
NAME	TITLE	Real increase/ decrease in pension at age 60 (Bands of £2,500)	Real increase/ decrease in lump sum at aged 60 (Bands of £2,500)	Total accrued pension at age 60 at 31st March 2014 (Bands of £5,000)	Total accrued related lump sum at age 60 at 31st March 2014 (Bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31st March 2013	Cash Equivalent Transfer Value (CETV) at 31st March 2014	Real increase/ decrease in Cash Equivalent Transfer Value	Employers contrib-utation to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
Board Members									
Paul Haigh	Chief Officer	7.5 – 10	27.5 – 30	50 – 55	156 – 160	859	1103	225	0
Philippa Lowe	Chief Financial Officer	0 – 2.5	2.5 – 5	40 – 45	120 – 125	757	799	25	0

Cash Equivalent Transfer Value

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.

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.

Pension Contribution Rates

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

Full-time pensionable pay/earnings used to determine contribution rate	2014/15
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	2015/16
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 NHS Pensions and are applicable to all members.

Past and present employees are covered by the provisions of the NHS pension scheme.

Scheme benefits are set by the NHS Pensions and are applicable to all members. All employees are covered by the provisions of the NHS pension scheme. For full details of how pension liabilities are treated please refer to page 81 of the Annual Accounts.

Pay Multiples

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 calculation is based on the full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis, and the figures below, including that for the banded remuneration of the of the highest paid director/member in 2014/15, have been calculated on this basis.

The banded remuneration of the highest paid director/member in NHS City & Hackney CCG in the financial year 2014-15 was £155k to £160k (2013-14, £135k to £140k). This was 3.3 times (2013-14 3.1 times) the median remuneration of the workforce, which was £48,050 (2013-14, £37,600).

In 2014-15, nil (2013-14, nil) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £10k-£15k to £155k-£160k (2013-14 £0k-£5k to £135k-£140k).

In 2014/15, there has been an increase in the number of staff within the CCG as a result of bringing in house of a number of services that were previously provided by other external organisations.

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.

	2014/15	2013/14
The banded remuneration of the highest paid director / member	£155k – £160k	5.0%
Median remuneration of the CCG workforce	£48,050	5.6%
Ratio of highest paid director / member to median paid employee	3.3	7.1%
No. of employees who were paid more than the highest paid director / member	0	0
Remuneration ranges in the year	£10k – £15k to £155k – £160k	£0 – £5k to £135 – £140k

Remuneration Report Certification

I certify that the information contained in this Remuneration Report complies with NHS England guidance and the clinical commissioning groups statutory responsibilities.

Paul Haigh
Accountable Officer
Thursday 28 May 2015

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Officer, Paul Haigh, 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 Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

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

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

- 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 Clinical Commissioning Group Accountable Officer Appointment Letter.

Paul Haigh
Accountable Officer
Thursday 28 May 2015

Governance statement

Introduction & Context

The clinical commissioning group was licensed from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

As at 1 April 2014, the clinical commissioning group was licensed without conditions.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

Compliance with the UK Corporate Governance Code

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

The CCG Governing Body operates under the principles of good governance – accountability, transparency, probity and focuses on the sustainable success of the CCG over the longer term as laid down by "The Healthy NHS Board Principles of Good Governance" – National Leadership Council and the "NHS Clinical Commissioning Groups Code of Governance" – ICSA November 2013.

Good governance is embedded in our values and how we operate and enshrined in our constitution. The Governing Body benefits from the strong clinical leadership of its GP Chair and the challenge provided by its diverse and experienced Lay, Clinical and independent Members as well as the contributions of our Healthwatches, our patients in both the PPI committee and programme boards and debates at our Health and Wellbeing Boards. The Governing Body places a high emphasis on conducting its business in a transparent manner in public, and accepts questions and challenges from public attendees throughout each of its meetings, seeking to engage and involve local residents and patients in our discussions. We try to avoid meeting, making decisions and conducting business in private and publish all our papers on our website for public scrutiny.

The Governing Body conducts an annual self-assessment process, involving members questioning and challenging each other on our effectiveness and ways of working in order to highlight and implement possible improvements. This process also feeds into the annual development of strong leadership objectives, which flow from the Governing Body across the whole of the CCG. We operate a learn by doing approach and have run a number of training sessions where we take real situations or issues and test out our systems and processes

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.*

The CCG membership comprises the 43 GP practices within the area of City of London and Hackney. The membership retains authority for Governing Body appointments via our members' forum and for holding the Governing Body to account for carrying out their wishes. GP Governing Body members are appointed following an open election from the

membership. Each member practice is represented at one of a number of Consortia of practices, the Chairs of those Consortia being elected and becoming members of the Clinical Executive Committee, which is a committee accountable to the Governing Body.

The CCG Governing Body membership

The Governing Body has the following members:

- Three GP members:
  - One of whom is the Chair of the Governing Body and the CCG;
  - One of whom is the Clinical Vice Chair and chairs the Clinical Executive Committee;
  - One of whom is a Governing Body GP.
- Two Lay Members:
  - One to lead on governance, audit and remuneration;
  - One to lead on patient and public involvement and participation.
- One registered nurse;
- One secondary care doctor;
- The Accountable Officer;
- The Chief Finance Officer;
- Two Associate Lay Members who, although have no voting rights, are in attendance at Governing Body meetings.

Other colleagues have a regular invitation to attend and contribute on a non-voting, attendance only basis, including Healthwatch representatives from the City of London and London Borough of Hackney, the local Director of Public Health and a Local Medical Committee representative.

All members of the CCG's Governing Body

Each member of the Governing Body share responsibility as part of a team to ensure that we exercise our functions effectively, efficiently and economically, with good governance and in accordance with the terms of our Constitution. Each brings their unique perspective, informed by their expertise and experience but work together to ensure we commission the best for our patients.

Governing Body meetings and attendance

The Governing Body ordinarily meets on a monthly basis. In addition, there are occasions when extra meetings may be required and so during the period between 1 April 2014 and 31 March 2015 there were 12 meetings held with the following members attending:

Governing Body Role	Governing Body Member	Governing Body meetings attended
Chair	Dr Clare Highton	10
General Practitioner	Dr Gary Marlowe	9
Clinical Vice Chair	Dr Haren Patel	9
Accountable Officer	Paul Haigh	10
Chief Financial Officer	Philippa Lowe	12
Secondary Care Consultant	Christine Blanshard	11
Independent Nurse	Siobhan Clarke	10
Governance Lay Member	Mariette Davis	10
Public and Patient Involvement Lay Member	Jaime Bishop	5 (part year)
Public and Patient Involvement Lay Member	Catherine MacAdam	7 (part year)
Associate Lay Member	Honor Rhodes	10

The CCG Governing Body Committees

The roles of each of the Governing Body committees are set out broadly below:

- Each of the Governing Body committees has defined terms of reference which are reviewed at least once a year. Each committee is authorised by the Governing Body to pursue any activity within their terms of reference and within the scheme of reservation and delegation of powers;
- The terms of reference of each committee of the Governing Body are referenced within the CCG's Constitution and are available on the CCG's website;
- Each committee of the Governing Body produced a report of its activities to the Governing Body on its proceedings after each meeting on all matters within its duties and responsibilities

CCG Committee	Number of times met in 2014/15
CCG Governing Body	12 times
Audit Committee	8 times
Finance and Performance Committee	9 times
Clinical Executive Committee	11 times
Contracts Committee	4 times
Prioritisation and Investment Committee	4 times
Public and Patient Involvement Committee	11 times
Safeguarding Group	4 times
Remuneration Committee	1 time
Clinical Commissioning Forum	11 times
Members Forum	5 times

Committees of the Governing Body are only able to establish their own subcommittees to assist them in discharging their respective responsibilities if this permission has been delegated to them by the Governing Body.

All decisions taken in good faith at a meeting of the Governing Body or any committee or sub-committee of it shall be valid even if there is any vacancy in its membership or if it is discovered subsequently that there was a defect in the calling of the meeting, or in the appointment of a member attending the meeting, if the meeting in question meets the quoracy requirements set out in the relevant terms of reference.

With the creation of the GP Confederation and in the light of opportunities to take more responsibility for commissioning primary care, under the auspices of the Audit Committee we undertook a comprehensive review of how we handle conflicts of interest. We appointed an independent GP advisor to help us where our own GP members may be conflicted and established our Contracts Committee, with a lay chair and meeting in public to provide added scrutiny of all contractual arrangements involving local GP providers (individual practices, CHUHSE the GP OOH provider and the GP Confederation). We developed new registers of interests and new paperwork and processes to demonstrate how we mitigate conflicts of interests in our contractual dealings with local GP providers and these are both in the public domain and shared with our two Health and Wellbeing Boards. We reviewed our arrangements again when new NHSE guidance was issued in December 2014 although we had already introduced most of the recommendations.

We also reviewed our governance arrangements during the year, streamlining some reporting arrangements and establishing new committees undertaking some functions previously undertaken by the Audit Committee. This has helped ensure that our Audit Committee can maintain a role of scrutiny and assurance to the Governing Body. We keep our governance under constant review and make improvements where we identify a need or gap or members highlight how we might do better.

The CCG committee structure ensures that our key local stakeholders have an opportunity to input in to the risk management process and clinical service development and management functions of the CCG. The CCG Governing Body meetings are held in public as are the Contracts Committee and Prioritisation and Investments Committee. Further to this there is the Public and Patient Involvement Committee attended by a number of key stakeholders including:

- Patient representatives;
- Commissioning Support Unit Representatives;
- Homerton University Hospital NHS Foundation Trust;
- London Borough of Hackney & City of London Healthwatch Representatives;
- GP Clinical leads;
- Members of the Public.

We share many of our decisions with our Health and Wellbeing Boards and scrutiny committees and keep them informed about key developments and our business.

Roles and responsibilities of important CCG committees and meetings

The Audit Committee

CCG Audit committee meetings and attendance were as detailed below during 2014/15:

Date	Mariette Davis	Honor Rhodes	Jaime Bishop (until 31/7/2014)	Catherine Macadam (from 1/8/2014)
10/4/2014	√	√	√	–
8/5/2014	√	√	X	–
30/5/2014	√	√	√	–
5/6/2014	√	√		–
31/7/2014	√	√	X	–
4/9/2014	√	√	–	√
13/11/2014	√	√	–	√
8/1/2015	√	√	–	√
12/3/2015	√	√	–	√

The Audit Committee's role is to seek assurance that financial reporting and internal control principles are applied and to maintain an appropriate relationship with the organisation's auditors, both internal and external. The Audit Committee offers scrutiny and advice to the Governing Body about the reliability and robustness of our processes of internal control.

The Audit Committee supports the Governing Body by critically reviewing governance and assurance processes on which the Governing Body places reliance. These include the risk management system underpinned by the Board Assurance Framework.

As the Governing Body increasingly relies on its Assurance Framework to monitor strategic objectives and identify significant inherent risks, the Audit Committee can provide assurance to the Governing Body that it is valid and suitable for the Governing Bodies requirements. In doing this the Audit Committee can review whether:

- The format of the Assurance Framework is suitable;
- The processes around the Framework are robust and relevant;
- The objectives in the Framework seem appropriate;
- The controls in place are sound and complete;
- The assurances are reliable and of good quality;
- The data the assurances are based on is reliable.

As part of its work, the Audit Committee has the option to commission a number of "deep dives" throughout the year in order to assess how well risks are being identified and managed in practice.

The Audit Committee meets on a bi-monthly basis and is chaired by the Governance Lay Member.

The responsibilities of the Audit Committee fall into the following main categories:

- The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the CCG's activities that supports the achievement of the organisation's objectives;
- The Audit Committee satisfies itself that the organisation has adequate arrangements in place for countering fraud, corruption or possible breach of ethical standards, conflicts of interest or legal or statutory requirements and reviews the outcomes of counter fraud and related work;
- The Committee ensures that there is an effective internal audit function established by management that meets Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Officer and the Governing Body;
- The Committee reviews the work and findings of the appointed external auditors and considers the implications of, and management's responses to, their work;
- The Committee reviews the findings of other significant assurance functions, both internal and external to the organisation, and considers the implications for the governance of the CCG. These include, but are not be limited to, any reviews by Department of Health arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.);
- The Committee reviews the work of other committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work.

The Committee requests and reviews reports and positive assurances from CCG directors and managers on the overall arrangements for governance, risk management and internal control;

- The Audit Committee monitors the integrity of the financial statements of the CCG and any formal announcements relating to the CCG's financial performance;
- The Committee ensures that the systems for financial reporting to the Governing Body including those of budgetary control are subject to review as to completeness and accuracy of the information provided to the Governing Body;
- The Audit Committee reviews the annual report and financial statements before submission to the Governing Body.

The CCG Audit Committee met on 8 occasions in 2014/15. Items covered were, Fraud risk assessment and counter fraud planning, Quality assurance of the NEL CSU, Risk management policy and Board Assurance Framework, Governance of payments to GPs as providers, Conflicts of Interest, payments to GPs and due diligence of the GP Confederation, Internal Audit procurement, Board Assurance Framework, Information Governance, Internal Audit plan and delivery, Review of Out of Hours contract and due diligence refresh of service provider, Annual accounts review and review of CCG accounting policies, including advice from external audit.

The Finance and Performance Committee

The Finance and Performance Committee is responsible for ensuring that financial and performance risks are identified and managed and for including and reporting the management of financial and performance risks to the CCG's strategic objectives in the BAF. The Chief Financial Officer is the lead executive for managing these risks on behalf of the Governing Body.

The Finance and Performance Committee meets on a monthly basis and is chaired by the CCG Chair.

The Finance and Performance Committee has the following roles on behalf of the CCG Governing Body:

- Receive a monthly report on the CCGs financial performance, incorporating year to date performance against and forecast outturn for budgets, contracts, quality, innovation, productivity and prevention measures, non-recurrent funding and other financial key performance indicators;
- Understand the drivers behind any variances against plans and ensure that the relevant CCG Programme Boards have identified any risks and have mitigating actions in place to address these, and to monitor progress and performance against these plans;
- Oversight of the CCG performance in all other areas (and against other key contracts and other key providers) and to ensure where plans are in place to improve quality/ performance or reduce any financial risks to the CCG, monitoring progress and performance against these plans;
- Provide assurance to the Governing Body in respect to the CCGs performance;
- Ensure that Committee members and the Governing Body has an understanding of all performance areas relating to the CCGs responsibilities in order to be accountable to NHSE and the public;
- Receive detailed activity, finance and performance reports from each CCG Programme Board every six months;
- Maintain oversight of the Commissioning Support Unit delivery feeding into CCG performance discussions with the Commissioning Support Unit;
- Oversee contractual strategies taking into account both of the CCG clinical ambitions and financial strategies.

Clinical Executive Committee

The Clinical Executive Committee meets on a monthly basis and is chaired by the Clinical Vice Chair.

The Clinical Executive Committee has the following role on behalf of the CCG Governing Body:

- Development and implementation of the CCG clinical ambitions and strategy;
- Ensures extensive clinical examination, debate and membership ownership of clinical plans;
- Coordinates the work of the CCGs Programme Boards;
- Receives six monthly updates from Programme Board Clinical Lead GPs of their work plans and commissioning activities;
- Debates clinical policy and strategic clinical issues and development;
- Ensures effective consultation and discussion with member practices about our clinical plans and that our plans have member support;
- Has oversight of member practice duty of candour responsibilities and the Programme Boards responsibility to manage issues;
- Hear about local problems and quality concerns discussed by our consortia and ensure these are addressed in our commissioning plans.

Consortia

Each Consortium plays a key role in providing a peer support network for constituent practices, for communication and input to CCG plans, thinking and decisions.

Consortium Lead

Consortium Leads are key members of the Clinical Executive Committee. The role of the elected Consortium lead is to undertake the following on behalf of the CCG:

- Represent the Consortium rather than represent their own individual practices;
- Support the work of the Consortia;
- Provide input to the CCG's clinical plans and represent the Consortium via membership of the Clinical Executive Committee (CEC);
- Chair the Consortium meetings;
- Ensure effective two-way communications with constituent practices, representing their views at CCG meetings and feeding back on CCG work.

Contracts Committee

The CCG's Contracts Committee was established in May 2014 and has responsibility from the CCG Governing Body for ensuring the delivery of the CCG's clinical strategy through robust contractual arrangements where the providers could include local GP providers.

Local GP provider means a GP practice operating in the CCG area and/or a company, mutual or other corporate entity (whether social enterprise or otherwise) with GP members (who are also members of the CCG) that provides or is seeking to provide health care services in the CCG area.

The Committee is charged by the CCG Governing Body to ensure that any decisions are transacted in a robust way to manage conflicts of interests.

The Contracts Committee meets on a bi-monthly basis and is chaired by an Associate Lay Member.

The CCG Contracts Committee:

- Oversees the planning and development of extended primary care and out of hospital clinical service provision where required by Programme Boards to achieve their plans;
- Considers, scrutinises, reviews, and agrees the associated service specifications and contractual arrangements and in particular those where:
    - The CCG is potentially contracting with local GP providers for list based services or extended primary care/out of hospital services, including GP out of hours services;
    - Where local GP providers are a potential provider under any CCG procurement exercise.
- Ensure that proposals represent value for money, will deliver clinical outcomes and improved performance and are within the CCG's statutory responsibilities;
- Makes recommendations to the CCG Governing Body on formal contractual arrangements;
- Makes recommendations to the CCG Governing Body on whether in year contractual payments should be made.

The Committee has been particularly active in assuring the Governing Body on the handling of conflicts of interests where GPs may have a financial benefit from CCG commissioned contracts or procurements.

Prioritisation and Investment Committee

The Prioritisation and Investment Committee reviews bids for new recurrent or non-recurrent investment into service provision and provides recommendations to the CCG Governing Body.

The Prioritisation and Investment Committee meets on a bi-monthly basis and is chaired by the Public and Patient Involvement Lay Member.

The Prioritisation and Investment Committee has the following roles on behalf of the CCG Governing Body:

- Recommends to the CCG Governing Body all proposals for use of recurrent and non-recurrent investment;
- Receives advice from the Chief Officer and Chief Financial Officer on resources available and the CCG Chair on clinical ambitions and strategy;
- Assess bids, scores and prioritises against the agreed prioritisation framework;
    - The framework is reviewed annually with support from Public Health and other relevant, evidence based sources and organisations.
- Proposals received in the form of Project Initiation Documents are assessed to ensure value for money, impact on patients and clinical outcomes and to ensure they are in line with the CCG clinical and financial strategy;
    - The Project Initiation Document pro-forma are reviewed annually and updated with support from Public Health and other relevant, evidence based sources and organisations.
- Considers service specifications, key performance indicators, metrics and the proposed contractual arrangements;
- Any Project Initiation Document which is about investment in local GP providers will require the additional scrutiny of the CCG Contracts Committee once agreed by the Prioritisation and Investment Committee before consideration by the CCG Governing Body;
- The Committee also receives assurance that member and patient consultation has been achieved through our Clinical Executive Committee, Clinical Commissioning Forum and Patient and Public Involvement Committee.

Patient and Public Involvement Committee

The primary role of the Patient and Public Involvement Committee is to ensure that the participation of patients and the public, their views and voices influence every stage of the clinical commissioning cycle.

The Committee also has an important role in promoting partnership working between patients and clinicians throughout the CCG and this is also actively supported through the role of GP Clinical Lead for Patient and Public Involvement.

The Committee has a role in overseeing the implementation of our Communication and Engagement Strategy on behalf of the Governing Body, holding the CCG Governing Body to account in the Patient and Public Involvement area and challenging the Governing Body.

The Committee promotes good practice in patient and public engagement and involvement, both in the commissioning cycle and in their own care.

The Patient and Public Involvement Committee meets on a monthly basis and is chaired by the Public and Patient Involvement Lay Member.

The Patient and Public Involvement Committee has the following roles on behalf of the CCG Governing Body:

- Holds the CCG Governing Body to account for embedding the views of patients and the public in its commissioning decisions;
- Reviews and comments on whether draft and final commissioning intentions reflect the needs and priorities of patients and local communities;
- Ensures that patient feedback in proposed commissioning includes significant feedback from patients also using the service;
- Gives a citizen / patient view of commissioning (separate from patient experience input);
- Ensures that patient experience consultation meets equalities criteria & is taken on board;
- To capture the voice of the local population through service users, patient panels, and outreach work across the locality;
- To ensure that there is meaningful public consultation on proposals to change the services provided or the ways in which those services are provided;
- Monitor the quality of services from a high level public and patient perspective and to ensure that the CCG addresses issues of concern;
- Members will represent the disparate views of those groups, surgeries and health providers across City and Hackney, avoiding centralisation;
- To support the development and effectiveness of Patient Participation Groups and to work with them to ensure that patient voices are heard and listened to at Practice and Consortium level;
- To hear feedback from other patient groups and experiences to and from Programme Board representatives;
- To develop and implement an annual plan for Public and Patient Engagement.
- To publish key facts and figures and the story about the work of the CCG in a style(s) and format(s) which will be accessible by members of the public and which is likely to engage their interest;
- To hold an Annual General Meeting to open up the work of the CCG to public scrutiny and to enable members of the public to question and challenge the CCG.

Safeguarding Group

The Safeguarding Group brings together the clinical commissioners for City and Hackney residents to oversee the monitoring of the quality of services with respect to adult and children's safeguarding and to provide assurance to the Governing Body that all commissioned organisations are working together and effectively tackling any issues arising.

The Safeguarding Group meets on a quarterly basis and is chaired by an Associate Lay Member.

The Safeguarding Group has the following roles on behalf of the CCG Governing Body:

- Reviews and assesses the assurances from the Commissioning Support Unit, CCG and other involved partner organisations that all services used by City and Hackney residents are proactively assessed and monitored for their safeguarding arrangements;
- Receives reports, agrees and monitors any action plans where improvements are required;
- Considers the outcomes of any serious case reviews, relevant Serious Incidents (SIs), and HealthWatch reports, complaints and other hard and soft intelligence and ensures that remedial action plans are developed, implemented and monitored;
- Receives reports from the local Safeguarding Boards (adults and children's) and considers any actions needed;
- Ensures that the CCG can provide the requisite assurance to the local Safeguarding Boards on the quality of what is commissioned;
- Considers the detailed safeguarding reports from commissioned providers which form part of the CCGs Quality Report.

Remuneration Committee

The Remuneration Committee meets on an as required basis and at least once per year. It is chaired by the Lay Member for Governance.

The Remuneration Committee met once in 2014/15 and considered the following items:

- Remuneration of GPs and Very Senior Managers
- Management changes following the transfer of services and staff from NELCSU.

(Attendance Mariette Davis 1 of 1, Clare Highton1 of 1, Jamie Bishop 1 of 1)

The Remuneration Committee has the following roles on behalf of the CCG Governing Body:

- Agrees the remuneration packages and other terms of service for members of the CCG Governing Body, Clinical Executive, Clinical Leads and other GP and clinical remuneration / sessional rates;
- Determines the remuneration and conditions of service of the CCG staff who are on the very senior management pay grade;
- Considers the remuneration, terms and conditions as part of the appointment of the Chief Officer & Chief Finance Officer;
- Makes recommendations on any severance payments of the Chief Officer and Chief Finance Officer, seeking HM Treasury approval as appropriate in accordance with the guidance 'Managing Public Money' (available on the HM Treasury.gov.uk website);
- Takes independent advice where appropriate in order to properly exercise its functions;
- Makes recommendations to the CCG Governing Body on any proposals for a new pay and remuneration framework for employees of the CCG, people who provide services to the CCG, and allowances under any pension scheme it might establish if not the NHS pension scheme;

- Receives an annual report on the arrangements for CCG Governing Body and clinical leadership – CCG Governing Body members, Clinical Executive and Clinical Lead roles – sessional commitments, attendance records and payments made and note any changes made by the Chair / Chief Officer / Chief Finance Officer under their delegated responsibilities;
- Receives at least an annual report on the CCG management structure from the Chief Officer and note any changes made to the structure or grades by the Chair / Chief Officer / Chief Finance Officer under their delegated responsibilities;
- Holds an extraordinary meeting if required to consider proposals for supporting the delivery of any additional functions which the CCG takes on;
- Receives an annual report on the CCG expenditure against its running cost allowance;
- Any other function delegated to it by the CCG Governing Body in line with the CCG's Constitution.

Clinical Commissioning Forum

The CCG uses the monthly Clinical Commissioning Forum (amongst other engagement routes), to consult and engage all member practices to debate clinical plans, for early involvement from practices in shaping plans, service models and strategies and for testing out ideas. The Clinical Commissioning Forum is open to all GPs working for a City and Hackney practice and each Practice is expected to send at least one representative to each meeting.

Practice Representative

Practice Representatives represent their Member's views and act on behalf of the Member in matters relating to the Forum. The role of each practice representative is to:

- Ensure effective two way communications between the CCG and the Member Practice;
- Engage in Consortia, Clinical Commissioning Forum (CCF) and other activities;
- Ensure democracy and input to CCG decisions;
- To be a member of the Members' Forum.

Members' Forum

The role of the Members' Forum is to:

- Consider and agree any changes to the Constitution including changes in membership of the CCG;
- Confirm the appointments process for Governing Body members;
- Ratify all appointments to the Governing Body;
- Consider any issue of no confidence in Governing Body members either individually or collectively;
- Debate any concerns regarding discussions and decisions by the Governing Body.

Clinical Commissioning Group Risk Management Framework

We are an open and learning organisation and want to ensure that our management processes make a difference to our patients. We have always had since our inception a 'duty of candour' system for patients to raise issues of concern. Consortia debate the issues which are identified and we ask our Programme Boards to investigate and reflect changes in our commissioning plans. We have a similar system to capture the views of our patients. During 2014/15 we strengthened our system so that we share issues raised formally with our providers at Clinical Quality Review meetings. Two examples of issues raised are, concerns from practices about the responsiveness and working arrangements in Community Nursing which we have addressed through our One Hackney initiative; and issues raised by our practices about administrative system at Barts Health and their impact on patient care. This led to a debate at the Governing Body to which we asked the Trust Medical Director to attend as well as highlighting our concerns to the Care Quality Commission (CQC) and an investment plan of £500k to tackle the issues.

Risk Management Strategy

Risk management is the proactive identification, assessment and control of risks that might affect the delivery of objectives or outcomes. Risks are identified via a number of methods which includes, but is not limited to the following:

- Proactive risk assessments;
- Service alerts;
- Incident reports;
- Complaints;
- Audits.

It is important to recognise that risk can never be eliminated and the aim of risk management is to progressively manage risk within what the organisation agrees are 'acceptable' levels.

Risk appetite has been defined as 'the amount of risk that an organisation is prepared to accept, tolerate or to be exposed to at any point in time' (HMT Orange Book definition 2005).

The CCG Governing Body determine the amount and type of risk the CCG is willing to take and ensure our staff have a clear understanding of what risks are and are not acceptable. This is influenced by a number of key factors such as the external environment, operational, regulatory, political and economic. Risks and how to address them are identified and managed by our Programme Boards.

The Governing Body uses a Board Assurance Framework, which is populated and monitored through all levels of the CCG to help us manage, assess and address risk.

The Governing Body receives a number of reports which identify risk, potential risks and mitigation. The Finance and Activity report is received monthly and details the key financial risks, the likely impact and the steps we are taking to mitigate and is scrutinised in detail at the Finance and Performance Committee. The CCG Governing Body receives a quarterly comprehensive quality and performance report which also highlights the key risks and steps being taken to mitigate. This covers performance across all our commissioned providers and helps the Governing Body to identify where specific attention should focus. For example the Governing Body requested a focus on the pathway for patients with cancer between Homerton and Barts Health which has long waits. Quality performance management with providers is via the monthly Clinical Quality Review Meetings (CQRM), which is a contractual requirement for each provider. Similarly, non-clinical quality issues will be managed through the Service and Performance Review Meetings. Our Programme Boards attend the CQRMs every six months to talk about their work to improve clinical quality and share the results of joint clinical audits undertaken which have led to service improvements.

Once a risk is identified, the risk is scored using a system both for likelihood of it occurring and impact should it happen. We use a 5 point scoring system for both elements. The two scores are then multiplied to give an overall score with an associated RAG red, amber, green) rating. This consistent approach to measure impact and likelihood enables the development of a hierarchy of risk for our risk registers.

RAG Table

	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Certain
	<10%	10% - 24%	25% - 45%	50% - 74%	>75%

Rating	Description	Objectives/ Projects	Harm/Injury to patients, staff, visitors, and others	Actual/ Potential complaints and claims	Service Disruption	Staffing and Competence	Financial	Inspection/Audit	Adverse Media
1	Insignifcant	Insignificant cost increase/ time slippage. Barely noticable reduction in scope or quality	Incident was prevented OR incident occurred and there was no harm	Locally resolved Complaint	Loss/ Interruption more than 1 hour	Short term low staffing leading to reduction in quality (Less than 1 day)	Small loss <£1000	Minor Recommendations	Rumours
2	Minor	Less than 5% cost or time increase. Minor reduction in scope or quality	Individual(s) require first aid. Staff needed <3 days off work or normal duties	Justified complaint peripheral to clinical care	Loss of one whole day of working	On-going low staffing levels reducing service quality	Loss of 0.1% budget. <£10,000	Recommendations given. Non-compliance with standards	Local media column
3	Moderate	5-10% cost or time increase. Moderate reduction in scope or quality	Individual(s) require a moderate increase in care. Staff needed >3 days off work	Below excess claim. Justified complaint involving inappropriate care	Loss of more than one working day	Late delivery of key objects/ service due to lack of staff. On going unsafe staff levels	Loss of more than 0.25% of budget >100,000	Reduced Rating. Challenging recommendations non-compliance with standards	Local media front page story
4	Major	10-25% cost or time increase. Failure to meet secondary objectives	Individual(s) suffered from permenant harm. Staff have sustained a major injury	Claim above excess level. Multiple justified complaints	Loss of more than one working week	Uncertain delivery of services due to lack of staff. Large error owing to insufficient training	Loss of more than 0.5% of budget <500,000	Enforcement action. Critical report. Major non-complaince with core standards	Local media-short term
5	Severe	>25% cost or time increase. Failure to meet primary objective	Individual(s) died as a result of the incident	Multiple claims or single major claim	Permenant loss of premise or facility	Non delivery of service. Critical error owing to insufficient training	Loss of more than 1% budget >500,000	Prosecution. Zero rating. Severly critical report	National media. More than 3 days. MP Concern

During the course of the 2014/15 year we have revised the Risk Management Policy and re-launched the Board Assurance Framework (BAF) through both the CCG Governing Body and Audit Committee.

Board Assurance Framework

The CCG Governing Body collectively is responsible for the management of risk. It is important to note that our Executive Officers have the prime responsibility for managing risk, which they do by applying controls to mitigate it. However, the Governing Body has responsibility for monitoring actions taken to reduce risk to its strategic objectives.

The CCG Governing Body fulfils these responsibilities through the operation of a Board Assurance Framework (BAF). The BAF continues to evolve as a dynamic document which is reviewed by the Governing Body at least quarterly and updated to reflect the discussions at the Governing Body meetings as well as being reviewed by the Audi

Committee. The BAF is intended to provide Governing Body members with oversight of the risks facing the CCG and how those risks are being managed. The Governing Body needs to assure itself that not only are the controls and assurances in the BAF appropriate, but also that they are working in practice. The Audit Committee has been supporting the Governing Body in the development of the BAF.

The BAF sets out the following:

- The strategic objectives of the organisation;
- The principal risks which threaten the achievement of each of the objectives;
- The key controls applied to manage the identified risks;
- The assurances in place relating to the controls;
- Gaps in controls;
- Gaps in assurance;
- Any actions required;
- Evidence that the risks are being regularly reviewed and where appropriate updated.

During 2014/15 the potential to take on responsibility for primary care commissioning from NHSE was discussed both with members and at Governing Body meetings and the risks as they emerged were openly debated, leading ultimately to the Governing Body deciding not to pursue the application due to the risks involved. We felt that the risks could not be mitigated properly without potentially impacting on City and Hackney residents. Ongoing financial and quality concerns at Barts Health have also featured in discussions at the members' forum and the Governing Body meetings. Although we remain a small commissioner the Governing Body has wanted to ensure that any plans developed by the Trust or by local CCGs do not adversely impact on City and Hackney residents and has also continued to remind local GPs that unresolved financial and quality issues need to be considered before referring patients to the Trust.

Risk Registers

We have established separate risk registers for each of our Programme Boards and in addition has separate registers for Information Governance, Finance and Corporate risks. Programme Boards and other risk register owners update their registers on an ongoing basis and these feed into the BAF where any red risks or risks where the score has significantly increased will be captured. Changes in scores are reported to the Governing Body.

Risk Registers are used for recording risks at both a strategic and operational level and cover the following key areas:

- Risk Owner;
- Description of risk;
- Impact/likelihood/risk rating;
- Controls;
- Assurances;
- Gaps in control;
- Gaps in Assurance.

The Corporate Risk Register covers those corporate wide risks that are not covered by the Programme Board Risk Registers, for example Finance and Information Governance whilst Programme Boards are responsible for identifying, managing and documenting risks connected with their work programmes and the patient groups or areas of practice with which they are concerned.

As the Programme Boards are a central point of commissioning activity it is anticipated they will have numerous risks although not necessarily red. As part of the review of Programme Board activity, the risk registers are reported to the Clinical Executive Committee twice per year.

The Finance and Performance Committee plays a critical role in reviewing the risks of each Programme Board through their regular reporting arrangement. The FPC over the last year looked in detail at the performance risks around 111, London Ambulance Service and IAPT balancing performance risks against clinical risks and helping to debate improvement plans with Programme Boards for further discussion with members and providers.

Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. The CCG was self-assessed as compliant with the relevant sections of the toolkit in 2014/15.

We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

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

Financial risks

The CCG financial risks are reported through the Programme Boards and also through the Finance and Performance Committee which meets monthly. Following this the finance report is presented at the CCG Governing Body meeting.

The CCG Governing Body monitors the financial risks carefully at each meeting. This includes the probability of the risk, its impact and mitigation. The risks feed through to the financial forecast. The major financial risk in 2014/15 was the ability to mobilise the non-recurrent investments quickly enough to match the annual funding cycle; the risk being that slippage of funds would be lost at year end and not available in 2015/16 to meet project costs. The CCG was able to formally agree an increased surplus in 2014/15 of £7.5m which could be drawn down in 2015/16 to meet project costs. We were also able to mitigate further risk of slippage by funding a project management officer to oversee the agreement of all schemes and also funded 2 project posts at Homerton University Hospital FT, where many projects were running and at risk of slippage. We faced additional risks of activity pressures on all contracts leading to increased costs. Most of these were well contained by Programme Boards and through the targeting of non-recurrent schemes to address potential pressure areas where demand needed to be contained (eg waiting list initiatives for community rehabilitation and physiotherapy services). Continuing healthcare pressure continued to prove challenging in 2014/15 and

we are reviewing our management arrangements for this in early 2015/16 to ensure they are fit for purpose.

We continued to take a prudent line in managing overall risks and ensure we always contain our recurrent spend at or below our recurrent target allocation, thus using additional headroom non-recurrently to fund projects to deal with potential pressures through service changes. We held a contingency of 1% to deal with operational risks and utilised around 50% of this. We also held a 1% acute contract risk reserve, which was fully utilised. The CCG Governing Body received monthly updates on risks with a financial consequence and was able to track performance and quality risks through detailed quarterly quality and performance reports. The Governing Body discussed some risk issues directly with providers at some of its Governing Body meetings where specific issues had been identified, for example, concerns GPs had identified about the provision of services to City and Hackney patients from Barts Health NHS Trust.

The CCG has analysed the key areas of financial risk. These are summarised in the table below.

Description of risks Events that may happen	**Assessment**
Activity risks	Calculation of 5% activity over planned levels on non-controllable activity
QIPP Under-Delivery	Calculation of assumed 50% slippage
Risks from Service changes	Detailed assessment of potential impact
Baseline funding	A log is being maintained of potential liabilities which are assumed to happen and benefits which are assumed to not accrue.
Contract risks	Assessment based on contract discussions

We have reviewed our capacity to handle the level of risk identified above which will be mitigated through the following actions and consideration:

- Potential sources of funds to mitigate risk;
- Uncommitted Funds;
- Contingency;
- Surplus brought forward;
- Local reserve for specific badged risks;
- Further savings opportunities;
- Delay / reduce Investment plans.

We have agreed a further level of mitigation via a risk sharing agreement with other Inner North East London CCGs. The level of risk exposure and mitigation is reviewed by CFOs based on an agreed consistent methodology. In 2014/15, we made a £2m transfer to NHS Waltham Forest CCG to cover short-term risks. Currently no payment or drawdown under the risk sharing agreement has been identified for 2015/16.

Quality, performance and clinical risks

Management of CCG quality risk and our system of 'duty of candour' is undertaken by the Clinical Executive Committee (which captures feedback from Consortia), Clinical Quality Review Meetings with providers, and individual Programme Boards. Performance risks are reported and managed through the Finance and Performance Committee and Contracts Committee. The Sub-Committees and Programme Boards report to the CCG Governing Body who retain ultimate responsibility for Quality Management and have many debates about clinical quality, benefiting from the perspectives of our Governing Body clinical members. Clinical Quality risks are also discussed at the Public Participation Involvement Committee which is also used to gather patient views and concerns.

Quarterly quality reports are produced by the CCG Head of Quality which are scrutinised by

Sub-committees and Programme Boards. These reports are available on the CCG website and discussed in detail at the Governing Body meetings.

They outline a range of measures and performance at our commissioned providers. We use "hard" benchmarked information about performance as well as "soft" information from member and patient feedback to get a rounded perspective of quality. Our clinical strategy is underpinned by clinical audit to measure performance and clinical quality particularly across providers and 'hand offs' between services. We are also using external peer reviews to help inform us about quality and where things could be better.

The CCG continues to maintain the Duty of Candour journal to practices via the consortia structure, the Clinical Commissioning Forum and Clinical Executive Committee, for registering and escalating concerns raised. Responsibilities are assigned to address these concerns and actions are feedback. The collective debate about issues raised is an important function of our members and sub committees and helps us agree what the issues and remedies might be.

Risk of outsourcing functions

The CCG buys a number of support functions from NEL CSU, a shared services for CCGs in north central, north east London and East Anglia. From the 1st April 2014, we transferred a number of functions from NEL CSU in house, reducing the associated risks and increasing our ability to influence performance and delivery in these areas as well as at a reduced cost, we are pleased with the impact this has had. We have recognised that the relationship with NELCSU continues to carry a number of risks. To mitigate the risk, the 12 North Central and North East London CCGs formed an Assurance Committee to review the risks and the performance of the CSU and engaged Baker Tilly to undertake in depth reviews and provide assurance on the safe operation of the controls in the CSU. NHS England also provide a 'Service Auditor' report on the CSU following review by Deloitte of the controls in place.

Fraud risks

We undertook a fraud risk assessment and have established a programme of work to ensure awareness of the risk of fraud is communicated throughout the CCG and fraud risk management is overseen by the Audit Committee. We engaged Baker Tilly to assess the adequacy of arrangements to counter fraud. We are confident that we have a robust system of balances, checks and challenge and we achieve this through our Public and Patient Involvement Committee and the scrutiny provided by our Audit Committee and the fact that our Governing Body meetings are held in public with representation from local Healthwatches. Importantly, commissioning activities are developed by our members, local GPs working at the heart of our community and we ensure we involve our patient representatives and other key stakeholders as we develop new services through our Programme Boards ensuring patient needs remain at the heart of everything we do.

In our dealings with our local GP providers, given the creation of the City and Hackney GP Confederation which now holds a number of contracts for extended primary care services, we remain open and transparent. Our contracts committee meeting in public, in conjunction with our independent GP advisor plays a vital role of scrutiny in our dealings, in how we have handled conflicts of interest and that our plans will deliver patient benefit.

Fraud, bribery and corruption training was provided to Governing Body members during the year and the CCG also participated in the National Fraud Initiative run by the Audit Commission. We publish all details of our expenditure transactions on our website for wider public scrutiny and share a lot of information formally and informally with the Health and Wellbeing Boards, scrutiny committees and local stakeholders. For example, we share details of our financial outlook and our spending plans.

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

The CCG inherited a portfolio of services from City and Hackney PCT and has undertaken a steady and detailed review of all contracts and budgets to understand what is being commissioned and the value for money of these services. In particular, we have reviewed all contracts we inherited with our GP practices and these have been scrutinised by our contracts committee which has no local GP members. In addition, we have worked with the Homerton University Hospital to review a number of services which sit outside of the national tariff, such as

community health services to determine the service content, performance metrics and delivery and the ratio of direct service costs to overheads. The CCG has also taken the same rigorous approach with its contracts with the new GP Confederation for list based services (i.e. services that are dependent on a GP practice list so not suitable to procurement), requiring an open book approach and scrutiny by our Contracts Committee. Our Contracts Committee has a vital role to play to scrutinise our plans when we intend to contract with local GP providers or where they may be a bidder for a service we are procuring. We must ensure that our decisions are right by our patients and will improve outcomes and in doing so that our local GPs have not had undue influence.

During the year, the CCG commenced the following services resulting from a procurement exercise to test the market:

- Audiology (Any Qualified Provider);
- Direct Access Diagnostics (Any Qualified Provider);
- Looked After Children's Services (joint procurement with the local authority).

In addition, a consultant led warfarin management service tender is work in progress. Any contract award is anticipated in July 2015 for a service to commence in October 2015.

The CCG has identified a number of service areas which it will be reviewing in 2015/16, some of which may go through a market testing exercise:

- Community Phlebotomy;
- Community Dermatology;
- Community Gynaecology;
- Community Matrons;
- Community Heart Failure;
- Community ENT;
- Minor Surgery;
- Bi Lingual Advocacy;
- Nursing Homes – medical cover;
- Children's Services;
- Tier 3 Weight Management Services;
- Post Operative Wound Care.

We have to separately account for our running costs, i.e. management and administration costs. In 2014/15 we received an allocation of £6.5m, which we are not permitted to exceed. Any underspend on running costs is permitted to be spent on programme costs i.e. the cost of direct services to patients. The CCG only spent £3.7m of our running costs, leaving £2.6m available to spend on patient care services. In 2015/16, running cost allowances have been reduced by 10% (£0.6m), and we anticipate we will continue to run very lean back office functions and will continue to contribute more resource from money allocated for management and administration in to direct front line services; this will continue to be reviewed in the light of us meeting our statutory duties, delivering key targets and improved health outcomes and being able to manage increased demands of assurance from NHS regulatory bodies. We are committed to keeping lean, having a flat non heirarchical clinically led structure, and minimising bureaucracy to smooth our decision making and keep our overheads down but at the same time not compromise on good governance and standards of public accountability. Our Governing Body plays a key role in overseeing this balance and ensuring we meet our obligations and our Constitution.

We are committed to ensuring services meets patient needs and deliver a high quality. Patients are actively involved in our service reviews and these views are vital to us. Clinicians are also at the heart of decisions on services. The CCG is further committed to openness and transparency in our decision making. Our Governing Body and most Committee meetings are held in public. Patients are represented on all Programme Boards and the two local Healthwatch organisations provide an invaluable input. We also publish all our expenditure transactions online. We are also committed to learning from our practices and seek independent review of our actions to find ways to improve what we do, such as via internal audit, specialist input such as from the Primary Care Foundation or a new collaboration with University of East Anglia on evaluation and using the London Clinical Senates and others to help us with peer review and benchmarking

By embedding our fundamental commitment to the above key principles throughout our governance and actions, we believe we can give assurance to the public and taxpayers that we are continually striving to deliver economy, efficiency and effectiveness in the use of our resources.

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

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

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving our principal objectives have been reviewed. The risks are identified and owned by our Programme Directors and the Audit Committee reviews the constantly developing Board Assurance Framework at its meeting. Changes to the Board Assurance Framework are reported to the Governing Body meeting who review the document on a quarterly basis. We also use the debate at the Governing Body to review the risks included in the Board Assurance Framework. However, this is more than a document and a process.

In relation to our systems of internal control we have three decision points for any investment proposal:

- The first is our Programme Board where ideas are debated with public health, Local Authority and public representatives alongside clinicians and CCG managers;
- The second is our Prioritisation and Investment Committee, chaired by our Lay Member from the Governing Body, and meeting in public, with our two HealthWatches and Health and Wellbeing Board Chairs present;
- The final is the Governing Body meeting again meeting in public. For any proposal to invest in a local GP provider these go through the added scrutiny and assurance of our Contracts Committee, again with an Associate Lay Member Chair and meeting in public and with no local GP members.

These checks and balances and three decision points are a critical feature of our internal control systems and I rely on the Audit Committee and the internal auditors to keep these processes under review and provide assurance to myself and the Governing Body that these are robust. We only release funding when we have agreed a service specification with clear outcomes and key performance indicators which are used as the basis of contract variations with providers. Performance is reviewed during the year by the Finance and Performance Committee, chaired by the CCG Chair. I also ensure we remain a learning organisation by taking 'real life' issues to test our governance systems and using comments and feedback to inform where we need to make changes.

In developing our new conflicts of interest policy in the light of the new guidance published by NHS England in December 2014, we worked on the policy with our solicitors, took it to the Audit Committee where members and the internal auditors and local counter fraud specialists reviewed it, tested it against the NHS England framework and our operating model, and made changes before it was presented for approval to the Governing Body. We established our contracts committee to oversee all contracts with local GP providers and to scrutinise how Programme boards are managing conflicts of interest. We also appointed an independent GP advisor from outside City and Hackney to provide clinical advice to Programme Boards and the Contracts Committee where local GPs may be conflicted and advice to the contracts committee.

Again the role of the Audit Committee and internal auditors in this process is critical for providing Governing Body assurance. We have also undertaken internal training and development on the operation and implementation of the conflicts of interest policy and a review of its effectiveness and our adherence to it has been included in the internal audit forward plan. We have also shared the policy with partners, with the Health and Wellbeing Boards and with the Local Authority Health Scrutiny Committees.

The Chair of our Audit committee is also the Governance Lay Member and does not chair any other Sub Committees (other than the Remuneration

Committee) to maintain an independence which I believe is best practice in providing challenge and scrutiny and thereby effective internal control systems. The Audit Committee keeps an overview of our processes and governance and will test out our adherence to policies and operating principles throughout the year, choosing areas where they want to focus.

As a CCG, the role of our clinicians is essential in understanding clinical risk and quality – they take an active role in reviewing all serious incidents and ensuring that any learning for our commissioned services is implemented. They suggest metrics which relate to improving clinical quality and outcomes and which are included in our service specifications and contracts, they are involved in joint clinical audits to review clinical practice and identify where improvements can be made. We focus on the clinical quality agenda of each Programme Board at both our Clinical Executive Committee and the Clinical Quality Review Meetings with our local providers, receiving reports on a six monthly cycle from each Programme Board. We formally contract for a quality and audit programme with Homerton University Hospital NHS Foundation Trust, which is agreed by our Clinical Executive Committee as well as using the national Commissioning for Quality and Innovation schemes. We use benchmarked information to identify where we and / or our providers could do better and use this to inform our plans and we have a robust duty of candour system for our practices to report areas of concern and an investigation and feedback loop via our Programme Boards.

Our Governing Body receives a very comprehensive clinical quality report every quarter looking at a range of national and local measures for all our commissioned services and we believe that retaining responsibility for clinical quality at the Governing Body demonstrates the importance of and focus on quality of our organisation. Our internal auditors reviewed our processes and their report provided assurance on their robustness and the direct changes which they have brought about. Collecting rounded information – from our member practices, from our patients and our Lay Representatives, looking at benchmarked performance against national and local standards, undertaking clinical audits and using peer reviews and assessments – are the key features of our approach. We maintain an, open mind and a questioning approach, use the difference in perspectives of our Governing Body members and our clinical members, ensuring a culture of challenge and feedback to the values embedded in our constitution, to constantly see how we could improve and so do better for our patients.

As well as my personal responsibility I also rely on the following:

The Chief Financial Officer (CFO)
The CFO, working closely with the Finance and Performance Committee, has particular responsibility for identifying financial and information risks, for ensuring that these are being managed effectively and for providing assurance to the Governing Body that this is the case. The CFO is responsible for commissioning audits which impact on areas of risk or on the systems of internal control and also for identifying and managing any risks associated with fraud, corruption or lack of financial probity.

The Programme Directors
We are fully committed to the principles of clinically led commissioning and ensuring our clinicians, not our managers, drive our plans. We exercise this through a highly devolved leadership of commissioning for particular service areas to Programme Boards which are accountable to the Clinical Executive and ultimately to the CCG Governing Body. As such, Programme Boards have a critical role to play in the identification and management of risks and the operation of controls to mitigate risk.

Each Programme Board is chaired by an appointed Clinical Lead and supported by a programme director who are both responsible for delivering particular objectives and for assuring the quality and safety of the care and the contractual arrangements commissioned in their area of responsibility and expertise and providers performance in delivering the CCGs commissioned requirements. Each Programme Board reports to the Clinical Executive Committee and to the Clinical Quality Review Meetings every 6 months on their work plans and quality initiatives as well as to the Governing Body. The objectives of the

Clinical Lead and Programme Director are agreed with the Chair and Chief Officer and regularly reviewed.

Programme Directors are responsible for ensuring their risk registers are regularly reviewed and updated. We use the oversight of our Governing Body and our sub committees to ensure our Programme Boards are making a difference and acting appropriately.

The Head of Corporate Services
The Head of Corporate Services is responsible for ensuring ownership of relevant sections of the BAF by relevant CCG members and staff, developing and communicating risk management processes to all CCG members and staff through a risk policy document, and ensuring that the BAF is managed, updated and considered by the Audit Committee and Governing Body regularly.

The Head of Corporate Services ensures risk registers are maintained and risk systems are updated and developed as required.

Internal Auditors
The Internal Auditors advise on aspects of risk management and carry out annual reviews of the CCG's risk management processes as well as undertake specific reviews in to our functions and our adherence to best practice. These reports are important tools for highlighting where we can make improvements as well as assuring me of the robustness of our approach.

Review of Effectiveness
In summary, my review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework as well as the culture, governance systems and individuals across the organisation. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving our principle 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, reports from our internal and external auditors, clinical executive committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of our system of risk management, governance and internal control. The Head of Internal Audit conclusion is produced here.

Head of Internal Audit Opinion
The following Head of Internal Audit Opinion was reached by Baker Tilly, the CCGs internal audit provider through 2014/15.

Based on the work undertaken in 2014/2015, significant assurance can be given that there is a generally sound systems of internal control, designed to meet the organisations's objectives, and that controls are generally being applied consistently. However, some weaknesses were identified that put the achievement of particular objectives at risk.

Based on the work the CCGs internal auditors have undertaken on the CCG's system on internal control they do not consider that within these areas there are any issues that need to be flagged as significant internal control issues within the Annual Governance Statement.

Internal Audit reporting

During the year, the Internal Audit provider issued the following audit reports with a conclusion of limited assurance:

- None

Although internal auditors have not issued any RED reports during the course of the year, they have raised a number of recommendations to help us improve the controls around the operation and effectiveness of the BAF. Our Governing Body has developed an action plan for implementation and will prioritise this work in 2015/16.

Managing Conflicts of Interest

As required by section 14O of the 2006 Act and as inserted by section 25 of the 2012 Act, we have made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the CCG will be taken and seen to be taken without any possibility of the influence of external or private interest. This is particularly important as an organisation made up of GP members when we are also commissioning services from our member practices. We abide by the safeguards set out in the NHS England guidance Managing Conflicts of Interest: Statutory Guidance for CCGs which was issued in December 2014 and we reviewed and agreed a revised CCG Conflicts of Interest policy in the light of this.

The aim of our policy is to protect both the CCG and the individuals involved from any appearance of impropriety and demonstrate our culture of openness and transparency to the public and other interested parties.

Our policy is more than a document, it reflects how we work and helps us test the robustness of our arrangements which have been a major piece of work in 2014-15.

We established a Contracts Committee in 2014 which has an Associate Lay Member Chair, meets in public, publishes its papers on our website, has no local GP members and members of our two Healthwatches to scrutinise all proposed contracts with local GP providers and all payments to local GP providers.

We also employed an independent GP adviser from outside City and Hackney to provide an independent clinical perspective and advice on our contracts with local GP providers. We share the outcome of the Contracts Committee with the Governing Body and with our Health and Wellbeing Boards. We also maintain a register of interests, which is on our website where all interests are declared and this is reviewed at each meeting of the Governing Body, our sub committees and Programme Boards.

In addition to the Conflicts of Interest Policy we also have a Whistleblowing Policy that defines the requirement to raise concerns over improper conduct or unethical behaviour including conflicts of interest. The policy clearly maps out the process for reporting and investigating concerns including timescales.

The Governing Body's members have ultimate responsibility for all actions carried out by staff and committees throughout our activities. This responsibility includes the stewardship of significant public resources and the commissioning of healthcare to the community. We are therefore committed to ensuring that we inspire confidence and trust amongst our partners, members and patients by demonstrating integrity and avoiding any potential or real situations of undue bias or influence in our decision-making.

Data Quality

The CCG relies heavily on the quality of data submitted by providers and managed on our behalf by NELCSU. The CSU's systems are reviewed by Deloitte employed by NHS England to undertake a Service Auditor Report and the CCG engages with other customers of the CSU to employ Baker Tilly to undertake quality assurance reviews. No significant issues with data quality have come to the attention of the CCG Governing Body in 2014/15.

Business Critical Models

We have has established a framework to ensure business critical models are effective and quality assured. The main CCG critical model is our Long Term Financial model, the output of which is subject to NHS England assurance and internal audit review. All other business critical models are held by third parties, in particular NEL CSU. We are an active participant to a quality assurance process with 11 other local CCGs and delivered by Baker Tilly to review these systems and models. Further assurance is provided by a Service Auditor Report on the NELCSU systems commissioned by NHS England and made available to all CCGs in contract with the CSU.

Data Security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment.

Discharge of Statutory Functions

During establishment, the arrangements put in place by the clinical commissioning group and explained within the Corporate Governance Framework were developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of the Harris Review, we have reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated within the CCG structures ensuring the necessary capability and capacity is available to undertake all of the clinical commissioning group's statutory duties.

Conclusion

As well as the robustness of the organisation, our systems and governance I am delighted by our commissioning work and approach which continues to make a real difference to our patients. We will continue to develop our Board Assurance Framework next year to ensure that the other Governing Body members and myself can rely on this document as part of our system of internal control. However, we need to do more than rely on a document and we are fortunate that our clinical leads, our culture, values and approach (as embedded in our constitution) and our Governing Body and CCG staff all contribute to our success, which ultimately has an impact on the members and people we serve.

Paul Haigh
Chief Officer
Thursday 28 May 2015

Independent Auditor's Report

Independent Auditor's Report to the Members of City and Hackney Clinical Commissioning Group

We have audited the financial statements of City and Hackney Clinical Commissioning Group for the year ended 31 March 2014 on pages 72 to 94. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Members of City and Hackney Clinical Commissioning Group, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Members of the Clinical Commissioning Group, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Clinical Commissioning Group, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the City and Hackney Clinical Commissioning Group's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer, and the overall presentation of the financial statements.

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Clinical Commissioning Group as at 31 March 2014 and of its net operating costs for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England, except that the Clinical Commissioning Group has not included the required disclosures in respect of the pensions entitlement of general practitioners employed by the Clinical Commissioning Group in a senior management capacity; and
- the information given in the Strategic Report and Members' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with NHS England's Guidance;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Clinical Commissioning Group has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report any matters that prevent us from being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in October 2013. We have considered the results of the following:

- our review of the Governance Statement; and
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the Clinical Commissioning Group.

As a result, we have concluded that there are no matters to report.

Certificate

We certify that we have completed the audit of the accounts of City and Hackney Clinical Commissioning Group in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Neil Thomas for and on behalf of KPMG LLP,
Statutory Auditor
Chartered Accountants
15 Canada Square
London E14 5GL
6 June 2014

NHS City and Hackney Clinical Commissioning Group – Annual Accounts 2014-15

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

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	4.1.1	3,872	1,541
Other costs	5	338,361	331,044
Other operating revenue	2	(905)	(1,943)
Total Comprehensive Net Expenditure for the year		**341,328**	**330,642**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	1,803	935
Other costs	5	1,917	4,150
Other operating revenue	2	(5)	(11)
Net administration costs before interest		**3,715**	**5,074**
Programme Income and Expenditure			
Employee benefits	4.1.1	2,069	606
Other costs	5	336,444	326,894
Other operating revenue	2	(900)	(1,932)
Net programme expenditure before interest		**337,613**	**325,568**

The notes on pages 75-92 form part of this statement

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Current assets:			
Trade and other receivables	8	2,357	1,298
Cash and cash equivalents	9	58	190
Total current assets		**2,415**	**1,488**
Total assets		**2,415**	**1,488**
Current liabilities			
Trade and other payables	10	(49,469)	(31,799)
Provisions	11	0	(326)
Total current liabilities		**(49,469)**	**(32,125)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(47,054)**	**(30,637)**
Financed by Taxpayers' Equity			
General fund		(47,054)	(30,637)
Total taxpayers' equity:		**(47,054)**	**(30,637)**

The notes on pages 75-92 form part of this statement

The financial statements on pages 1 to 21 were approved by the Governing Body on 28 May 2015 and signed on its behalf by:

Paul Haigh
Accountable Officer
Thursday 28 May 2015

Statement of Changes In Taxpayers Equity for the year ended 31 March 2014

	Note	General fund £000	General fund £000
Changes in Taxpayers' Equity for 2014-15			2013-14
Balance at 1 April 2014		(30,637)	0
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15			
Net operating costs for the financial year	SOCNE	(341,329)	(330,642)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year		**(341,329)**	(330,642)
Net funding		324,912	300,005
Balance at 31 March 2014		**(47,054)**	**(30,637)**

Statement of Cash Flows for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(341,329)	(330,642)
Increase in trade & other receivables	8	(1,059)	(1,298)
Increase in trade & other payables	10	17,670	31,799
(Decrease)/Increase in provisions	11	(326)	326
Net Cash Outflow from Operating Activities		**(325,044)**	(299,815)
Net Cash Outflow before Financing		**(325,044)**	(299,815)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		324,912	300,005
Net Cash Inflow from Financing Activities		**324,912**	300,005
Net Increase (Decrease)/Increase in Cash & Cash Equivalents	**9**	**(132)**	190
Cash & Cash Equivalents at the Beginning of the Financial Year		**190**	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**58**	**190**

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

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

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

1.5 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.

1.5.1 Critical Judgements in Applying Accounting Policies

There have been no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commission group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1.5.2 Key Estimations

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 notified by the Provider trusts through the NHS Agreement of Balances exercise.

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, unless covered by a contract. The CCG agrees to use the figures calculated by the local providers.

Continuing health care retrospective case provision

Provisions comprise an estimated amount which the CCG believe it will be liable to pay in relation to continuing healthcare retrospective claims to be received for activities for periods of care post 1st April 2012. The CCG uses the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care to evaluate a claim and forms an opinion on the likelihood of that claim being upheld.

Prescribing liabilities

NHS England actions monthly cash charges to the CCG for prescribing contracts. These are issued approximately 6 weeks in arrears. The CCG uses information provided by the NHS Business Authority as part of its estimate for full year expenditure.

1.6 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.

1.7 Employee Benefits

1.7.1 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.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

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

1.8 Other Expenses

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

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.

1.9 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.

1.9.1 The Clinical Commissioning Group as Lessee

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.

1.10 Cash and 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.

1.11 Provisions

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

1.12 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.

1.13 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.

1.14 Continuing healthcare risk pooling

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

1.15 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.

1.16 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.

1.16.1 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 initialrecognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17 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.

1.18 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.

1.19 Third Party Assets

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

1.20 Losses and 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).

1.21 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

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

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

The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they to be applied in that year.

2 Other operating revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Education, training and research	**(11)**	(11)	0	11
Charitable and other contributions to revenue expenditure: non-NHS	**90**	0	90	0
Non-patient care services to other bodies	**507**	16	491	1,583
Income generation	**0**	0	0	318
Other revenue	**319**	0	319	31
Total other operating revenue	**905**	**5**	**900**	**1,943**

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services. 2013-14 Income generation relates to a charge for the use of facilities by NHS North and East London CSU for which the CCG received a specific allocation to match it.

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

3 Revenue

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods.

4 Employee benefits and staff numbers

4.1.1 Employee benefits

	2014-15	Total			Admin			Programme		2013/14
	Total £000	Perm E'ees £000	Other £000	Total £000	Perm E'ees £000	Other £000	Total £000	Perm E'ees £000	Other £000	Total £000
Employee Benefits										
Salaries and wages	**3,419**	2,141	1,278	1,566	1,116	450	1,853	1,025	828	1,293
Social security costs	**216**	216	0	117	117	0	99	99	0	109
Employer Contributions to NHS Pension scheme	**237**	237	0	120	120	0	117	117	0	139
Gross employee benefits expenditure	**3,872**	**2,594**	**1,278**	**1,803**	**1,353**	**450**	**2,069**	**1,241**	**828**	**1,541**

As per the Manual for Accounts the overarching principle is that transactions should be accounted for in accordance with International Financial Reporting Standards (IFRS), with all treatments having been agreed by both parties. Generally, this determines that revenue income and expenditure should be recorded gross, unless the transaction is of a non-trading nature and an organisation is deemed to be acting solely as an agent and does not gain any economic benefit from the transaction. Therefore employee benefits are shown on a net basis as disclosed within note 1.1. Only the element of the salary relating to the CCG has been recorded as expenditure as in substance the employee works for both organisations and the recharge is merely an administrative arrangement.

4.2 Average number of people employed

	Total Number	Perm emp'd Number	Other Number	Total Number
Total	**40**	**34**	**6**	17

4.3 Staff sickness absence

	2014-15 Number	2013-14 Number
Total Days Lost	113	74
Total Staff Years	40	18
Average working Days Lost	**3**	**4**

4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

4.4.1 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

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

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

4.4.3 Scheme provisions

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

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of

the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

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

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

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

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

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

5 Operating expenses

	2014-15 Total £000	2014-15 Admin £000	2014-15 Prog. £000	2013-14 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	3594	1525	2069	1247
Executive governing body members	278	278	0	294
Total gross employee benefits	**3872**	**1803**	**2069**	**1541**
Other costs				
Services from other CCGs and NHS England	**3429.12**	1125.78	2303.34	5723
Services from foundation trusts	**218590.75**	0	218590.75	216126
Services from other NHS trusts	**46991.19**	14.63	46975.56	48068
Services from other NHS bodies	**0**	0	0	0
Purchase of healthcare from non-NHS bodies	**28212.06**	0	28212.06	20781
Chair and Non Executive Members	**160.83**	160.83	0	169
Supplies and services – clinical	**0**	0	0	0
Supplies and services – general	**30.18**	18.19	11.99	150
Consultancy services	**139.11**	82.22	56.89	274
Establishment	**659.4**	150.29	509.11	184
Transport	**0.14**	0.07	0.07	0
Premises	**1812.96**	109.73	1703.23	3148
Impairments and reversals of receivables	**-347.71**	0	-347.71	839
Audit fees	**95.4**	95.4	0	104
Prescribing costs	**28803.87**	0	28803.87	30037.4
Pharmaceutical services	**0**	0	0	0
General ophthalmic services	**1.29**	0	1.29	1
GPMS/APMS and PCTMS	**8639.14**	9.16	8629.98	4402.4
Other professional fees excl. audit	**661.91**	100.67	561.24	637
Clinical negligence	**5.86**	2.72	3.14	6
Education and training	**293.45**	46.84	245.61	68.6
Provisions	**-326**	0	-326	325.6
CHC Risk Pool contributions	**510**	0	510	0
Total other costs	**338,361**	**1,917**	**336,444**	**331,044**
Total operating expenses	**342,233**	**3,720**	**338,513**	**332,585**

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

*** Fees paid and payable to the CCG's external auditor, KPMG**

	£000	£000
Audit Services – Statutory Audit	80	87
VAT payable	15	17
Total fees paid and payable to the CCG's external auditor including VAT:	**95**	**104**

6.1 Better Payment Practice Code

Measure of compliance	2014-15 Number	2014-15 £000	2013-14 Number	2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	5,213	32,520	3416	23128
Total Non-NHS Trade Invoices paid within target	4,964	30,807	3008	21340
Percentage of Non-NHS Trade invoices paid within target	**95.22%**	**94.73%**	**88.06%**	**92.27%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,783	263,372	1,599	255485
Total NHS Trade Invoices Paid within target	3,257	259,386	1,244	239220
Percentage of NHS Trade Invoices paid within target	**86.10%**	**98.49%**	**77.80%**	**93.63%**

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

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

The CCG did not incur any costs under this Act and does not have any amounts to disclose.

7 Operating leases

7.1 As lessee

7.1.1 Payments recognised as an Expense

	Buildings	Other	2014-15 Total	2013-14 Total
	£000	**£000**	**£000**	£000
Payments recognised as an expense Minimum lease payments	1,753	4.71	**1,758**	3,018
Total	**1,753**	**4.71**	**1,758**	**3,018**

The clinical commissioning group occupies property owned and managed by NHS Property Services Ltd. For 2013-14, a transitional occupancy rent based on annual property cost allocations has been proposed by the Department of Health. This is reflected in Note 7.1.1.

While our arrangements with NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed.

8 Trade and other receivables

	Current 2014-15 £000	Current 2013-14 £000
NHS receivables: Revenue	26	52
NHS prepayments and accrued income	1,813	1,003
Non-NHS receivables: Revenue	410	839
Non-NHS prepayments and accrued income	70	243
Provision for the impairment of receivables	0	(839)
VAT	36	0
Other receivables	2	0
Total Trade & other receivables	**2,357**	**1,298**

8.1 Receivables past their due date but not impaired

	2014-15 £000	2013-14 £000
By up to three months	388	52
By three to six months	1	–
By more than six months	1	–
Total	**390**	52

£240,990.47 of the amount above has subsequently been recovered post the statement of financial position date.

8.2 Provision for impairment of receivables

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	(839)	0
Decrease/(Increase) in receivables impaired Increase in receivables impaired	839	(839)
Balance at 31 March 2015	**0**	**(839)**

9 Cash and cash equivalents

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	190	–
Net change in year	(132)	190
Balance at 31 March 2015	**58**	**190**
Made up of: Cash with the Government Banking Service	58	190
Cash and cash equivalents as in statement of financial position	**58**	**190**
Balance at 31 March 2015	**58**	**190**

10 Trade and other payables

	Current 2013-14 £000
NHS payables: revenue	10,963
NHS accruals and deferred income	8,578
Non-NHS payables: revenue	542
Non-NHS accruals and deferred income	9,106
Social security costs	19
Tax	22
Other payables	2,569
Total current payables at 31 March 2014	**31,799**

Other payables include £22,000 outstanding pension contributions at 31 March 2014.

11 Provisions

	Current 2014-15 £000	Current 2013-14 £000
NHS payables: revenue	18,022	10,963
NHS accruals and deferred income	7,519	8,578
Non-NHS payables: revenue	9,244	542
Non-NHS accruals and deferred income	6,334	9,106
Social security costs	37	19
Tax	47	22
Other payables	8,266	2,569
Other payables	**46,469**	**31,799**
Total current and non-current	**46,469**	**31,799**

	Continuing Care 2014-15 £000s	Continuing Care 2013-14 £000s
Balance at 1 April 2013	**326**	**0**
Arising during the year	0	326
Reversed unused	(326)	0
Balance at 31 March 2014	**0**	**326**
Expected timing of cash flows: Within one year	0	326
Balance at 31 March 2014	**0**	**326**

12 Contingent Assets / Liabilities

The CCG does not have any Contingent Assets or Liabilities.

13 Financial instruments

13.1 Financial risk management

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

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

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

13.1.1 Currency risk

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

13.1.2 Interest rate risk

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

13.1.3 Credit risk

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

13.1.3 Liquidity risk

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

13.1.4 Financial assets

	Loans and Receivables 2014-15 £000	**Loans and Receivables 2013-14 £000**
Receivables:		
• NHS	26	52
• Non-NHS	410	839
Cash at bank and in hand	58	190
Other financial assets	2	0
Total at 31 March 2015	**496**	**1,081**

	Other 2014-15 £000	Other 2013-14 £000
Payables:		
• NHS	25,541	19,541
• Non-NHS	23,844	9,648
Total at 31 March 2015	**49,385**	**29,189**

14 Operating segments

The clinical commissioning group consider that they have only one segment: commissioning of healthcare services.

15 Intra-government and other balances

	Current Receivables 2013-14 £000	Current Payables 2013-14 £000
Balances with:		
• Other Central Government bodies	173	3,658
• Local Authorities	302	2,584
Balances with NHS bodies:		
• NHS bodies outside the Departmental Group	558	782
• NHS Trusts and Foundation Trusts	1,281	24,759
Total of balances with NHS bodies:	**1,839**	**25,541**
• Bodies external to Government	43	17,686
Total balances at 31 March 2015	**2,357**	**49,469**

	Current Receivables 2013-14 £000	Current Payables 2013-14 £000
Balances with:		
• Other Central Government bodies	0	63
• Local Authorities	839	1,557
Balances with NHS bodies:		
• NHS bodies outside the Departmental Group	1,003	2,444
• NHS Trusts and Foundation Trusts	52	17,097
Total of balances with NHS bodies:	**1,055**	**19,541**
• Bodies external to Government	(596)	10,638
Total balances at 31 March 2014	**1,298**	**31,799**

16 Related party transactions

16.1 Related party transactions 2014-15 (Non-NHS)

City and Hackney CCG is required to disclose transactions and outstanding balances with its related parties.

HM Treasury considers Government Departments and their agencies, and Department of Health Ministers, their close families and entities.

Voting members of the Governing Body have declared their interests, which are shown in the Annual Report section of this document.

The transactions listed below are in relation to interests declared, other than those relating to member general practices, where payments were over £10,000:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Acorn Lodge Care Home	228	0	34	0
Age Uk East London	155	0	0	0
City & Hackney Urgent Healthcare Social Enterprise	2,384	0	314	0
St Josephs Hospice	1,602	0	0	0
St Josephs Hospice Hackney	876	0	784	0

Clinical commissioning groups are clinically led membership organisations made up of general practices.

The members of City and Hackney Clinical Commissioning Group are contained within the constitution. Where payments of over £100,000 have been made to these practices, these are listed below. The majority of the payments are in relation to agreed extended primary care services.

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
At Medics Ltd Merriam Avenue	112	0	0	0
Barton House Group Practice	704	0	50	0
Cedar Practice	180	0	0	0
City & Hackney Gp Confederation	1,278	0	970	0
Clapton Surgery	173	0	0	0
De Beauvoir Surgery	163	0	0	0
Dr Hg Patel & G Patel	507	0	0	0
Elsdale Street Clinic	212	0	0	0
Elsdale Street Surgery	198	0	0	0
Heron Practice	302	0	0	0
Hoxton Surgery	164	0	0	0
Latimer Health Centre	195	0	2	0
Lawson Practice	799	0	0	0
Lea Surgery	285	0	0	0
London Fields Medical Centre	352	0	0	0
Lower Clapton Group Practice	934	0	143	0
Newman Practice	104	0	0	0
Nightingale Practice (The)	551	0	0	0
Queensbridge Group Practice	268	0	0	0
Shoreditch Park Surgery	373	0	0	0
Somerford Grove Health Centre	427	0	0	0
Sorsby Health Centre	156	0	0	0
Spitzer Practice- Cranwich Road Surgery	110	0	0	0
Springfield Health Centre	200	0	0	0
Stamford Hill Group Practice	278	0	0	0
Statham Grove Surgery	203	0	0	0
Tollgate Lodge Practice	404	0	0	0
Well Street Surgery	369	0	0	0
Whiston Road Surgery	107	0	0	0
Wick Health Centre	172	0	0	0

Cecil Lobo (£254k) is merged with Nightingale Practice(The) (£197k) as the payments relate to the same GP Practice.

16 Related party transactions 2013-14

16.1a Related party transactions 2013-14 (Non-NHS)

City and Hackney CCG is required to disclose transactions and outstanding balances with its related parties.

HM Treasury considers Government Departments and their agencies, and Department of Health Ministers, their close families and entities controlled or influenced by them, as being parties related to NHS bodies.

Voting members of the Governing Body have declared their interests, which are shown in the Annual Report section of this document. This information is also on the CCG's website.

The transactions listed below are in relation to interests declared, other than those relating to member general practices, where payments were over £10,000:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Acorn Lodge Care Home	128	0	2	0
Age Concern England	28	0	0	0
Fleet Architects Ltd	17	0	0	0

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

The members of City and Hackney Clinical Commissioning Group are contained within the constitution. Where payments of over £10,000 have been made to these practices, these are listed below. The majority of the payments are in relation to agreed extended primary care services.

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Abney House Medical Centre	16	0	0	0
Allerton Road Medical Centre	38	0	0	0
At Medics Ltd Merriam Avenue	22	0	0	0
Athena Medical Centre	43	0	0	0
Barton House Group Practice	118	0	0	0
Beechwood Medical Centre	13	0	0	0
Brooke Road Surgery	16	0	0	0
Cedar Practice	47	0	0	0
Clapton Surgery	31	0	0	0
Dalston Practice	26	0	0	0
De Beauvoir Surgery	62	0	0	0
Dr Gangola & Partner	35	0	0	0
Dr HG Patel & G Patel	57	0	0	0
Dr Tibrewal & Partner	29	0	0	0
Elsdale Street Clinic	55	0	0	0
Elsdale Street Surgery	188	0	0	0
Fountayne Road Health Centre	16	0	0	0
Gadhvi Fountayne Road Health Centre	21	0	0	0
Gadhvi Practice	16	0	0	0
Heron Practice	81	0	0	0
Hoxton Surgery	61	0	0	0
Kingsmead Medical Centre	24	0	28	0
Latimer Health Centre	26	0	0	0
Lawson Practice	201	0	0	0
Lea Surgery	81	0	0	0
London Fields Medical Centre	104	0	0	0
Lower Clapton Group Practice	505	0	0	0
Healy Medical Centre	21	0	0	0
Neaman Practice	10	0	0	0
Newman Practice	36	0	0	0
Nightingale Practice (The)	166	0	0	0
Queensbridge Group Practice	75	0	0	0
Rosewood Practice	28	0	0	0
Sandringham Practice	38	0	0	0
Shoreditch Park Surgery	170	0	21	0
Somerford Grove Health Centre	112	0	0	0
Sorsby Health Centre	50	0	0	0
Spitzer Practice - Cranwich Road Surgery	45	0	0	0
Springfield Health Centre	68	0	0	0
Stamford Hill Group Practice	97	0	0	0
Statham Grove Surgery	67	0	0	0
Tollgate Lodge Practice	30	0	0	0
Upper Clapton Surgery	19	0	0	0
Well Street Surgery	138	0	0	0
Whiston Road Surgery	41	0	0	0
Wick Health Centre	58	0	0	0

Cecil Lobo (£40k) is merged with Nightingale Practice(The) (£126k) as the payment relate to the same GP Practice.

16 Related party transactions 2013-14

16.2 Related party transactions (NHS and Other Government)

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. The disclosure below relates to bodies where payments or receipts were over £1m:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Barts Health Nhs Trust	25,916	0	4,190	0
East London Nhs Foundation Trust	44,390	(20)	5,427	0
Guys & St Thomas Hospital Nhs Foundation Trust	2,294	0	363	0
Homerton University Hospital Nhs Foundation Trust	145,784	(34)	8,630	0
London Ambulance Service Nhs Trust	10,318	0	621	0
Moorfields Eye Hospital Nhs Foundation Trust	6,251	0	1,016	0
NHS North And East London CSU	2,677	(7)	253	0
North Middlesex University Hospital Nhs Trust	1,380	0	90	0
Royal Free London Nhs Foundation Trust	1,678	0	214	0
University College London Hospitals Nhs Foundation Trust	12,715	0	2,448	0
Whittington Hospital Nhs Trust (The)	5,027	0	457	0
NHS Property Services	1,777	0	2,026	0
Community Health Partnerships	0	0	1,549	0
Tavistock and Portman NHS Foundation Trust	1,389	0	412	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. The disclosure below relates to bodies where payments or receipts were over £1m:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
London Borough Of Hackney	12,788	(374)	2,584	(302)
National Health Service Pension Scheme	231	0	32	0
HM Revenue and Customs	219	0	84	(36)

16 Related party transactions 2013-14

16.2a Related party transactions – 2013-14 (NHS and Other Government)

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. The disclosure below relates to bodies where payments or receipts were over £1m:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
NHS North & East London CSU	4675	-318	328	-318
Barts Health NHS Trust	26977	0	3274	-40
London Ambulance Service NHS Trust	9451	0	111	0
North Middlesex University Hospital NHS Trust	1345	0	137	0
Whittington Hospital NHS Trust	5689	0	923	0
East London NHS Foundation Trust	50306	0	4574	0
Guy's And St Thomas' NHS Foundation Trust	2229	0	221	0
Homerton University Hospital NHS Foundation Trust	141019	0	2419	0
Moorfields Eye Hospital NHS Foundation Trust	5440	0	599	0
Royal Free London NHS Foundation Trust	1800	0	357	0
University College London Hospitals NHS Foundation Trust	10721	0	1831	0
NHS Property Services Limited	1490	0	294	0
Community Health Partnerships	1528	0	1528	0

17 Events after the end of the reporting period

There are no events after Balance Sheet to report.

18 Losses and special payments

18.1 Losses

There were no material events after the reporting period.

	Total Number of Cases 2014-15 Number	**Total Value of Cases 2014-15 £'000y**	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £'000
Administrative write-offs	1	(348)	0	0
Total	**1**	**(348)**	**0**	**0**

A bad debt provision was raised in 2013/14 against Prescribing drug recharges to Hackney Council totalling £839k. In 2014/15 recharges were agreed with Hackney Council (Public Health) relating to 2013/14 totalling £348k. This part of the bad debt provision was therefore not utilised and the £348k has been reversed back as a one-off benefit into the 2014/15 accounts

19 Financial performance targets

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

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

	2014-15 Target	**2014-15 Performance**	**Duties Achieved Y/N**	2013-14 Target	2013-14 Performance
Expenditure not to exceed income	383,748	342,233	Y	359,830	332,582
Revenue resource use does not exceed the amount specified in Directions	382,843	341,329	Y	357,890	330,642
Revenue administration resource use does not exceed the amount specified in Directions	6,974	3,715	Y	6,540	5,074

Note: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).