



*Hounslow
Clinical Commissioning Group*

Annual Report and Accounts 2015/16

PERFORMANCE REPORT	5
1 OVERVIEW	5
1.1 Statement from our Chair and Accountable Officer	5
1.2 The purpose and activities of the CCG	7
1.2.1 Our vision and who we are	7
1.2.2 How the CCG works	7
1.2.3 Transforming care in North West London	8
1.2.4 Working with partners to achieve our vision and values	10
1.2.5 Health of the borough	11
1.2.6 Achievements 2015/16	12
1.2.7 Priorities 2016/17	16
1.2.8 Engagement with local people	19
1.3 Key Issues and Risks	22
1.3.1 Key issues	22
1.3.2 Key risks	23
1.4 Performance Summary	24
1.4.1 Overview of the CCG finances	24
1.4.2 How we spent your money	25
1.4.3 Funding allocations	26
1.4.4 Performance against financial targets	26
2 PERFORMANCE ANALYSIS	27
2.1 How the CCG measure performance	27
2.2 Development and performance during the year	29
2.3 Performance on other matters: sustainability	29
2.4 Quality and Safety	30
2.4.1 Safeguarding adults and children	30
ACCOUNTABILITY REPORT	31
CORPORATE GOVERNANCE REPORT	31
3 MEMBERS' REPORT	31
3.1 List of Hounslow CCG member practices	31
3.2 Hounslow CCG Governing Body and Audit Committee	32
3.2.3 Governing Body members	33
3.2.4 Audit Committee members	33
3.3 Members' Interests	33
3.4 Personal data-related incidents	34
3.5 Statement as to disclosure to auditors	34

3.6	Approval of Members' Report	34
4	STATEMENT OF THE ACCOUNTABLE OFFICER'S RESPONSIBILITIES	35
5	ANNUAL GOVERNANCE STATEMENT	36
5.1	Introduction and context	36
5.2	Scope of responsibility	36
5.3	Compliance with the UK Corporate Governance Code	36
5.4	The Clinical Commissioning Group Governance Framework	36
5.5	Governance Structure	37
5.5.1	Governing Body	37
5.5.2	Audit Committee	38
5.5.3	Finance and Performance Committee	39
5.5.4	Remuneration Committee	40
5.5.5	CWHHE Investment Committee	41
5.5.6	CWHHE Quality & Patient Safety Committee (until December 2015)	42
5.5.7	CWHHE Performance Committee (until December 2015)	43
5.5.8	CWHHE Quality and Performance Transition Committee	43
5.5.9	Quality, Patient Safety & Equalities Committee	44
5.5.10	Other CCG Committees	45
5.6	The Clinical Commissioning Group Risk Management Framework	49
5.6.1	Risk Management Strategy	49
5.6.2	Embedding Risk Management	50
5.6.3	Public Stakeholder Engagement	51
5.6.4	Control Mechanism	51
5.6.5	Deterrent to risks arising	52
5.6.6	Risk Assessment and Risk Profile	53
5.6.7	Risks to Governance, compliance, management and internal control	53
5.6.8	Principal Risks to Compliance	53
5.7	The Clinical Commissioning Group Internal Control Framework	54
5.7.1	Information Governance	54
5.7.2	Review of Economy, Efficiency & Effectiveness of the Use of Resources	55
5.7.3	Underlying financial position	55
5.7.4	Feedback from delegation chains regarding business, use of resources and responses to risk	55
5.8	Review of the effectiveness of Governance, Risk Management & Internal Control	56
5.8.1	Capacity to Handle Risk	56
5.8.2	Review of Effectiveness	57
5.8.3	Head of Internal Audit Opinion	57
5.8.4	Data Quality	59
5.8.5	Business Critical Models	59
5.8.6	Data Security	59
5.8.7	Emergency preparedness, resilience and response	60
5.8.8	Health and safety performance	60
5.8.9	Policy on countering fraud corruption	61

5.8.10	Complaints and principles for remedy	61
5.8.11	Discharge of Statutory Functions	62
5.8.12	Conclusion	62

REMUNERATION REPORT **63**

6.1	Remuneration committee members and attendance	63
6.2	Remuneration Policy	63
6.2.1	Chair and elected governing body members	63
6.2.2	Lay members	64
6.2.3	Senior managers performance-related pay	64
6.3	Compensation on early retirement or for loss of office (subject to audit)	64
6.4	Payments to past senior managers (subject to audit)	64
6.5	Pay multiples (subject to audit)	64
6.6	Senior Managers Definition	66
6.7	Senior managers – salaries and allowances	66
6.8	Salaries and allowances (subject to audit)	67
6.9	Senior Managers – salaries and allowances - joint appointments (subject to audit)	68
6.10	Senior Managers - Pensions benefits (subject to audit)	71

7 STAFF REPORT **72**

7.1	Number of Senior Managers by Band	72
7.2	Staff Numbers	72
7.3	Staff Composition	72
7.4	Sickness Absence Data	73
7.5	Staff Policies	73
7.5.1	Equality	73
7.6	Expenditure on Consultancy	73
7.7	Off-payroll engagements	74
7.8	Exit Packages (subject to audit)	75
7.9	Approval of Remuneration and Staff Report	75

AUDIT OPINION **76**

FINANCIAL STATEMENTS **80**

PERFORMANCE REPORT

1 Overview

1.1 Statement from our Chair and Accountable Officer

The annual report offers an opportunity to take stock of our progress during 2015/16 and highlight our vision and plans and priorities for the coming year.

Our vision for health services is to develop personalised, localised, integrated and specialised care for local people. To do so we have agreed two programmes of work covering all eight boroughs in North West London. One is Shaping a Healthier Future (SaHF), the other is Like Minded, which looks at improving mental health and wellbeing.

SaHF consists of two main parts: out of hospital and local service improvements, which includes primary care transformation, whole systems integration and other local service improvements; and changes to our hospitals. In this report we will set out the strategy behind these changes and detail the progress that is being made.

This includes our ambitious strategy to make 19 more services available to patients in convenient GP settings; the introduction of our community recovery and care navigators service, social workers being present in GP surgeries, and laying the groundwork for an integrated patient transport system.

Over the past twelve months, we have also played a key role in driving forward transformational activity at a local level as well as being a leading player in the agenda set out nationally by Simon Stevens in the Five Year Forward View. We have joined with our CCG partners in North West London to deliver our Sustainability and Transformation Plans (STPs) programme for improved health, care and finances over the next five years. We have also been active in looking at NHS Devolution in London.

It is also the year that Hounslow CCG broadened its influence and began co-commissioning more primary care services with NHS England. We anticipate greater decision-making powers in this area as time goes on, allowing us to work more closely with fellow health professionals such as pharmacists, dentists and opticians, and better enabling us to respond effectively to changing local needs.

It is important to plan ahead and set clear goals for Hounslow CCG and its partners. This allows us to demonstrate measureable results to the public and stakeholders to whom we are accountable.

The plan is drawn up in consultation with our patient representatives and User Panels, and other stakeholders such as the London Borough of Hounslow, and the Health and Wellbeing Board. A partnership approach becomes more crucial than ever when we are so acutely aware that our resources are finite.

We do this work against the backdrop of the complex demographics of Hounslow – high ethnic and cultural diversity which is increasing at a fast rate. Hounslow CCG has historically received less funding per head of population than other comparable CCGs and has been under significant financial pressure. This has to a certain degree been alleviated over the last two years when allocation increases have allowed the CCG to

invest more, particularly in mental health and community services. However increasing demand and more restricted uplifts in the future mean that the CCG will need to work hard with partners in Hounslow to ensure the needs of patients are met within the available resources.

In spite of the ambitious nature of our work programme and financial objectives, we are confident that we can continue to build strongly upon the past year's progress. We know that people in Hounslow want to see sustainable and high quality health services and we look forward to sharing a constructive and supportive dialogue with the public as we press on with this challenging yet vital work.

We would like to end by saying thank you to all our partners and their staff who provide care for our residents. We would especially like to thank our GP membership for their continued support and hard work. It is only by working together that we can continue to deliver the excellent services that our patients deserve.

Dr Nicola Burbidge
Chair, NHS Hounslow CCG

Clare Parker
Accountable Officer,
NHS Hounslow CCG

1.2 The purpose and activities of the CCG

1.2.1 Our vision and who we are

NHS Hounslow Clinical Commissioning Group (CCG) is the GP led organisation responsible for planning and buying (commissioning) health services for the people living in Hounslow. Hounslow CCG was set up in April 2013 under the Health and Social Care Act 2012.

The CCG is made up of 53 GP member practices that in 2015/16 served an estimated registered patient population of 305,626. We are committed to improving the care provided to patients, reducing health inequalities and raising the quality and standards of GP practices whilst achieving a financial balance.

1.2.2 How the CCG works

CCGs put local GPs at the heart of deciding what health services local people need and receive. All of our GPs use their experience and knowledge to influence and shape the decisions the CCG makes, with some more heavily involved as representatives of the CCG Council of Members and Governing Body.

The CCG Chair is elected by the Governing Body members. Representatives include GPs, lay members, a secondary care consultant and CCG officers. It is the Governing Body that oversees the day to day running of the CCG, supported by a team of officers, who together undertake service development, contracting and performance management of local health services. You can find out more about the CCG and how it works at www.hounslowccg.nhs.uk.

We work with clinicians, patients and carers to make sure your health and social care services are effective and coordinated. The CCG has an annual budget of £342m. We buy a range of services including:

- Planned surgery (elective hospital care)
- Rehabilitation care
- Urgent care and emergency care
- Community health services
- Mental health and learning disability services
- Some primary care services.

Our aim is to ensure the highest quality of care is delivered by the organisations best qualified to do so for the diverse needs of our patients, carers and the public, and at the best value for money so that we spend public money wisely.

Each year, Hounslow CCG develops and publishes our plans for the year ahead. Our priorities for 2015/16 included:

- Working with our local NHS Trusts to ensure delivery across all national standards
- Continuing to invest in and develop more out of hospital services with a focus on developing integrated services across health and social care
- Continuing to improve services for people with long-term and mental health conditions
- Working to reduce emergency hospital admissions through a broad range of initiatives.

Although we do not directly commission all primary care services (GPs, dentists, pharmacists and optometrists, which are commissioned by NHS England) we recognise our role in helping to develop primary care and improving access to these services and this year entered into primary care co-commissioning arrangements with NHS England.

1.2.3 Transforming healthcare in North West London

In North West London, the NHS is working together to improve healthcare services for the two million residents who live in the area. Our vision is that we will deliver care that is:

- **Personalised:** Care is to be personalised, enabling people to manage their own care themselves and to offer the best treatment to them. This ensures care is unique.
- **Localised:** Care is to be localised where possible, allowing for a wider variety of services closer to home. This ensures care is convenient.
- **Integrated:** Delivering care that considers all the aspects of a person's health and wellbeing and is coordinated across all the services involved. This ensures care is efficient.
- **Specialised:** Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures care is better.

By CCGs in North West London working together to realise this vision, we can achieve patient-centred care in all our care settings, ensuring reduced inequality of care outcomes and delivery of services that are tailored to the needs of the local population.

That means being able to get appointments with a GP quickly and conveniently; making sure more specialist doctors are available, no matter what day of the week it is; that your mental health is considered at the same time as your physical health, with a single, coordinated approach by health and voluntary sector organisations; and that when you need longer term care from different people, it is joined up and you do not need to keep repeating your story.

We're also making sure the public helps shape care, involving them from an early stage in the design of services, and listening to their feedback along the way. Through this joint approach, we will improve people's health and wellbeing, giving them a better quality of life.

To improve physical health care and mental health and wellbeing across North West London, the local NHS agreed two programmes of work covering all eight boroughs. One is Shaping a Healthier Future (SaHF); the other is Like Minded, which looks at improving mental health and wellbeing. The SaHF case for change has been discussed many times, and fully consulted on. Although we will not repeat the details here it is worth highlighting that the fundamental challenge facing the health service in North West London – a growing, ageing population living with more long term conditions and continues to become ever more acute.

SaHF consists of two main parts: out of hospital or local service improvements, which includes changing and improving GP services, improving the way services work together and other local service improvements; and changes to our hospitals. Our aim is to ensure expertise is in the right place to make the biggest difference to local people.

The programme is clinically led and aims to provide the best possible outcomes and

experience for the people of North West London, 24 hours a day, seven days a week, 365 days a year. The services our hospitals provide need to change to match the needs of our population, including more specialisation and technology, and with more services provided closer to peoples' homes.

As well as improving the quality of care and bringing in much needed investment, our work helps tackle the biggest factors in dissatisfaction with NHS services according to the latest British Social Attitudes patient satisfaction survey. These are waiting times for GP and hospital appointments, not enough staff and under-funding.

The CCG has already invested significantly in out of hospital services including primary and community care in recent years. This is set to continue the CCG plans to make further investments in community and primary care in 2016/17 and beyond. We will also continue to work with acute partners on delivery of high quality acute care at the hospital sites across North West London.

All nine hospitals in North West London also have 24/7 urgent care centres which can treat the majority of patients needing urgent care. To increase patient access to specialised care, Central Middlesex Hospital is being developed as a specialist hospital for planned (elective) care such as hip operations, and Hammersmith will specialise in areas including cancer care and as a heart attack centre.

Hospitals, and especially A&E and maternity services, are often seen as a barometer for the health of the NHS. Yet GPs and primary care see over 90 percent of patients and this is where SaHF is making the biggest difference to patients most quickly.

Current estimates show that failure to implement SaHF would lead to an estimated £500m gap across the region with patients not receiving planned clinical benefits and longer waits for diagnosis and treatment. All the trusts and CCGs are in deficit and are running a combined £834m maintenance backlog which has not been addressed. In short, doing nothing is not an option.

In 2016/17 our focus will be the:

- Delivery of a revised Implementation Business Case for approval by the NHS and HM Government, allowing for capital investments to be made to transform NHS estates in North West London.
- Delivery of the transition of paediatric services from Ealing Hospital by June 30, as agreed by Ealing CCG Governing Body (on behalf of all other Governing Bodies in North West London) earlier this year.
- Planning for the transition of other services from Ealing and Charing Cross Hospitals as we continue to transform these sites to their future state.

Planning across North West London is now being carried forward in the shape of the Sustainability and Transformation Plan.

The North West London Sustainability and Transformation Plan

The local health and social care system in North West London has joined together to create an ambitious Sustainability and Transformation Plan (STP) for improved health, care and finances over the next five years. Dr Mohini Parmar, Chair of Ealing Clinical Commissioning Group (CCG) has been appointed lead for North West London's STP programme. Dr Mohini Parmar will be supported in her role by senior officers from CCG, provider and local authority organisations.

The one footprint in North West London reflects the strong record of joining up health and social care and means we are well placed to deliver a robust, comprehensive STP. The single STP for the area is being developed by local leaders from NHS commissioners and providers, local authorities and patient representatives. The result will be a place-based five year plan built around patients and joint-working, rather than a more traditional approach based around individual organisations. The STP will show how the existing 'Shaping a Healthier Future' vision and plans will be used to achieve the goals of the five year forward view in North West London. Progress will be assessed in mid-April and the deadline for the final STP is the end of June 2016.

Other areas of strategic development include:

NHS health devolution in London

London's CCGs and London Councils have agreed to work closely together to go further and faster in integration and collaboration using devolution as a tool to achieve this. NHS England and Public Health England as well as central government all agree to support this agenda by being active partners in the pilots and demonstrating a shared commitment to health and care devolution in London. The parties to the 'London Health and Care Collaboration Agreement' are:

- All 32 London Clinical Commissioning Groups (CCGs)
- All 33 local authority members of London Councils
- The Mayor of London
- NHS England
- Public Health England.

The London Health Devolution Agreement has been signed by these parties in addition to central government.

1.2.4 Working with partners to achieve our vision and values

Hounslow CCG works in partnership with a wide range of organisations to ensure that our residents receive the health and social care services that they need. These organisations include:

- Hounslow Council
- Feltham and Bedfont Locality Limited (GP Federation)
- Brentworth Locality Limited (GP Federation)
- Hounslow Health Locality Limited (GP Federation)
- Chiswick Healthcare Locality Limited; (GP Federation)
- Great West Road Healthcare Limited (GP Federation)
- Individual GP practices
- Imperial College Healthcare NHS Trust
- Chelsea and Westminster Foundation Trust
- West Middlesex University Hospital (01/04/2015 to 31/08/2015)
- Chelsea and Westminster Foundation Trust, West Middlesex University Hospital site (01/09/2015 to present)
- Ashford and St Peter's NHS Foundation Trust
- West London Mental Health NHS Trust
- Hounslow and Richmond Community Healthcare NHS Trust
- Voluntary/community organisations
- The Metropolitan Police
- Healthwatch Hounslow.

Of particular importance is the Hounslow Health and Wellbeing Board, of which the CCG is a member. The board is made up of representatives from the local authority, the NHS and the voluntary sector and is the place for key partners to work together to improve the health and wellbeing of our population.

CWHHE Collaborative

Hounslow CCG works with Central London, West London, Hammersmith and Fulham, and Ealing CCGs in the CWHHE Collaborative. Working in a collaborative means we have a stronger influence. It also allows us to provide greater scrutiny and influence on any decision that affects our area.

Improving patient safety and the quality of services local people get from our hospitals and other providers are just two areas we have more influence on if we join together. For example, we have a collaborative safeguarding team, working across the five CCGs providing support to us all. By working together we are able to fulfil our statutory safeguarding duties with regards to children and other vulnerable patients, which is an important aspect of the work we do.

Alongside the CCG's dedicated team, we also share a larger collaborative team with a number of shared posts. This includes our Chief Officer, Chief Financial Officer, Director of Nursing, Quality and Safety, and Director of Compliance.

North West London Collaboration of Clinical Commissioning Groups

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

Central London CCG hosts a range of support services for the five CWHHE CCGs including finance, quality and performance.

In addition, Brent CCG hosts a number of shared services such as communications, human resources, information technology, business information and commissioning and performance management from which we all benefit.

The Office of London CCGs coordinates collaborative working across the 32 CCGs in London. Working in this way allows the CCGs to manage collective commissioning arrangements and strategic change that crosses CCG boundaries. It also promotes shared learning to improve performance.

NHS England and primary care co-commissioning

In May 2015, Hounslow CCG entered into primary care joint co-commissioning arrangements with NHS England. This means that your local CCG has more influence over the commissioning of General Practices for Hounslow and to ensure that health services are joined up across all parts of the health services in the borough. A core area of focus this year has been the primary medical services review and establishing the new governance arrangements.

1.2.5 Health of the borough

The London Borough of Hounslow is the ninth largest borough in London. Geographically, the borough is situated between the Thames, Heathrow Airport and central London. Both the environment and the population of Hounslow are diverse.

Each of the local wards and communities differ greatly in character, all with unique health needs, challenges and priorities.

The percentage of the Hounslow population that identifies as 'White British' has reduced from 55.8 per cent in 2001 to 37.9 per cent in 2011. The second largest group in the population identifies as Indian or British Indian, making up 19 per cent of the population.

Around 19.1 per cent of the population is under the age of 15, 7.7 per cent is under 5, 63-64 per cent of the population is aged between 20 and 64 and 5 per cent of the population is 75 and above. The Greater London Authority predicts an increase in Hounslow's population between 2011 and 2031 of about 27 per cent.

The 2014 Joint Strategic Needs Assessment (JSNA) produced by the Public Health Department at Hounslow Council, in partnership with the NHS and community representatives, and is founded on a strong evidence base of need.

The key factors impacting Hounslow's health demographic for both Hounslow and the other West London Alliance local authorities, the majority of the population lives in areas that are more deprived than the national median. Hounslow is one of the most deprived boroughs in West London with areas of deprivation contrasting with more affluent areas. The key factors impacting Hounslow's health demographic are:

- Language and cultural barriers
- That the borough performs significantly worse than the national average in terms of alcohol-specific mortality and alcohol-specific admissions for males, and alcohol-attributable admissions, which in 2012/13 were more common amongst males and amongst 45-64 year olds
- Hounslow has significantly more deaths from heart disease and stroke than the England average
- Obesity is prevalent in about 22 per cent of the adult population in Hounslow, significantly more are overweight (approximately 40 per cent)
- Hounslow has an overall smoking prevalence of 16.9 per cent, equivalent to approximately 30,500 smokers
- Hounslow has a higher proportion of adults in residential nursing home care than other areas.

For more information on the JSNA health report '*This is Hounslow*', visit www.hounslow.gov.uk.

1.2.6 Achievements 2015/16

Hounslow CCG's aim is to deliver high performing, good quality and cost effective hospital and community based healthcare for our residents. Over the past year we have introduced many new services and progressed many programmes and initiatives that reflect our overall strategic intentions outlined under SaHF (out of hospital and local service improvement) and Like Minded (improving mental health and wellbeing).

Improving local services

Primary care transformation – changing and improving GP services

Primary care is at the centre of our ambitions to improve out of hospital care in Hounslow. As part of the Prime Minister's Challenge Fund (PMCF) over 2014 and 2015, our patients now have weekend access to GP services. Many patients

can now also book appointments online, access their records online, and benefit from alternative forms of access for consultations (including telephone, email and video consultations). Our GP practices have come together to form the Hounslow GP Federations to deliver higher quality services and more efficient administration, and to provide a strong voice for general practice within the developing Accountable Care Partnerships (ACPs).

Hounslow CCG and NHS England made good progress locally with the national review of GPs' Personal Medical Services (PMS) contracts. Some GP practices under the PMS contract receive extra funding per patient that was not available to their colleagues who receive funding under different contracting arrangements.

The purpose of the PMS review is to ensure that this extra PMS funding is aligned to services which best meet the needs of all of the local population, and that where it isn't, it is reinvested to the benefit of all GP practices and all patients across the Clinical Commissioning Group (CCG) area. Future investment will:

- Secure services or outcomes that go beyond what is expected of core general practice
- Help reduce health inequalities
- Give equality of opportunity to all GP practices
- Support fairer distribution of funding.

The review requires the CCG and NHS England (NHSE) to create one set of additional services to be paid for with the released funding. All practices (PMS, GMS and APMS practices) will be asked if they wish to provide these services and, over a period of transition, the funding will become divided between all eligible practices in the CCG. The review is due to be completed in the summer of 2016.

Community recovery service

As part of our work to empower patients by bringing care closer to home, Hounslow CCG launched a Community Recovery Service in 2015/16. The service is intended to support patients to become independent again as quickly as possible following acute illness or injury, or changes in life circumstances.

Health and social care professionals from four different teams share resources to create one single talent pool, which includes physiotherapists, occupational therapists, social workers, support workers and rehabilitation assistants, and at least one specialist Parkinson's nurse and one Multiple Sclerosis nurse plus a neuropsychologist.

This model co-ordinates care in an efficient way, with the patient in control of their own self-management and with all information shared in a timely and secure way.

Care Navigator service

GPs can refer patients to the care navigator service which helps to direct people to all the health and social care support they may need. The service helps to prevent pressure on hospital and emergency services by directing people to alternatives services and catching issues early before they need acute care. Piloted in 2014/15, the service in 2015/16 with the addition of telephone and face-to-face appointments, increasing the number of people supported.

Social workers in GP surgeries

Building on work from 2014/15 we extended the presence of social workers in general practice to all five localities in 2015/16. The social workers in the localities are an integral part to the multi-disciplinary approach to care.

Increasing the number of services delivered in primary care

Seven day access to a GP is one of the 19 services delivered by GP surgeries as part of the Local Services Strategy. The other 18 services include blood pressure monitoring, anticoagulation services for those on blood-thinning medication, complex wound management, electrocardiogram (ECGs), and some mental health services. All 53 GP practices in the CCG area will be working together to deliver these services to a common standard so that they are available to all patients in a convenient community setting.

Patients get tailored help to beat Type 2 Diabetes

Patients living in Hounslow at high risk of Type 2 diabetes are being invited to join a programme helping them avoid developing the condition as a new national scheme launches across the country.

It is part of the national Healthier You: NHS Diabetes Prevention Programme, and looks to help people at high risk of the condition change their lifestyles.

GPs across the region expect to begin to refer people they know to be at high risk during 2016. Those referred will get tailored, personalised help to reduce their risk of Type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing the disease.

The nationwide programme will start this year with a first wave of 27 areas covering 26 million people, half of the population, and making up to 20,000 places available. This will roll out to the whole country by 2020 with 100,000 referrals available each year after.

Community diabetes intermediate care

We commissioned a new Community Diabetes Intermediate Care Service with three distinct elements of service delivery that went live in May 2015. The service includes care for intermediate patients with diabetes, foot protection, and patient education. The service is providing patients in Hounslow with a robust, safe and reliable community-based diabetes care that meets their needs and improves their health outcomes.

Care Plans

Using IT systems that are integrated across services as a platform for care plans for over 75s and people with long-term conditions has increased their effectiveness. In 2015/16 we offered these care plans to 7,000 local patients, supporting people more effectively and treating problems earlier to avoid hospital.

Dementia diagnosis rate success

Hounslow CCG is working hard with its partners to improve dementia diagnosis rates. Our work so far has included providing greater support for GPs in identifying and referring patients to memory assessment services, commissioning more frontline services, such as dementia-specialist nurses and ensuring there is sufficient post-diagnosis support in place so as to encourage patients to get help faster in the earlier stages of the condition.

Primary care co-commissioning

Primary care is currently commissioned by NHS England, with very limited local influence. A number of options for co-commissioning were developed by NHS England and across North West London all eight CCGs opted to explore the potential of the joint commissioning option. Co-commissioning brings CCGs into the commissioning process for GP services and provides the potential for its alignment to local plans. Only with expanded influence through co-commissioning can the CCG be sure that primary care can act as a driver for

our ambitious plans for transforming the local health and care economy.

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

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

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

In March 2015 member practices voted in support of the CCG entering into joint primary care co-commissioning arrangements with NHS England.

A joint co-commissioning committee has been established with NHS England. This is a formal sub-committee of the Governing Body and, under agreed delegation, can take decisions over primary care in our area. It includes a range of clinical, executive, and lay members. The London wide LMC was consulted throughout the design of the co-commissioning structure and will also attend the co-commissioning committee meetings.

Improving care for adults and children with mental health needs

Transforming mental health and wellbeing services

In 2015/16 we developed a strategic plan to transform mental health and wellbeing services across North West London. The plan involves partnership working across health and social care and other partners.

Improvements to mental health urgent care - Single Point of Access (SPA)

A 24/7 urgent and crisis mental health Single Point of Access (SPA) support service was successfully launched in November 2015. The service is provided by West London Mental Health Trust. Staffed by mental health professionals with psychiatrists in support, the service gives advice and reassurance over the phone, books appointments for follow-up care and, when urgent care is needed, dispatch a rapid response home treatment team to be at the caller's home within four hours. The model was developed with service users, commissioners, providers and partners including the Metropolitan Police.

£0.5 million boost to young people's mental health services

In January 2016, £0.5 million was awarded to CCGs across North West London, including Hounslow CCG, to deliver their mental health plan for children and young people. The CCG's plan for the cash aims to improve the quality of and access to mental health services for young people.

IAPT Hounslow continues to improve mental health services access

Hounslow continues to promote and invest in local talking therapies services through the IAPT (Increasing Access to Psychological Therapies) service for residents who are experiencing serious but non-urgent mental health problems such as anxiety, stress, sleep problems, and depression. Talking therapies are delivered at a number of locations across

Hounslow, including some GP practices, health centres and community venues. Therapies available include computer-based CBT (cognitive behavioural therapy), mindfulness courses, stress management courses, and postnatal support groups.

Improving care in our hospitals

Development and Implementation of the children's paediatric assessment unit (PAU) at West Middlesex Hospital

The Paediatric Assessment Unit (PAU) at West Middlesex Hospital has been operational since 21 September 2015. The PAU is a six-bedded unit that provides rapid assessment of children and young people who require a length of stay in hospital of less than 24 hours, and aims to assess, treat and discharge home as early as clinically safe. In most cases, children are referred to the PAU from their local GP, the Urgent Care Centre (UCC) or A&E department at WMUH. Since opening, the PAU has seen over 2,300 children and young people. The PAU has enabled WMUH to more effectively manage the additional non-elective activity generated as a result of the Ealing transition. Paediatric consultants are based in the PAU 8:30am-10:30pm, seven days a week and during this time they are able to provide specialist advice to GPs via the PAU telephone hotline.

Social workers in emergency departments

In 2015/16 we supplied additional social workers in hospital emergency departments, available seven days a week, to ensure that people are discharged safely and effectively to their normal place of residence to reduce admissions and delays in transfers of care.

Improvements to maternity services in North West London

To improve the quality of care for mothers and babies across North West London, maternity services in the region underwent significant change in July 2015, including the closure of Ealing Hospital's maternity unit and development of community services. These clinically-led changes were essential to: respond to the increasing number of women with complex health needs during pregnancy; provide consistent high-quality maternity care by concentrating staff, expertise and resources in fewer centres and; increase the number of midwives and the hours of senior consultant cover.

Across NW London we have improved the midwife to birth ratio so that on average we are meeting the London Quality Standards minimum staffing ratio of one midwife to thirty births (1:30). Pre-transition there was also on average 101 hours consultant cover. North West London set out to achieve 123 hours in 2015/16 and we are now at 122 hours. 100 new midwives have been recruited to North West London as a result of these changes.

A review of the North West London Maternity and Neonatal Services Transition found that the NHS in North West London has managed a complex service change safely and with clear benefits to patients, mothers and their babies. The changes were aligned with the national maternity review, meaning North West London is already delivering the majority of the standards of care outlined in the review.

The Royal College of Midwives endorsed the transition and congratulated North West London NHS on the model of care and the detail in the transition. The review of the North West London maternity and neonatal service transition of July 2015 is available at www.healthinorthwestlondon.nhs.uk.

1.2.7 Priorities 2016/17

Hounslow CCG's priorities for 2016/17 have been agreed in partnership with a wide range of stakeholders. They focus on the areas of greatest need detailing how, where and when

services will be commissioned. The main priority for 2016/17 is to commission care that is personalised; localised; integrated; and specialised. Others are detailed below:

Improving local services

Primary Care Transformation

The main aim of the programme is to place primary care at the heart of whole system working, and improving access to GP services. Primary care, and in particular general practice, is at the centre of our collaborative vision. The aims are for patients to benefit from:

- Improved health outcomes, equity of access, reduced inequalities and better patient experience
- Services that are joined up, coordinated and easy to use
- More services available, closer to homes
- High quality out-of-hospital care
- More local patient and public involvement in developing services, with a greater focus on prevention, staying healthy and patient empowerment.

As we move through this year, our priority areas in 2016/17 are as follows:

- Approving the new model of primary care through the joint co-commissioning committees in common and implementing this across North West London and ensuring that this is a fundamental part of an integrated care offer for patients.
- Working to ensure that all necessary enablers are in place to support the new model of care rollout (including workforce, technology and contracts).
- Putting the right support in place to nurture and grow GP federations so they are able to deliver sustainability in the long term as part of Accountable Care Partnerships (ACPs).
- Progressing with the primary care estates strategy that takes into account the development of local services hubs across Hounslow. The long-term plan is to develop multiple hubs at a number of locations including Heston Health Centre, Brentford Health Centre, Chiswick Health Centre and Feltham Health Centre to increase accessibility. These hubs will provide a range of integrated services, closer to people's homes.

Integrated care

Our Whole Systems Integrated Care (WSIC) programme is about giving people more say over their care, when and where they receive it, so that care is planned jointly between patients, their carers and the teams that support them.

By involving patients and carers on the journey from day one, we have a much better chance of achieving our vision: care that enables each of us to help ourselves. And by widening access to services that aren't necessarily provided by the NHS, such as local exercise groups run by third sector parties, we can better support people to maintain independence and lead full lives as active participants in their communities.

This work and the progress in integrating service design and delivery over the last 2 years demonstrates the benefits that can be realised from a fully joined up approach. But pockets of excellence do not necessarily translate into sustainable transformation and we believe that the best way to truly embed the progress being made is through the development of implementation of Accountable Care Partnerships (ACPs).

If WSIC is about bringing service delivery together in an integrated way, ACPs are about bringing organisations together, removing organisational barriers and establishing (and incentivising) a clear shared responsibility for delivering fully integrated care.

During 2016/17 we will be further developing our plans for the implementation of ACPs to begin in April 2018 and we will continue to involve and work with our patients, residents and partners throughout.

Information sharing

Around 250 of 389 GP practices in North West London are now signed up to an information sharing agreement to allow data extraction of care records in order to produce dashboards to support integrated care. Data linkages are now complete for acute, community, and mental health providers. Loading of data from GP practices is currently underway, and the aim is to start loading social care data in the coming months. Plans are in place for full dashboard rollout to all practices within 12-16 months.

New wheelchair service to launch in North West London

In 2016, Hounslow CCG will be one of seven clinical commissioning groups to launch an innovative new integrated community wheelchair service for people of all ages who have a long-term need for a wheelchair. This can range from people who need a chair occasionally to those who are fully dependent on a wheelchair for all their mobility needs.

A broad range of wheelchair service users from across North West London were involved in designing the new provision. It was remodelled to ensure that people that need a wheelchair are able to access the right wheelchair quickly, and with appropriate support. Service users, lay representatives and key stakeholders have endorsed the approach the CCGs are taking which takes into account service users' three key wishes:

- Users want a more personalised service that reflects their needs and allows for choice
- Users want a fast and reliable service
- Users want excellent hardware and repair services.

The specifications and principles of the new service take into consideration the ten points of the Wheelchair Charter which was launched by the Wheelchair Leadership Alliance in July 2015. These include equality of access and provision irrespective of age or postcode; regular reviews with the wheelchair user or their carer; recruitment of qualified staff; and assessments for all wheelchairs within a nationally mandated timeframe.

Contracts for delivery of the service for these seven boroughs of North West London have been awarded to AJM Healthcare (for NHS Brent CCG, NHS Barnet CCG, NHS Ealing CCG, NHS Central London CCG, NHS West London CCG, and NHS Hammersmith and Fulham CCG) and Central London Community Healthcare NHS Trust (for Hounslow CCG) and are expected to go live in July 2016.

Integrated patient transport service

Working together with other CCGs, patients, and local community groups, Hounslow CCG has established a set of clear, enforceable standards for patient transport to hospital settings to ensure that quality is consistent regardless of where the patient happens to live, or where they need to travel to. The standards are known as the Quality Standards and Patient Charter, and were developed by a patient-led group called the Patient Transport Steering Group, and were also influenced by a survey of 700 patients. The Charter will be a mandatory requirement of all transport procurement going forward.

A similar review of transport services to mental health and community settings is planned for the coming year.

The Better Care Fund

Better Care Fund (BCF) programmes across North West London (NWL) are expected to be broadly consistent in priority from the previous plans across North West London and to focus on reducing the need for acute care by looking after people better in the community, and where acute care is required making sure that people return to their community setting as quickly as possible. We expect progress will be measured against two main metrics: reducing non-elective admissions (NELs) and delayed transfers of care (DTocS).

Improving our hospital care

An improved model of care for children

In June 2016 we will introduce an improved model of paediatric care for children in North West London. This will be achieved by moving inpatient paediatric services (for children who require emergency treatment or an overnight stay in hospital) will move from Ealing Hospital onto five other hospital sites in North West London, all of which have expanded their capacity by either increasing their number of inpatient beds or increasing the size of their paediatric A&E units. They will also have more senior doctors on site for longer hours, seven days per week, and have more paediatric nurses.

These changes will ensure that children receive consistently high-quality seven-day care, with more specialist senior doctors available to treat children for longer times. This will improve the quality of clinical care and patient experience in our hospitals, and get children back to health more quickly.

Improving mental health services for adults and children

In the year ahead we wish to improve mental and physical health through developing and introducing integrated services. North West London is committed to collaborating with key partners to co-produce a mental health and wellbeing strategy which will improve outcomes and value. Across the system we have agreed to ensure that there is:

- Support for people who have experienced mental health problems to live well in the community
- Promotion of recovery, resilience and deliver excellent health and social care outcomes including employment, housing and education
- Development of new high quality services in the community, focusing on community based support rather than inpatient care so that people can stay closer to home
- Urgent help and care available 24 hours a day, seven days a week for people who experience, or are close to experiencing, a crisis.

We want providers to be proactively involved in transformation work and in implementing the outputs of transformation work. Specifically in 2016/17 we want to focus on:

- Implementation of new urgent care pathways and compliance with national target waiting times
- Implementation of Future in Mind, the national strategy for children and young people to respond to local needs
- Work with local specialist Mental Health and Learning Disabilities providers to implement local pathways to enable people to be cared for within North West London
- Work collaboratively to implement the emerging outputs of the Like Minded strategy.

1.2.8 Engagement with local people

Engagement and participation

We are committed to active community engagement, to ensure that we fully understand the issues that affect our community. Over the past year, we have progressed a wide range of initiatives to ensure that the voice of patients is heard both in making strategic decisions around service reviews and commissioning decisions, and through on-going engagement with forums, patient participation groups and engaging with our local partners in Hounslow.

Engagement principles

Working with our partner CCGs in the CHWWE collaborative, we have taken steps to align and forward plan our engagement activity. This includes a shared set of principles for all engagement activity:

- Patients and public are at the centre of informing, influencing and shaping
- CCG commissioning and development and we have on-going conversations
- Agreement to align engagement mechanisms and share best practice where pragmatic and find common solutions to problems
- Engagement and involvement is systematic and on-going, using both new and innovative methods as well as tried and tested techniques
- We will change the culture about the value of engagement and involvement and how it will influence, 'we asked, you said and this is how it was changed'
- Ensuring key issues and insights are levered into strategic plans and acted upon, systematic feedback on how patient insights have been used to inform commissioning and influence process
- Honest, open and transparent about patient experience and their stories
- Actively listening, asking communities once, using plain language
- Agreement to work on issues together whenever possible and to be planned and timely – and in partnership with other organisations where we can
- Valuing the differences of the communities in each locality and between each locality and ensuring work is locality driven.

On-going participation

Patient and Public Engagement Committee meets six times a year, offering a chance for local people to engage with healthcare partners and help to shape local NHS services. During this year the PPE Committee received delegated responsibility from the Governing Body to progress the recruitment process of elected Locality Patient Participation Group (LPPG) representatives. It also discharged other key functions in line with its terms of reference such as: reviewing work programmes against participation duties, the publishing of Equality Information and advising on key partnership work such as engagement for the 'Stay well this winter' campaign.

Patient and Carer Reference Group (PCRG) meets bi-monthly, attracting strong attendance from patients and carers as well as the voluntary and statutory sectors and contributing to the development of strategic plans for local healthcare. The PCRG acts as a forum to advice around patient engagement and patient experiences with the CCG.

Patient Participation Groups (PPGs) meet on a regular basis to discuss the services on offer from their practice, and how improvements can be made. Patients can choose their level of involvement, from attending meetings to taking part in a 'virtual group'.

We have worked with and supported PPGs over the last 12 months by:

- Mapping which of our member GP practices have a PPG, so we can keep in touch
- Providing training to PPG chairs

- Engaging with PPG members and chairs to get a patient perspective on the development of local health services such as end of life care, diabetes, urgent care and COPD
- Attending PPG meetings to provide information about the CCG and patient involvement.

One of our priorities is to support the development of PPGs. From April 2015 it became a contractual requirement for all GP surgeries to have their own PPG. To this end we are helping support existing GP practices with PPGs and will be looking to help those without to set up new PPGs.

Healthwatch

Healthwatch works to give users of health and social care services a stronger voice, and we work closely together to identify problems and opportunities for improvement. Through our Governing Body, we respond to the quarterly produced patient experience reports from Healthwatch. A key priority for 2015/16 will be to continue to strengthen the relationship and ensure joint working between Healthwatch and the CCG. This will include Healthwatch continuing to attend the PRG, the CCG and Healthwatch continuing to hold six weekly meetings, the CCG attending Healthwatch's AGM and the CCG working closely with Healthwatch on various projects.

Website

Along with others in the CCG Collaborative, the CCG's website was updated and refreshed during the year, to make it more user-friendly, give key information about our work and encourage people to have their say and get involved. We have also established our presence on Twitter and Facebook, and will combine these accounts with the other social media feeds.

Social Media

More and more of us are using social media sites like Twitter to communicate on a daily basis. Hounslow CCG recognises the value of social media in connecting with – and listening to – the people of Hounslow. To help us listen and learn, we have started using Twitter to share key news stories, events and updates we feel would be of interest to our local population.

Hounslow Stakeholder Newsletter

The newsletter was launched in the winter 2015 which is circulated to the CCG stakeholder database and to all Patient Participation Groups (PPGs). The aim is to keep them aware of the work of the CCG and ask for ideas and feedback, and to present opportunities for partnership working.

Forums

The CCG regularly attends and supports local forums in Hounslow to listen to the concerns of local patients, service users and their families and carers. These forums promote issues of importance to older people, carers, mental health services users and users of maternity services.

Stakeholder list

The CCG has a well-established, wide ranging stakeholder list of local community groups, voluntary groups and organisations, including those that represent groups with protected characteristics. This is maintained and utilised to identify those people who may be interested in being involved in particular projects.

Volunteers

We are committed to working with the voluntary sector to ensure patients have access to

expert support and advice to help them with their day to day health and wellbeing.

Ealing Community Voluntary Service who manages the voluntary sector in Hounslow held a general workshop session was held with the attendees to discuss and give their feedback on how the CCG and voluntary sector can work more closely together. Several questions were covered:

- how would organisations feel more engaged with CCGs
- what can the CCG do more
- what can organisations do more
- would this be useful
- what could such a group achieve for both the CCG and organisations?

Feedback from the group discussions indicated that a closer working arrangement between the CCG and voluntary organisations was important. It was felt that organisations need to be part of the primary care sector, having more of a presence within GP surgeries with events that include representatives from surgeries, practice managers/PPG members to gain knowledge and understanding of what is available to patients.

The CCG have commissioned discrete pieces of engagement work from local voluntary sector groups as part of our commitment to improve services and to tackle inequities in accessing services within Hounslow. Speak Out in Hounslow (SoH) consulted with a group of people with learning disabilities to gather their experiences of going to the GP and their access to annual health checks. The Mulberry Centre interviewed Hounslow residents about barriers to taking part in cancer screening.

Our engagement plans in 2016/17

Since January 2015, the monthly campaigns have included diabetes, mental health awareness, cancer screening, ACT Fast – stroke awareness and obesity awareness. We also have run two large scale campaigns which have been promoted across the borough in newspapers, bus shelter advertising etc. These are diabetes screening and Stay well this winter. Other activities planned include:

- A review of our organisational priorities which will be tested with local people
- The introduction of a new online business planning system which will be used across the CCG. It will further ensure that engagement planning and delivery is integral to all our projects, plans and initiatives
- A programme of quality assurance visits is to be undertaken with local providers which will include patient representation on the visiting group
- Establish and embed the 2015/16 patient engagement plan alongside the CCG's business plan
- Work with patient participation groups in practices to support engagement at practice, local care network and borough level.

1.3 Key Issues and Risks

There are a number of key issues and risks that could affect Hounslow CCG in delivering its objectives:

1.3.1 Key issues

Transforming the NHS in North West London

In the year ahead we will continue our work to deliver change across all aspects of healthcare: hospitals, mental health, community and primary care. Hounslow CCG will

continue to work closely with the other seven CCGs in North West London, as well as providers, partner organisations and the public and patients to ensure all parties can contribute their views on the changes and their implementation.

Primary Care Co-Commissioning

Hounslow CCG has entered into joint arrangements for primary care commissioning with NHS England. This will give us greater ability to commission services that will deliver changes to local healthcare services in line with our strategic aim of localising services out of hospital where possible and integrating care around patients' needs. As we are a GP-led organisation, and primary care is provided by GPs, it is essential that we ensure that conflicts of interest are sufficiently understood and managed appropriately. This will rely on such principles as ensuring independent scrutiny of commissioning plans through use of lay members and officers, and ensuring that the focus is on commissioning services that are best able to deliver improvements to patient outcomes.

Improving performance

All NHS organisations are trying to deliver improved performance against a backdrop of increasing demand. This has been particularly noticeable in North West London's accident and emergency departments, although this trend has been recognised across the country. In the short-term, extra funding received by the CCGs is being used to implement a number of initiatives in hospital, community and primary care to help A&E departments meet their performance targets. If successful, some of these schemes could be rolled out on a permanent basis.

Significant investment is also taking place in improving clinical services across all hospitals in North West London. In the longer term the transformational changes described elsewhere in this report are designed to help the NHS meet the needs of local people.

Working with partner organisations

All organisations in the public sector face pressure on resources because of the tight economic climate we are operating in. Hounslow CCG will continue to be an active partner in Hounslow Health and Wellbeing Board, which agrees joint strategies and plans to support the health and wellbeing needs of the community. We will also continue to develop our plans for whole systems integrated commissioning with the Hounslow Council to deliver patient centred joined up health and social care services, utilising the Government's Better Care Fund (BCF).

Procurement and Contract register

Following an internal audit review of our Procurement and Contract register, our internal auditors advised that for the first half of the 2015/16 year the contracts registers in place were not fit for purpose. They recognised however that considerable effort had been taken during 2015/16 to update contract registers and improve the systems for demonstrating value for money. The CCG is now in a stronger position in terms of contract management and an ability to evidence the value for money brought about from procurement moving into 2016/17.

1.3.2 Key risks

The CCG has assessed its key risks and uncertainties throughout the year using the board assurance framework. The board assurance framework sets out the risks to delivering our strategic objectives and how these risks are managed. Each risk is scored using the 5x5 matrix described in the risk management strategy. The assurance framework is presented to the Governing Body at every meeting so members can review the risks and mitigations and receive assurances that the risks are being managed. Further details on risk are included in the governance statement.

The highest scoring risks for Hounslow CCG as at March 2016 were:

- Care Homes and Care Packages: quality and financial challenges in care providers (such as care homes, supported housing, domiciliary care or other care packages commissioned by CCGs) leads to patient harm and / or safeguarding concerns, as well as putting pressure on Accident and Emergency (A&E) and non-elective activity
- If we do not successfully empower patients and change behaviours, activity will continue to grow and the system will become unsustainable
- London Ambulance Service (LAS): workforce is not in place to deliver the high quality, value for money service required, leading to delays in attending patients and risk of serious patient harm
- Federations: Primary Care is unable to deliver increased activity due to organisational and workforce issues (includes implications of working at scale and establishing GP federations)
- Strategic Change (workforce): that we do not have the required resources in place across the system to deliver strategic change.

1.4 Performance Summary

1.4.1 Overview of the CCG finances

Hounslow CCG met its financial targets in 2015/16 and ended the year having exceeded its planned surplus of £3.4m, achieving a year-end surplus of £6.3m.

Although all five CCGs in the CWHHE collaborative (Central London, West London, Hammersmith and Fulham, Hounslow and Ealing) are autonomous organisations with separate financial targets and budgets, the CCGs share some senior management (including the Accountable Officer and Chief Finance Officer) and a common financial strategy. All five CCGs have agreed to participate in a financial risk sharing arrangement.

Hounslow CCG received a higher allocation increase than any of the other CCGs in the Collaborative in 2015/16 and was able to meet all its financial commitments without drawing on support from the other CCGs through the risk-share and in fact was able to make a contribution of £2.2m in to the risk share to support Central London and Hammersmith and Fulham CCGs.

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

The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

Hounslow CCG's accounts have been prepared on a "going concern" basis, i.e. it has been assumed that the organisation will continue operating into the future. Public sector bodies are generally assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as is the case in the NHS and for CCGs.

From 1 April 2013, Central London CCG has been responsible for commissioning (i.e. planning and purchasing) local health services; excluding primary care and specialised services, which are commissioned by NHS England. Previously Primary Care Trusts (PCTs) had responsibility for the full range of services. Some of the providers the CCG commissions from include Chelsea & Westminster NHS Foundation Trust (who run West Middlesex hospital as well as Chelsea & Westminster), Imperial College Healthcare NHS Trust (who run Hammersmith, Queen Charlotte's, St Mary's and Charing Cross hospitals), Hounslow & Richmond Community NHS Trust, The Hillingdon Hospitals NHS Foundation Trust, and West London Mental Health NHS Trust.

The CCG covers the borough of Hounslow but works closely with the four other CCGs in the CWHHE collaborative, as well as Brent, Harrow and Hillingdon CCGs. All eight CCGs together form the North West London (NWL) Collaboration.

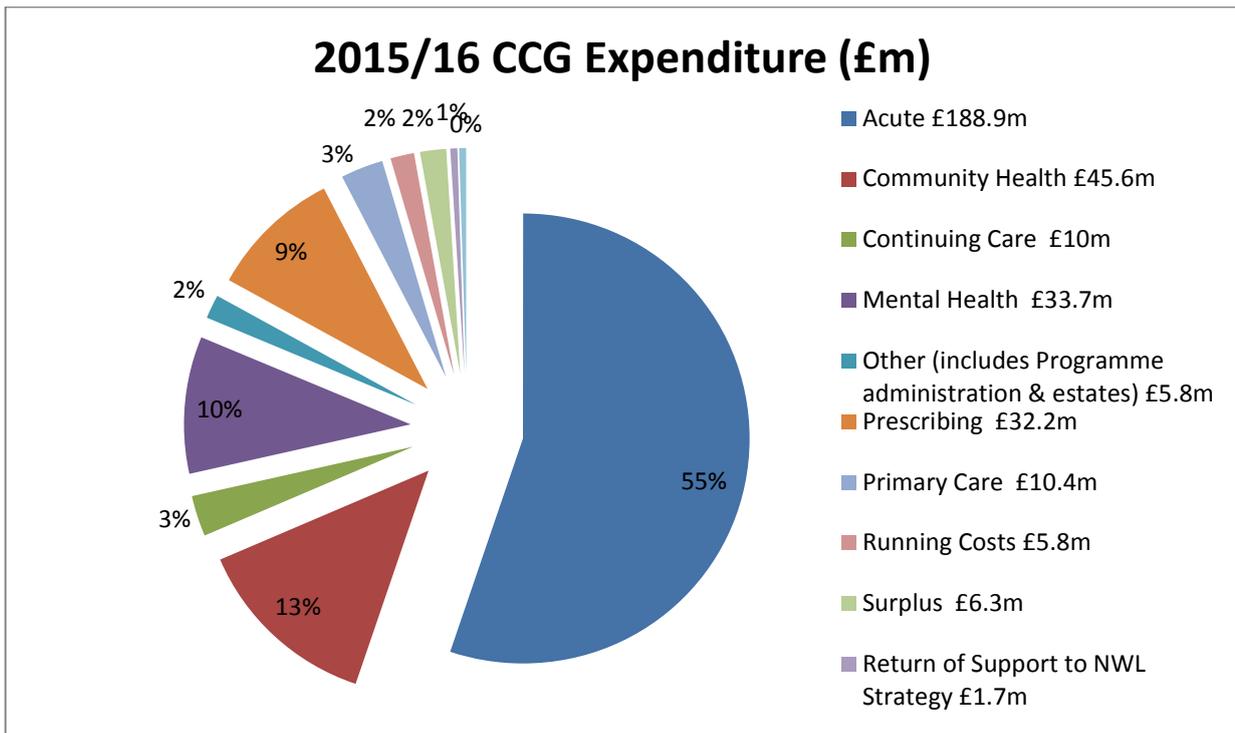
A shared financial strategy has been agreed across NWL Collaboration of CCGs. This comprises two elements. The first relates to a central budget which funds the Strategy and Transformation team which operates across NWL, as well as provider support for transformation change and other shared costs of transformation across the health economy. This element is hosted by Central London. Hounslow CCG made a contribution of £3.0m from its allocation to this budget in 2015/16.

The second part relates to a transfer of funding between the CCGs to allow those CCGs with more financial flexibility to support those with a more constrained position in order to ensure all CCGs in North West London are able to invest in common commissioning strategies such as Shaping a Healthier Future and out of hospital services. Hounslow CCG as a previously under-funded CCG received support of £3.7m from the other CCGs in 2015/16.

Overall it has been a difficult year financially and the CCG faces further challenges in the future. Many of the providers the CCG commissions from have also faced financial challenge, as have Local Authority partners and other stakeholders in the local health economy. This means that working closely with partners to deliver real transformational change both in Hounslow and throughout North West London is even more important than ever.

1.4.2 How we spent your money

The following pie chart gives a breakdown by service of the CCG spend against the final £342m (opening recurrent £313m, closing overall revenue £342m) allocation for 2015/16 (this included £3.7m support from NWL Strategy, this was originally £5.4m at the beginning of the financial year and the CCG returned £1.7m at year end). This comprises spend of £335.8m and delivery of a £6.3m surplus. Within the chart is £8.7m provider support for our main trust and £1.4m to support local transformation projects via NWL strategy.



1.4.3 Funding allocations

The Health and Social Care Act 2012 (HSC Act 2012) requires NHS England to look at reducing inequalities in access to, and outcomes from, healthcare. The new funding calculations for the CCG allocations (the money the CCG receives from NHS England for its local health services) includes population growth, based on 2011 census information and GP patient list sizes, the effect of relative deprivation and poverty on health need, the impact of an ageing population, and geographical cost differences across England. This calculation gives a target allocation for CCGs and NHS England will seek to reflect this in changes to allocations over the coming years.

Under this funding formula the CCG was deemed to be under funded by 9.3% and has therefore received the uplift for 2016/17 of 5.34%. In 2016/17 the CCG will receive a total commissioning budget £342m (opening recurrent £330m) and is planning a contribution of £2.1m to the NWL Strategy and to deliver a surplus of £3.5m.

1.4.4 Performance against financial targets

CCGs have a number of financial duties under the National Health Service Act 2006 (as amended) regarding the use of its resources. For 2015/16, Hounslow CCG's performance against each is summarised below:

- **Expenditure not to exceed its income**
For 2015/16 Hounslow CCG recorded a surplus of £6.3m.
- **Capital resource use not to exceed the amount specified in directions**
For 2015/16 Hounslow CCG did not have a capital allocation
- **Revenue resource use not to exceed the amount specified in directions**
For 2015/16 Hounslow CCG's net revenue expenditure totaled £335.8m against an overall revenue of £342m.

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

- **Capital resource use on specified matters not to exceed the amount specified in directions**
For 2015/16 Hounslow CCG did not have a capital allocation
- **Revenue resource use on specified matters not to exceed the amount specified in directions**
Hounslow CCG did not receive any resource on specified matters.
- **Revenue administration resource use not to exceed the amount specified in directions**
For 2015/16 Hounslow CCG had a surplus of £0.9m (running cost includes Quality Premium).

2 Performance analysis

2.1 How the CCG measures performance

Hounslow CCG has to report on the performance of a number of services defined nationally within the NHS Constitution, the Everyone Counts Guidance for 2015/16 (Operating Framework) and the NHS Mandated Outcomes Framework.

In 2015/16 Hounslow CCGs providers met the following NHS performance standards:

- **Access**
- 18 weeks referral to treatment - non-admitted pathway
- 18 weeks referral to treatment – incomplete pathway
- Patients waiting more than 6 weeks for a diagnostic test

Cancer waits

- Percentage of patients receiving first definitive treatment for cancer within 31-days
- Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is surgery
- Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is an Anti-Cancer Drug Regime
- Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a radiotherapy treatment course
- Percentage seen within two weeks of an urgent GP referral for suspected cancer
- Percentage seen within two weeks of an urgent referral for breast symptoms
- Percentage of patients receiving first definitive treatment for cancer within 62-days of an urgent GP referral for suspected cancer

Mental health

- Increasing access to psychological therapies (IAPT)
- IAPT waiting times - 6 weeks
- IAPT waiting times - 18 weeks
- CPA Reviews within 12 months
- Outcomes Data Completeness - CPA Patients
- CPA Follow-Ups within 7 days
- New psychosis cases served by EIS (breach by YTD)
- DNA - Follow-Ups Appointments

- CAMHS - 1st Appt. DNA Rates CAMHS -FU Appt. DNA Rates

Community services

- DNA rates all relevant services - first and follow up appointments

Urgent Care

- NHS 111 - % calls abandoned in 30secs

Hounslow CCG's providers did not fully meet the following performance standards:

London Ambulance Service (LAS)

- Category A Red 1 responses within 8min
- Category A Red 2 responses within 8min
- Category A 19 transportation within 19min

Accident & Emergency/LAS

- Total time spent in A & E < 4 hours (all activity types)
- Trolley Waits in A&E
- No. of LAS arrival to handover > 30mins
- No. of LAS arrival to handover >60mins

Access

- 18 weeks referral to treatment – admitted pathway
- 52 weeks referral to treatment waiters – incomplete pathway

Cancer waits

- Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service
- Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from a cons. upgrade.

Other measures

- Cancelled operations – 28 day guarantee breaches
- Urgent cancellations for the second time
- Mixed sex accommodation (MSA) breaches
- MRSA: reducing the number of outbreaks
- Clostridium difficile: reducing the number of outbreaks

Mental health

- IAPT - 50 % of people who complete treatment and are moving to recovery
- Inpatient gates kept by CRHT Teams
- Delayed Transfers of Care
- DNA - 1st Appointments
- HoNOSCA Completion rates on acceptance
- HoNOSCA Completion rates on discharge
- Patients 75 years and over assessed for dementia

Community services

- Adult Nursing - % of GP practices offered meetings
- CLA - IHAs completed within 20 days, including late notifications - Combined in and out-of borough
- CLA - IHAs completed within 20 days, including late notifications - In-borough

- CLA - IHAs completed within 20 days, including late notifications - Out-of borough
- CLA - RHAs completed within due date - Combined in and out-of borough
- CLA - RHAs completed within due date - In-borough
- CLA - RHAs completed within due date - Out-of borough
- CLA - RHAs completed within agreed timescales - Combined in and out-of borough
- CLA - RHAs completed within agreed timescales - In-borough
- CLA - RHAs completed within agreed timescales - Out-of borough
- Children's OT - Initial assessments within 6 weeks of referral
- Children's Physio - Routine referrals within 6 weeks
- Community Paeds - Assessments for children with special educational needs within 6 weeks
- Podiatry - Low risk referrals seen within 10 weeks

Urgent care

- NHS 111 - % calls answered in 60 secs
- NHS 111 - % calls abandoned in 30secs

2.2 Development and performance during the year

A&E

Due to increasing demand A&E performance continues to be a challenge for key providers in North West London (NWL). NWL performance however continues to be above both National and London performance. Despite these challenges the CCGs continue to work with providers and the wider system to implement new and innovative patient pathways diverting pressure from A&E in to more appropriate out of hospital settings including increasing access to primary care and GPs into the evenings and weekends, improved urgent care centres and single points of access for mental health patients in crisis.

Referral to Treatment (RTT)

The CCG has delivered well against the standard Year to Date (YTD) but there continues to be issues with delivering the required capacity within our services to meet demand within the performance standards for referral to treatment. Initiatives have been undertaken during 2015/16 to increase the number of appointments available in the community and, therefore, reduce demand on the hospital trusts. The CCG has been working to agree additional actions that can be taken in 2016/17 to support the delivery of the standards and that this position is sustained going forward.

Cancer

The CCG and the boarder North West London Network (NWL) continues to demonstrate a strong and sustained delivery of cancer standards throughout the year. This is demonstrated above with the CCG achieving the majority of the cancer minimum waiting time standards for the year up to Month 11. Commissioners continue to work collaboratively across NWL and surrounding areas to further improve cancer services to the population through 2016/17 and beyond.

2.3 Performance on other matters: sustainability

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

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

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

Work is progressing on the preparation of a Sustainable Development Management Plan, together with the establishment of the necessary supporting structures to ensure its success. In the interim, a number of initiatives have been successfully implemented in the past year, as part of the CCG's commitment to creating a sustainable future, including:

- The introduction of a secure printing system which requires users to release their print jobs from output devices, thereby reducing printed waste from documents left uncollected at the printer.
- The introduction of a toner cartridge recycling programme to reduce our carbon footprint.
- A recycling system which has reduced our business waste. Posters and communications have been sent regularly to remind staff and under-desk rubbish bins have been removed to encourage correct recycling.

2.4 Quality and Safety

Hounslow CCG works closely with a number of organisations (statutory and non-statutory) to ensure that the services we commission have quality (encompassing patient safety, health outcomes and patient experience) at their core; similarly clinical commissioner led service and pathway redesign and transformation has improving quality at its heart. The CCG has a Quality, Patient Safety and Equalities Committee (a sub-committee of the Governing Body) that 'holds' and provides leadership for the quality agenda across the CCG.

The Francis report into Mid Staffordshire Foundation NHS Trust called for tighter supervision of providers by CCGs and a watertight 'corporate memory' to ensure candid information about providers is passed on. The report also called for CCGs to have 'powers of intervention' where substandard or unsafe services are being provided.

Working with our partner organisations, a key area of ongoing focus is to build on work related to quality improvement and clinical assurance in care homes and care delivered by domiciliary providers.

2.4.1 Safeguarding adults and children

Hounslow CCG has a statutory responsibility to ensure that the health services and the provider organisations we commission provide a safe system that safeguards children and vulnerable adults.

The CCG is a member of the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adults Boards (LSAB) for Hounslow. As members of these boards, the CCG works in partnership with the local authority to fulfil their safeguarding responsibilities.

The CCG works closely with the LSCB and LSAB to ensure that there are effective NHS safeguarding arrangements across the local health community. We have a safeguarding children's team which is made up of a designated nurse and doctor for safeguarding children, and a lead nurse for adult safeguarding and mental capacity. Each provider is requested to produce a quarterly safeguarding report providing assurance on training and supervision of staff, as well as issues such as Female Genital Mutilation (FGM) and the Mental Capacity Act. The quarterly report is reviewed at the CCG and issues are then escalated as required

to the CCG Quality and Patient Safety Committees and the Local Safeguarding Board (Child or Adult).

The CCG works with the LSCB to ensure that child deaths are reviewed effectively. This includes provision of a designated paediatrician for unexpected deaths that is able to work with the police to identify any immediate learning.

Ensuring robust systems and processes to fulfill our statutory safeguarding responsibilities are in place is a central component to our role as clinical commissioners.

In April the safeguarding measures from the Care Act 2014 came into force. Hounslow CCG has been working to make sure the accountability and assurance framework is fully up to date and correct. All adult safeguarding leads will continue to play a part in the revision of existing procedures. In addition to the standard assurance framework, the CCG undertakes regular clinical visits to ensure adults are properly safeguarded in especially vulnerable locations such as care homes.

Signed:

Clare Parker, Accountable Officer
NHS Hounslow Clinical Commissioning Group
Date: 25 May 2016

ACCOUNTABILITY REPORT

Corporate Governance Report

The Corporate Governance Report comprises of

- Members' Report
- Statement of the Accountable Officer's Responsibilities
- Annual Governance Statement.

3 Members' Report

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

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

3.1 List of Hounslow CCG member practices

- Bath Road Surgery
- Blue Wing Surgery
- Chestnut Practice

- Green Practice
- Hibernia House (closed on 21 November 2015)
- Hounslow Medical Centre
- Kingfisher Practice
- Redwood Practice
- The 303 Bath Road Surgery
- The Practice Heart of Hounslow
- Willow Practice
- Clifford Road Surgery
- Cranford Medical
- Crosslands Surgery
- Dr Sood's Practice
- Firstcare Practice
- Greenbrook Heston
- Hounslow Family Practice
- Jersey Practice
- North Hyde Medical Practice
- Skyways Medical Centre
- The Great West Surgery Formerly (Greenbrook Chinchilla)
- Carlton Surgery
- Clifford House Surgery
- Gill Medical Practice
- Greenbrook Bedford
- Grove Village Medical Centre
- Hatton Medical Practice
- Little Park Surgery
- Manor House Practice
- Mount Medical Centre
- Pentelow Practice
- Queens Park Medical Practice
- St David's Practice
- The Practice Feltham
- Twickenham Park Medical Practice
- Chiswick Family Doctors Practice
- Chiswick Health Practice
- Glebe Street Surgery
- Grove Park Surgery
- Grove Park Terrace Surgery
- Holly Road Medical Centre
- Wellesley Road Practice
- WEST4GPs
- Albany Practice
- Brentford Family Practice
- Brentford Group Practice
- Cole Park Surgery
- Greenbrook Isleworth
- Greenbrook Manor
- Grove Medical
- Spring Grove Medical Practice
- St Margaret's Medical Practice
- Thornbury Road Centre for Health.

3.2 Hounslow CCG Governing Body and Audit Committee

3.2.3 Governing Body members

The main function of the Governing Body is to ensure that Hounslow CCG has appropriate

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

- Dr Nicola Burbidge, Chair
- Dr Paul Shenton, Vice Chair
- Dr Prashant Gupta, GP member
- Dr Parvinder Garcha, GP member
- Dr Indevir Dhandee, GP member
- Dr Shantha Sethurajan, GP member
- Dr Brigitte Unger-Graeber, GP member
- Dr Richard Baxter, GP member
- Dr Ashok Gorasia, GP member
- Javed Khan, Lay member
- Trevor Woolley, Lay member
- Philip Young, Lay member
- Clive Chalk, Lay Member
- Clare Parker, Accountable Officer
- David Tomlinson, Interim Chief Financial Officer (until 31 July 2015)
- Helen Troalen, Acting Chief Financial Officer (1 August 2015 – 1 September 2015)
- Keith Edmunds, Chief Financial Officer (from 02 September 2015)
- Eva Horgan, Deputy Chief Financial Officer
- Dr Alan Hakim, Secondary Care Consultant
- Jonathan Webster, Nurse Member, Director of Nursing, Quality and Safety
- Sue Jeffers, Managing Director
- Ben Westmancott, Director of Compliance (non-voting).

3.2.4 Audit Committee

The Audit Committee is responsible for scrutinising the CCG's arrangements for risk management and internal control and supporting the maintenance of an appropriate relationship between the CCG and the auditors.

Membership consists of:

- Lay member lead audit and conflict of interest matters (Philip Young, Committee chair)
- Secondary care consultant governing body member (Alan Hakim)
- One other lay member (Trevor Woolley)
- CCG governing body representative (who is not the CCG Chair or one of the CCG officers – Dr Prashant Gupta).

Hounslow CCG holds Audit Committee meetings in common with Central London, West London, Hammersmith and Fulham and Ealing CCGs. Further information on the Governing Body and other committees are set out in the CCG's annual governance statement at section 5.

3.3 Members Interests

Directors/Member Interests

Hounslow CCG maintains a Register of Interests that details names of individuals and details of their interest. Individuals will declare any interest that they have, which may lead to a conflict with the interests of the CCG in relation to any decision to be made by the CCG. The Register of Interests is available at www.hounslowccg.nhs.uk.

3.4 Personal data-related incidents

There were no reportable incidents in 2015/16.

3.5 Statement as to disclosure to auditors

Each individual who is a member of the Governing Body confirms:

- So far as the member is aware, that there is not relevant audit information of which the CCG'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 CCG's auditor is aware of that information.

3.6 Approval of Members' Report

The Members' Report has been approved by the Audit Committee on behalf of the Governing Body of Hounslow CCG.

Signed:

Clare Parker, Accountable Officer
NHS Hounslow CCG
Date: 25 May 2016

4 Statement of the 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 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
- 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.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the entity's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make himself or herself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.
- That the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed:

Clare Parker, Accountable Officer
Hounslow CCG
Date: 25 May 2016

5 Annual Governance Statement

5.1 Introduction and context

The Clinical Commissioning Group was licensed from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. As at 1 April 2015, the clinical commissioning group was licensed without conditions.

5.2 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I also acknowledge my responsibilities as set out in my 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.

5.3 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 clinical commissioning group and best practice.

5.4 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 CCG has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it."

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

- Determining the arrangements by which the members of the CCG approve those decisions that are reserved for the membership
- The consideration and approval of applications to NHS England on any matter concerning changes to the CCG's constitution, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies
- Approving the arrangements for identifying practice members to represent practices in matters concerning the work of the CCG and appointing clinical leaders to represent the CCG's membership on the CCG's Governing Body, for example through election (if desired)

- Approving the appointment of Governing Body members, the process for recruiting and removing non-elected members to the Governing Body (subject to any regulatory requirements) and succession planning.

The Governing Body has supplemented the governance framework by the formal adoption of: the Nolan Principles on Standards in Public Life; the Code of Conduct and Accountability for NHS Boards; the CCG Code of Conduct; Standards of Business Conduct (incorporating Gifts, Hospitality and Sponsorship) Policy; Anti-Bribery Policy; and a Conflicts of Interest Policy.

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

5.5 Governance Structure

5.5.1 Governing Body

The functions of the Governing Body are:

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

During the course of the year the Governing Body has focused on amongst others on increasing integration in the Hounslow CCG area and has continued at pace with the development of a model of care which covers care provided in hospital, the community, GP practice and by the voluntary sector.

The model aims to help people to remain healthy and independent in their own homes for as long as possible and, when they do need health services to support them, as close to home as possible and to reduce the length of time spent in hospital.

This programme of work has also led to our local providers working and planning more closely together to ensure the Hounslow CCG health system is as joined up as possible for older people.

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

Governing Body Member

Attendance

Dr Nicola Burbidge	4 out of 6
Dr Paul Shenton	6 out of 6
Dr Prashant Gupta	5 out of 6
Dr Parvinder Garcha	4 out of 6
Dr Indevir Dhandee	5 out of 6
Dr Brigitte Unger-Graeber	6 out of 6
Dr Shantha Sethurajan	6 out of 6
Dr Richard Baxter	6 out of 6
Dr Ashok Gorasia	4 out of 6
Clare Parker	6 out of 6
Sue Jeffers	6 out of 6
David Tomlinson	1 out of 2
Keith Edmunds	2 out of 6
Eva Horgan	3 out of 5
Javed Khan	5 out of 6
Trevor Woolley	6 out of 6
Philip Young	5 out of 6
Dr Alan Hakim	5 out of 6
Jonathan Webster	4 out of 6
Ben Westmancott	5 out of 6
Clive Chalk	5 out of 6

5.5.2 Audit Committee

The Audit Committee reviews the establishment and maintenance of effective systems of integrated governance, risk management and internal control across the whole of the CCG's activities, designed to support the achievement of the CCG's objectives. Its work dovetails with that of the CCG's Quality, Patient Safety and Equalities Committee and Finance and Performance Committee, which the CCG has established to seek assurance that robust clinical quality is in place.

The Audit Committee reviews the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any appropriate independent assurances, prior to endorsement by the CCG Governing Body
- The underlying assurance processes that indicate the degree of achievement of each of the CCG's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to fraud, bribery and corruption as set out in the NHS Protect Standards for Commissioners and as required by NHS Protect
- In carrying out this work the Audit Committee primarily utilises the work of internal audit, external audit and other assurance functions but is not limited to these sources. Further reports and assurances are sought from directors and managers

as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness

- The Committee uses an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

In discharging the above, the Audit Committee has focused on the establishment of effective policies and procedures to control financial performance and to ensure compliance with relevant regulatory and legal requirements.

This work has included overseeing counter fraud arrangements, reviewing the Financial Control Environment Assessments, closely monitoring the contracting database developments, monitoring the refinement of risk management and overseeing the extension of Internal Audit and Counter Fraud Contracts.

At each meeting, the committee also reviewed the risk management and assurance framework arrangements to ensure effective management of the CCG's strategic, operational and collaboration risks. The Committee recognised that conflicts of interest, perceived or real, posed a particular challenge for the CCG. To ensure that all dealings were beyond reproach, it oversaw the ongoing development of the conflicts of interest policy, specific arrangements to oversee the co-commissioning of primary care services with NHS England and, transparency in the management of conflicts of interest. In so doing, the Committee met on seven occasions with attendance as follows.

Audit committee members	Attendance
Philip Young, Chair, Lay Member for Audit, Remuneration and Conflict of Interest matters	7 out of 7
Dr Alan Hakim, CWHHE Secondary Care Member	6 out of 7
Trevor Woolley, Lay Member	5 out of 7

Other, non-Hounslow-specific members of the CWHHE Audit Committees are:

Michael Morton, Lay member, Central London CCG
Simon Tucker, Lay member, West London CCG
Rohan Hewavisenti, Lay member, Hammersmith and Fulham CCG
Dr Raj Chandok, GP Governing Body Member, Ealing CCG
Dr John Riordan, Secondary Care Consultant, Ealing CCG (until December 2015).

Hounslow CCG's Audit Committee meets in common with the Audit Committees of the other four CCGs in the CWHHE collaborative (i.e. West London, Hammersmith and Fulham, Central London and Ealing CCGs), with Philip Young in the Chair. This means that, in addition to the above, there were places for a further four independent lay members and four GP leads at each meeting.

5.5.3 Finance and Performance Committee

CCG and any associated risks and it therefore operates to a programme of business, agreed by the Governing Body that is flexible to new and emerging priorities and risks. The general areas of responsibility for the committee are to:

- Seek assurance that the commissioning plan and strategy for the CCG is sustainable and affordable, keeping in mind that the strategy and response may need to adapt and change
- Provide assurance that commissioned services are being delivered in an efficient and effective manner, ensuring that quality sits at the heart of everything the CCG does. This includes jointly commissioned services
- Oversee and be assured that effective management of risk is in place to manage and address the finance of the CCG and to be able to monitor performance
- Receive and scrutinise independent investigation reports relating to finance and agree publication plans
- Receive and scrutinise business plans and make recommendations to the Governing Body
- Receive and scrutinise QIPP and other savings plans and make recommendations to the Governing Body
- Receive and scrutinise a medium term financial strategy and make recommendations to the Governing Body
- Ensure adequate resources and capabilities are in place to allow the CCG to develop proper financial plans and accounts
- Ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern.

Key areas of focus include the overall financial position, delivery of QIPP and planning for the following year and performance of the main providers of care.

Finance and Performance Committee 2015/16 (6 meetings held)

Finance and Performance Committee Members		Attendance
Prash Gupta	Chair of Committee	14 out of 15
Nicola Burbidge	CCG Chair	13 out of 15
Paul Shenton	CCG Vice-Chair	15 out of 15
Trevor Woolley	Lay Member	14 out of 15
Sue Jeffers	Managing Director	14 out of 15
Keith Edmunds	Chief Finance Officer	3 out of 8
Eva Horgan	Deputy Chief Financial Officer	9 out of 15
David Thomas	Deputy Director, Performance and Contracting	15 out of 15
James Eaton	Associate Director, Performance and Delivery	9 out of 15
Quentin Symington	Head of Finance (Interim)	9 out of 9
Richard Cullen	Head of Finance	8 out of 8
Geralyn Wynne	Deputy Managing Director	9 out of 15
Martin Waddington	Director of Joint Commissioning	12 out of 15

5.5.4 Remuneration Committee

The remuneration committee is responsible for agreeing, with the Governing Body, the framework for the remuneration and conditions of service of CCG staff including the Governing Body members, and reviewing the on-going appropriateness and relevance of the remuneration policy.

The membership consists of:

- Lay member lead for audit, remuneration and conflict of interest matters (Chair);
- Secondary Care Consultant member of the governing body; and
- Lay member lead for Patient & Public Participation Matters.

Attendance figures:

Philip Young (Chair)	3 of 3
Dr Alan Hakim (secondary care member)	3 of 3
Javed Khan (lay member)	2 of 3

This is a meeting in common with the remuneration committees of the other CCGs in the CWHHE Collaborative. Other attendees are:

Attendance figures:

Dr John Riordan (secondary care consultant)	3 of 3
Jane Wilmot (lay member)	3 of 3
Simon Tucker (lay member)	0 of 1
Gordon Hunting (lay member)	0 of 1

The committee advised the Governing Body on appropriate remuneration and terms of service for the accountable officer, senior managers and members of the Governing Body. It also advised on the application of the performance pay mechanisms in the context of the National Pay Arrangements.

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

A number of HR policies were reviewed by the committee and recommended to the Governing Body for approval.

5.5.5 CWHHE Investment Committee

The Investment Committee provides a forum for resolving issues and making recommendations to governing bodies where the CCG governing bodies face conflicts of interest. The Committee considers decisions referred to it by the CCG Governing Bodies and makes recommendations on how to proceed or ratifies the processes employed to address conflict of interest issues. The committee can make decisions on behalf of the Governing Body when asked to do so by the Governing Body.

Membership consists of:

- Lay member for audit, remuneration and conflict of interest matters (Chair)
- An additional lay member from each of the five CCGs
- Secondary Care Consultant governing body member for each CCG
- Chief Officer
- Chief Finance Officer
- CCG GP Chairs.

Lay members and secondary care consultants are considered independent members

unless they themselves have a conflict of interest with an item being discussed. The CCG chairs are also members of the committee but are not able to vote when they are conflicted and can be recused from meetings if deemed appropriate by the Committee Chair due to a potential conflict of interest.

Attendance figures:

Philip Young (Chair)	10 of 10
Simon Tucker (lay member – West London CCG)	2 of 10
Rohan Hewavisenti (lay member – Hammersmith and Fulham CCG)	4 of 10
Trevor Woolley (lay member – Hounslow CCG)	8 of 10
Dr Alan Hakim (secondary care consultant)	9 of 10
Dr John Riordan (secondary care consultant) (until December 2015)	6 of 8
Clare Parker (Chief Officer)	7 of 10
David Tomlinson (Interim Chief Finance Officer) (until 31 July 2015)	3 of 3
Keith Edmunds (Chief Finance Officer) (from 2 September 2015)	5 of 7
Eva Horgan (Deputy Chief Financial Officer) (25 February 2016 – 8 March 2016)	1 of 1
Dr Ruth O'Hare (Central London CCG Chair) (until September 2015)	2 of 4
Dr Neville Purssell (Central London CCG Chair) (from October 2015)	5 of 6
Dr Fiona Butler (West London CCG Chair)	3 of 10
Dr Tim Spicer (Hammersmith and Fulham CCG Chair)	7 of 10
Dr Nicola Burbidge (Hounslow CCG Chair)	8 of 10
Dr Mohini Parmar (Ealing CCG Chair)	7 of 10

The following Governing Body Members from across the CWHHE CCGs were also co-opted on to the Investment Committee in line with relevant Governing Body delegations for specific decisions or as deputies for regular Committee members:

Michael Morton (lay member – Central London CCG)	1 of 1
Dominique Kleyn (lay member – Central London CCG)	2 of 2
Carmel Cahill (lay member – Ealing CCG)	1 of 1
Jane Wilmot (lay member – Hammersmith and Fulham CCG)	1 of 1
Shanta Sethurajan (lay member – Hounslow CCG)	1 of 1
Dr Mona Vadiya (Vice Chair, Central London CCG)	1 of 1
Dr Rachael Garner (Vice Chair, West London CCG)	2 of 2

5.5.6 CWHHE Quality and Patient Safety Committee (until December 2015)

The Committee fostered and facilitated a culture of learning and on-going quality improvement across the collaborative. The Committee reviewed both quality improvement and clinical assurance on issues affecting the quality of all services commissioned across the CCGs in the collaborative, encompassing:

- Patient safety
- Clinical effectiveness
- Patient experience.

It also acted as the Health & Safety Committee of each CCG and provides assurance to the governing bodies on compliance with the Health and Safety at Work Act 1974.

The membership consisted of:

- Lay member (chair)
- Director of Patient Safety and Quality
- Secondary Care Consultant governing body member
- Chair of each CCG or nominated clinical deputy
- Chief Officer
- Director of Compliance
- A representative from the committee responsible for quality in each CCG in the collaborative.

5.5.7 CWHHE Performance Committee (until December 2015)

The Committee considered performance issues affecting more than one CCG in the collaborative, and recommend remedial actions. The Committee also acted as the system resilience group across the collaborative.

The membership consisted of:

- Two lay members (Chair and vice chair)
- Chief Officer
- Chief Finance Officer
- Secondary Care Consultant member of the governing body
- two representatives from each CCG (at least one must have been a clinician)
- Director of Contracts and Performance
- Director of Patient Safety and Quality
- Director of Compliance
- Associate Director of Performance and Reporting.

5.5.8 CWHHE Quality and Performance Transition Committee

Over the course of 2015/16, the above two collaborative committees' functions were reviewed and both were reconstituted into a single committee, which met formally for the first time in January 2016.

The purpose of the new committee is to consider quality and/or performance issues with commissioned services where more than one CCG is impacted by the issue and it is sensible to address the matters collectively. The Committee then makes its recommendations for action, further monitoring etc to the CCGs in question.

The membership of the Transition Committee consists of:

- Secondary Care Consultant (Chair)
- CWHHE Chief Officer
- CWHHE Chairs
- CWHHE Managing Directors
- Chairs of CCG Patient Quality and Performance Committee
- CWHHE Director of Quality, Nursing & Patient Safety
- CWHHE Programme Director
- CWHHE Associate Director for Performance and Delivery
- CWHHE Director of Compliance
- CWHHE Chief Finance Officer.

Attendance figures:

Alan Hakim (Secondary Care Consultant) (Chair)	2 out of 2
Clare Parker (CWHHE Chief Officer)	2 out of 2

Neville Pursell (Central London CCG Chair)	1 out of 2
Fiona Butler (West London CCG Chair)	0 out of 2
Tim Spicer (Hammersmith & Fulham CCG Chair)	1 out of 2
Nicola Burbidge (Hounslow CCG Chair)	1 out of 2
Mohini Parmar (Ealing CCG Chair)	1 out of 2
Matthew Bazeley (Central London CCG Managing Director)	0 out of 2
Louise Proctor (West London CCG Managing Director)	0 out of 2
Janet Cree (Hammersmith & Fulham CCG Managing Director)	2 out of 2
Sue Jeffers (Hounslow CCG Managing Director)	0 out of 2
Tessa Sandall (Ealing CCG Managing Director)	1 out of 2
Michael Morton (Central London CCG Patient Quality & Performance Committee Chair)	2 out of 2
Rachael Garner (West London CCG Patient Quality & Performance Committee Chair)	2 out of 2
Vanessa Andreae (Hammersmith & Fulham CCG Patient Quality & Performance Committee Chair)	2 out of 2
Clive Chalk (Hounslow CCG Patient Quality & Performance Committee Chair)	1 out of 2
Philip Portwood (Ealing CCG Patient Quality & Performance Committee Chair)	0 out of 2
Jonathan Webster (CWHHE Director of Quality, Nursing & Patient Safety)	2 out of 2
Lizzy Bovill (CWHHE Programme Director)	2 out of 2
James Eaton (CWHHE Assistant Director for Performance & Delivery)	1 out of 2
Ben Westmancott (CWHHE Director of Compliance)	2 out of 2
Keith Edmunds (CWHHE Chief Finance Officer)	0 out of 2

The following members from across the CWHHE CCGs also attended in the capacity of deputies for regular Committee members:

Mona Vaidya (Central London CCG Vice Chair)	1 out of 2
Elizabeth Ogunoye (CWHHE Assistant Director of Performance Management and Reporting)	1 out of 2

A separate Health and Safety Committee was agreed in March 2016 and was established in April 2016.

5.5.9 Quality, Patient Safety and Equalities Committee

The duties of the Quality, Patient Safety and Equalities Committee are driven by the priorities for the CCG and any associated risks or areas of quality improvement and therefore operates to a programme of business, agreed by the Governing Body, that is flexible. The general areas of responsibility for the committee are to:

- Seek assurance that the commissioning plan and strategy for the CCG fully reflects all elements of quality
- Provide assurance that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the

CCG does

- Oversee and be assured that effective management of risk is in place to manage and address clinical governance issues
- Have oversight of the process and compliance issues concerning serious incidents requiring investigation
- Seek assurance on the performance of NHS organisations in terms of the Care Quality Commission, Monitor and any other relevant regulatory bodies
- Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans
- Ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern
- Ensure the CCG complies with information governance requirements to new and emerging priorities and risks.

The CQC reports on providers, the CAMHS service and approval of service specification and care pathway changes designed to improve patient care. In order to discharge these responsibilities, the Committee met on eleven occasions during the year.

Quality, Patient Safety and Equalities Committee

Attendance

Jonathan Webster	Director, Quality, Nursing and Patient Safety	8 out of 11
Dr Parvinder Garcha	GP and Quality Clinical Lead	9 out of 11
Clive Chalk	Lay Member	10 out of 11
Sue Jeffers	Managing Director	3 out of 11
Tandeep Fairman	Head of Quality and Governance	9 out of 11
Kevin Hunter	Head of Quality and Governance (maternity cover)	1 out of 11
Sue Pascoe	Deputy Director, Quality, Nursing and Safeguarding	4 out of 11
Leigh Forsyth	AD for Quality Improvement and Clinical Assurance	3 out of 11
Benita Playfoot	Interim AD for Quality and Clinical Assurance	6 out of 11
Julie Hulls	Designated Nurse, Safeguarding Children	7 out of 11
Nicky BrownJohn	Associate Director, Safeguarding (27 Nov 2015)	3 out of 11
Julie Dalphinis	Designated Nurse, Safeguarding Adults	7 out of 11

5.5.10 Other CCG Committees

Information Governance and Management Technology Committee

The remit of this committee is to initiate and manage the IT strategy for the CCG which contributes to the achievements of the CCGs' strategic and commissioning objectives.

Patient and Public Engagement Committee

The purpose of this committee is to oversee and provide assurance that the CCG undertakes meaningful patient and public engagement that impacts on commissioning decisions.

Joint Committees with delegated decision making authority

Primary care co-commissioning

The CCG's primary care joint co-commissioning committee was established in April 2015. Since then, it has met in common every quarter with the joint committees of the other

seven North West London CCGs (Central London, West London, Hammersmith and Fulham, Ealing, Brent, Hillingdon and Harrow) and, from late 2015, also held individual local meetings.

The meetings in common have focused on devising a coordinated North West London approach to key strategic issues, such as the implementation of the Strategic Commissioning Framework and strategic approaches to estates development and the PMS review.

Locally, the joint committees have focused on formulating CCG-specific priorities for the re-investment of the local PMS premium, the development of local estates strategies and the deployment of funds through the Primary Care Transformation Fund. The private sections of the local meetings have considered confidential practice issues, including contract performance.

The joint committees have worked hard to engage local stakeholders (including Healthwatch and the Health and Wellbeing Boards) in co-commissioning. Through the North West London primary care transformation team, the joint committees have also supported lay member co-commissioning education sessions, including on the local primary care landscape, primary care finance, and the methodologies of the PMS review.

Primary Care (Local) Co-commissioning Group

Primary care co-commissioning will enable the CCG to ensure that primary care acts as a driver for ambitious plans to transform the local health and care economy, both locally and across North West London.

The joint committee:

- Is the commissioning body that decides how GP services are going to be delivered locally. Decisions will be taken jointly between the CCG and NHS England. Any decisions taken outside the joint committee will be according to the standing operating procedures (approved policies) and where urgent decisions, as defined in NHS England's London-wide operating model, might be required.
- To support its work, it will develop and adopt an operating model, which will set out the detailed decision-making processes required to support effective co-commissioning, to be referenced and evidenced as part of each of the relevant business areas dealt with at the meetings.
- Will review and agree the framework by which contract and contract performance management will be undertaken. A memorandum of understanding between the joint committee, Performance Directorate and Contracting team will make explicit the duties and responsibilities of all parties in contract and performance management.
- NHS England will conduct routine contract management of GMS, PMS and APMS contracts as before, together with offering and monitoring delivery of Directed Enhanced Services. Where issues are identified, this will include liaison with practices, development of appropriate action or improvement plans, and then monitoring delivery of these plans. The joint committee will receive aggregate reports on this routine contract and performance management.
- The joint committee will demonstrate its transparency to local people, as well as the CCG and NHS England, by meeting in public, both when meeting locally and when meeting in common.

The Primary Care (Local) Co Commissioning Group met once in public and four times in private in 2015/16.

Primary Care (Local) Co Commissioning Group		Attendance (public)	(private)
Clive Chalk	Lay Member	1 out of 1	4 out of 4
Philip Young	Lay Member (Audit)	1 out of 1	3 out of 4
Dr Nicola Burbidge	CCG Chair	1 out of 1	4 out of 4
Dr Ashok Gorasia	GP	0 out of 1	2 out of 4
Dr Alan Hakim	Secondary Care Member	1 out of 1	3 out of 4
Jonathan Webster	Director, Quality, Nursing and Patient Safety	0 out of 1	0 out of 4
Mary Mullix (Deputy for Jonathan Webster)		1 out of 1	4 out of 4
Sue Jeffers	Managing Director	1 out of 1	4 out of 4
Julie Sands	Head of Primary Care (NW London)	1 out of 1	3 out of 4
Rachel Donovan	(Deputy for Julie Sands)	1 out of 1	4 out of 4

Other joint committees

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

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

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

In September 2015, the NWL CCGs' Commissioning Delivery Group (CDG) replaced the old Shared Support Services meeting, which had held responsibility in this area throughout the 2015/16 contract rounds and which had met from October 2014 until June 2015. The CDG took on responsibility for steering the overall strategic approach to the 2016/17 contracts rounds through the locally based commissioning framework.

The Shared Support Services meeting was disbanded in June 2015, after having overseen the first nine months of commissioning support services since they were brought in-house, whilst having additionally dealt with other shared business in relation to the contracting process.

This change to the board's outline governance structure was to ensure that the board's time remains strategically focused and that day-to-day operational matters relating to the respective support services are managed by the Senior Management Teams of CWHHE and of BHH respectively.

5.5.5 Performance of the Governing Body

During FY2015/16, the collaboration board met to focus on a range of business areas as follows:

- Strategy and Transformation (including joint finance strategy) – ten meetings were held
- Business Intelligence and Informatics Strategy – eight meetings were held (NB. two of eight were significantly shortened, in January and in March 2016)
- Shared Support Services (until June 2015) – three meetings were held
- Commissioning Delivery Group (from September 2015) – nine meetings were held.

Clinical Board

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

- Monitoring and managing clinical risk to patients and the clinical delivery of services across NWL during reconfiguration implementation, agreeing collective action to address any issues
- Leading clinical implementation planning, in particular advising on safe sequencing of change and readiness for change
- Providing expert clinical advice on other programme deliverables if needed, including local workstream deliverables
- Seeking advice where necessary from the:
 - NW London Clinical Senate (once established)
 - Governing Body
 - Clinical Networks - expert advisory groups of clinicians in the key areas of Maternity, Paediatrics and Emergency and Urgent Care
- Commissioning the Clinical Networks / Clinical Implementation Groups to provide advice on any specialty-specific implementation issues.

***Shaping a Healthier Future* (SaHF) Implementation Programme Board**

The Implementation Programme Board oversees the implementation of the *Shaping a Healthier Future* (SaHF) reconfiguration programme in line with decisions taken by the North West London Joint Committee of Primary Care Trusts (NWL JCPCT – formed in 2012 and comprises the 8 NWL PCTs and three neighbouring PCTs (Camden, Richmond, Wandsworth). The Programme Board has responsibilities to:

- Bring together local commissioners and local providers to jointly manage reconfiguration implementation
- Plan, manage progress, resolve issues and manage risks and interdependencies
- Receive and discuss progress reports from workstream leads
- Track system wide delivery of QIPP and CIP and enabling projects as they pertain to the delivery of *Shaping a Healthier Future* reconfiguration by, for example delivery of admissions avoidance and reductions in length of stay
- Receive and discuss key programme deliverables, in particular:
 - System-wide deliverables such as common modeling assumptions
 - OBC and FBCs for capital expenditure
- Ensure the different parts of the programme maintain sufficient focus on issues relating to: clinical risk, workforce, travel and access, equalities and carers and that appropriate patient engagement continues

- Ensure appropriate links are made with other strategic programmes and organisations outside NW London.

Governing Body and committees effectiveness review

Strategic Planning Group (SPG)

In March 2016, the first meeting of the SPG was held, bringing together senior members from across the health and social care commissioners and providers. The group has no delegated decision making powers and was established in line with the Five Year Forward View and planning guidance as a mechanism to bring the right stakeholders together to deliver a Sustainability and Transformation Plan across North West London.

5.6 The Clinical Commissioning Group Risk Management Framework

5.6.1 Risk Management Strategy

The Risk Management Strategy outlines Hounslow CCG's approach to risk management and its vision in relation to assurance systems. The CCG has a responsibility to ensure that we are effectively governed in accordance with best practice across corporate, clinical and financial governance.

Every activity that the CCG undertakes or commissions others to undertake on its behalf, brings with it some element of risk that has the potential to threaten or prevent the organisation achieving its objectives. Risk management aims to draw attention to actual or potential problems and to encourage the appropriate response to them; risks are managed by the people who have the greatest ability to control them. Successful risk management involves:

- Identifying and assessing risks
- Taking action to anticipate or manage them
- Monitoring them and reviewing progress in order to establish whether further action is necessary or not
- Ensuring effective contingency plans are in place.

Through the management of risk the CCG seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Governing Body and management is not surprised by risks that could, and should, have been foreseen. Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk.

Considered risk taking is encouraged, together with innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational and reputational risks through awareness, competence and management. The CCG risk management processes ensure that risks are identified, assessed, controlled, and when necessary, escalated. These main stages are carried out through:

- Clarifying objectives
- Identifying risks to the objectives
- Defining and recording risks
- Completion of the board assurance framework and risk register and

- identifying actions
- Escalation of risks.

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

- Internal methods – such as complaints, claims, identification of trends, audits, QIPP related risks, project risks, patient satisfaction surveys, whistle-blowing and monitoring the quality of commissioned services.
- External methods - HM Coroner reports, media, national reports, new legislation, surveys, reports from assessments/inspections by external bodies (CQC), reviews of partnership working, horizon scanning.
- Liaison through practice visits, locality meetings, GP Forums, patient engagement forums, practice feedback forms and Practice Manager Meetings.

The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level. For example from a team or project (work stream) risk register to a Corporate register, or from the Team risk register to the Directorate Risk Register. It should be reviewed by the assigned committee.

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

- Some element of risk taking is necessary to allow the CCG to seize important opportunities.
- Risk-taking is more acceptable in some areas than in others.
- There is a point at which the management of a risk should be immediately escalated to the direct oversight of the senior management team.

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

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

The Governing Body has a Risk Scoring Appetite Matrix, which uses specific risk definitions determining both the likelihood and impact.

In the review and monitoring process, there is particular focus on the controls that have been applied to each risk, the extent of the assurances and the effectiveness of the risk's management. Each risk has an initial score, a current score and a target score (ie corporate appetite for that risk) determined for it on the matrix.

5.6.2 Embedding Risk Management

Our processes for embedding risk management include:

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

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

COMPETENCE: *Staff will be competent at managing risk.*

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

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

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

5.6.3 Public Stakeholder Engagement

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

5.6.4 Control Mechanism

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

- Governing Body
- Audit Committee
- Quality, Patient Safety and Equalities Committee
- Remuneration Committee
- CWHHE Investment Committee
- Primary Care Co-commissioning Group.

Risk Management by the Governing Body is underpinned by a number of interlocking systems of control: The Governing Body reviews risk principally through the following three related mechanisms:

- The Board Assurance Framework (BAF) sets out the strategic objectives, identifies risks in relation to each strategic objective along with the controls in place and

assurances available on their operation It describes gaps in control or assurance and what is being done about them;

- The CCG Corporate Risk Register is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the organisation
- The Audit Committee and other Governing Body Committees exist to provide scrutiny and assurance of the robustness of risk processes and to support the Governing Body.

Each work stream, team and directorate will have a forum, best practice directs, where risk is discussed, including the risk register, actions, and any required escalation.

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

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

Prevention of Risk

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

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

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

5.6.5 Deterrent to risks arising

Although internal controls are in place, reliance on external organisations to perform key functions exposes the CCG to some risk of fraud and bribery. Measures to mitigate these risks are included in the Counter Fraud policy and work plan 2015/16.

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

Risk Assessment

5.6.6 Risk Assessment and Risk Profile

Using the risk and control framework, risk assessment is conducted in a systematic manner across all aspects of the CCG's strategic and operational goals. The major risks confronting the organisation are set out below. The risks and the controls applied to them are actively scrutinised throughout the year by the Governing Body, responsible committees and the senior management team.

Each risk is assigned a target risk rating and if the Governing Body is satisfied that the level of risk has reduced to that level and is fully mitigated, it may direct that the risk be removed from the assurance framework. A formal risk appetite statement sets a clear process for the management of risk and enhances the reporting of any instances where the appetite and specific risk thresholds are reached.

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

The Governing Body has a Risk Scoring Matrix, which uses specific risk definitions.

5.6.7 Risks to Governance, compliance, management and internal control

As part of the approved internal audit plan for 2015/16, internal auditors were asked to undertake an audit of the CCG's Board Assurance Framework and Risk Management and Information Governance. The internal auditors concluded that the CCG has adequate and effective framework for risk management, governance, internal control and information governance. They have identified further enhancements to the framework of risk management, governance, internal control and information governance to ensure that it remains adequate and effective.

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

5.6.8 Principal Risks to Compliance

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

- Are local people getting good quality care
- Are patient rights under the NHS Constitution being promoted
- Are health outcomes improving for local people
- Are CCGs commissioning services within their financial allocations?

A named director is accountable for the risks in each domain and the process is overseen through the CCG governance arrangements. Every month, the senior management team, responsible committee and the Governing Body receive and

scrutinise performance in this area. Further assurance on the effective management of risks to compliance with the CCG's licence is obtained from the NHS England self-assessment process and regular review meeting with NHS England.

Responsibilities of Directors

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

Reporting lines and accountabilities between Governing Body and Committees

To support the Governing Body in carrying out its duties effectively, a number of Committees have been established [see section 5.5]. The committees are chaired by both lay members and GP members of the CCG Governing Body as appropriate. The remit and terms of reference of these committees have been reviewed in year.

5.7 The Clinical Commissioning Group Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives.

It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised, the impact should they be realised, and to manage them efficiently, effectively and economically.

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

The Chief Operating Officer is accountable for ensuring that appropriate controls are in place and that the controls are being monitored. This involves maintaining systems to:

- Identify and assess risk
- Ensure risk owners are nominated to populate and update risk registers
- Implement effective risk mitigations
- Report risk in accordance with the integrated risk management strategy; and
- Ensure all managers and staff members are aware of their responsibilities under the Risk Management and Assurance Strategy.

5.7.1 Information Governance

The CCG has policies and controls in place to ensure that we are able to protect and maintain the confidentiality, integrity and availability of our electronic data, as well as our physical and information assets. The CCG seeks assurances from our IT department regarding the robustness of our network infrastructure, and also the back up and business continuity processes in the event of a loss of service.

The 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 this 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.

The CCG places high importance on ensuring that there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit.

We have ensured all staff undertake annual information governance training and that there are processes in place for incident reporting and investigation of serious incidents. We have also developed information risk management procedures, and a programme to fully embed an information risk culture throughout the organisation has commenced.

Furthermore, a significant advisory audit was undertaken to test the coverage and veracity of our Information Governance Toolkit submissions prior to the 31 March 2016 deadline. The audit process, which was undertaken across all five CWHHE CCGs has enabled the establishment of a comprehensive and robust system and processes that provide robust assurance of Information Governance Toolkit compliance. We self-assessed in light of the auditors' findings and are compliant with Level 2 of the standards.

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

Jointly with Central London, West London, Hammersmith and Fulham and Ealing CCGs, we have established a collaborative arrangement to share a leadership team and work together to become effective commissioners. This collaborative agreement enables:

- The joint commissioning high quality care
- The CCG to tackle cross borough issues
- Maximum influence in negotiating and managing contracts with key providers;
- Shaping of the provider landscape in North West London
- Economies of scale.

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

- Primary Care Co-commissioning with NHS England
- A common financial strategy to deliver Shaping a Healthier Future (SaHF).

5.7.3 Underlying financial position

The CCG's planned surplus in 2015/16 was £3.4m, with recurrent support from the NW London Financial Strategy (£3.7m). The outturn position for 2015/16 is a surplus of £6.3m (with agreement from NHS England) and an underlying surplus of £7.9m (assuming the continuation of the NWL Strategy funding into 16/17).

For 2016/17, Hounslow CCG's planned surplus is £3.5m, with anticipated support from the NW London Financial Strategy (£1.5m).

5.7.4 Feedback from delegation chains regarding business, use of resources and responses to risk

The CCG had no delegated chains during the 2015/16 financial year.

5.8 Review of the effectiveness of Governance, Risk Management and Internal Control

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

5.8.1 Capacity to Handle Risk

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

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

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

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

- The Audit Committee, in line with the NHS Audit Committee Handbook, ensures the CCG has an effective process in place with regards to risk management and monitors the quality of the assurance framework, referring significant issues to the Governing Body
- The Quality and Patient Safety Committee has overarching responsibility for clinical risk management and health & safety risks
- The Information Governance and Management Technology Committee has overarching responsibility for information governance
- The Finance and Performance Committee continuously assesses financial and non-financial risks relating to the QIPP plans and ensures the CCG has in place measures and mitigations to manage risk.

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

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

5.8.2 Review of Effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and risk/clinical governance/ quality committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

5.8.3 Head of Internal Audit Opinion

Hounslow CCG has appointed RSM to act as its internal auditors. In accordance with the Public Sector Internal Audit Standards, the head of internal audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance statement.

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

Their opinion, based on work undertaken up to 20 April 2016, is set out as follows:

Head of internal audit opinion 2015/2016

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

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

Factors and findings which have informed our opinion

We have issued a report on Procurement with an AMBER RED (Partial Assurance) opinion given. For the first half of the year the contracts registers in place were not fit for purpose. We recognise that considerable effort has been taken during 2015/16 to update contract registers and improve the systems for demonstrating value for money. Since the beginning of our audit in June 2015, the contracts register has progressed from a spreadsheet to the WHYSE electronic system that is now in operation. Our opinion reflects that this has been a work in progress during 2015/16 and that these systems have not been embedded throughout the year. We are pleased to note a considerable

strengthening of the systems by the time we concluded our testing in February 2016, which should put the CCG in a stronger position in terms of contract management and an ability to evidence the value for money brought about from procurement moving into 2016/7. There were also a number of contracts having not been signed which also poses a risk to the CCG. The report opinion in general is a reflection that as the year has progressed the CCG has invested time and effort in improving the Procurement processes and reflects the full year effect of the process.

We have issued a final report on Continuing Healthcare with an AMBER RED (Partial Assurance) opinion. We found that a number of patients did not have three month or annual reviews undertaken on a timely basis. In addition, the Caretrack system was incomplete as patient details were not fully recorded or completed and care plans were not always developed or held. We also found issues with contracts with Providers not being signed off by both parties and decisions to provide funding for patients not always traceable back to panel review meetings where the decision was taken. However as the year has progressed the CCG has invested time and effort in implementing actions to address the issues raised with more positive outcomes as evidenced on the Continuing Healthcare Assurance Toolkit post our initial review.

We issued a Staff Resourcing and Use of Interims report with an AMBER RED (Partial Assurance) opinion given. There were several effective controls in place at the collaborative to pick up early any areas where financial implications of interim staff are affecting performance. The recording of interim staff details had improved since the introduction of the new procedures but the CCG is however on occasion recruiting agency staff which are not picked up centrally. There were instances where staff recruitment forms had not been retained on file evidencing agreed pay rates. There were also enhancement required on the reporting mechanism in place on the budgetary control aspect of the usage of interim staff in particular how much expenditure had been incurred in the year for interim staff against the original budget.

At the request of the Audit Committee we undertook an advisory report on management consultants. The key issues raised in the review were that tender documentation should be retained to demonstrate that the contract was procured via the formal tendering process. Furthermore, we found that the Waiver of Tender Procedures Application Form was not evident for all tender waivers made. One of the issues found related to the CCG not assuring themselves that only agreed management consultancy support fees are paid and that where any variance to the originally agreed contract value arises, the reason for the variance should be sought and this should be formally agreed prior to payment. A clear action plan was developed and agreed with Management and actions are followed up for implementation as and when they fall due with progress reported to the Audit Committee.

We have however, provided reasonable assurance (AMBER GREEN) for all other areas reviewed to date.

Issues judged relevant to the preparation of the annual governance statement

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

Remaining internal audit work for 2015/2016

The following assignments have yet to be completed and reported in final. We reserve the right to amend the opinion based on the outcome of these reviews but consider that this will be unlikely:

- Financial Feeder Systems – Draft issued (AMBER GREEN – Reasonable Assurance)
- Transfer of CSU functions – Draft issued (AMBER GREEN – Reasonable Assurance)
- QIPP and Investments – Draft issued (AMBER GREEN – Reasonable Assurance)
- Non Acute and Acute Commissioning and Contracting (AMBER GREEN – Reasonable Assurance)
- Board Assurance and Risk Management – Draft issued (Advisory)
- Business Continuity and Disaster Recovery
- Budget Setting, Budgetary Control and Financial Reporting

5.8.4 Data Quality

The CCG has robust processes and governance arrangements in place to ensure that the quality of data used by the membership body and Governing Body is accurate and fit for purpose. All data that is forwarded to the Governing Body has been discussed, and analysed at a minuted committee meeting prior to being submitted for discussion, noting or a formal decision at the Governing Body.

5.8.5 Business Critical Models

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

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

North West London CCGs are implementing a data warehouse solution (called WHYSE) which will substantially improve data quality for commissioners in the region. It will do this in a number of ways: by standardising a series of business rules used to pre-process Secondary Use Service data (obtained from HSCIC) into a format that can be used by all CCGs; by automating the data import and patient matching processes used by CCGs; by allowing the linking of other regional and local datasets; and, by allowing non-specialist staff to create and manage their own reports. During 2015/16 WHYSE has launched a number of analytical tools which provide GP benchmarking, NHS 111 service use and urgent care services use. From June 2016 CCGs will start to use WHYSE for routine analysis on Community, Mental Health and Acute care data. This will be followed by a deployment of a series of advanced analytical tools designed and built to monitor contracts and handle claims management. The service has been developed in partnership with the SE CSU and their CCGs which represents a substantial user-base.¹

5.8.6 Data Security

The CCG submitted a satisfactory level of compliance with the information governance toolkit assessment in 2015/16, meeting at least level 2 for all requirements. The requirements within the information governance toolkit that relate to data security seek assurances regarding the CCG's risk management framework, business continuity

plans and the robustness of the network infrastructure as well as outlining the standards to be attained for the confidentiality, integrity and availability of physical and electronic data, and information assets. The toolkit submission and supporting action plan was routinely scrutinised by the Information Governance Working Group. An action plan was developed and delivered to ensure that the CCG is able to maintain compliance with, and further embed information governance and data security into the culture of the CCG.

In 2015/16 NHS Hounslow CCG reported no serious incidents to the Information Commissioner's Office.

5.8.7 Emergency preparedness, resilience and response

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

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

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

Central London, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs are all committed to collaboratively implementing an integrated and dynamic business continuity management system and emergency prevention, preparedness and response capability to ensure the continued delivery of safe and effective healthcare commissioning and management across outer North West London.

We certify that Hounslow CCG has incident response plans in place, which are fully compliant with the NHSE Emergency Preparedness 2015 Guidance. The CCG regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

5.8.8 Health and safety performance

The Central London, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs have secured professional health and safety and fire safety support to fulfill the role of the competent person. Advice, support and training is available for all staff. A training needs analysis was undertaken by the HR department and health and safety training forms part of the core mandatory training identified for all CCG staff. The modules provided are as follows:

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

The CWHHE CCGs will continue to provide training, and monitor the uptake by staff

during 2016/17.

5.8.9 Policy on countering fraud corruption

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

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

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

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

Central London, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs also have a policy on Standards of Business Conduct and Gifts and Hospitality. Both of these can be found at www.hounslowccg.nhs.uk.

5.8.10 Complaints and principles for remedy

The NHS believes complaints are a valuable source of feedback, which help to shed light on the quality of local health services. A national complaints process applies to all NHS organisations and seeks to provide complainants with explanation and, where appropriate, an apology, and the correction for an error or other remedial action.

The NHS also seeks to learn from complaints and improve procedures to prevent problems being repeated. The NHS complaints procedure adheres to the Principles for Remedy published by the Parliamentary and Health Service Ombudsman.

From 1 April 2015 to 31 March 2016 the CCG received a total of 55 complaints. Sixteen of these related to the commissioning decisions taken by the CCG and were investigated and responded to under the NHS Complaints Procedure. Nine complaints were about primary care contractors and were forwarded to NHS England for investigation and response. Thirty complaints were about other providers and were forwarded to the appropriate organisations for investigation and response. Where appropriate, the CCG requests a copy of the final response for monitoring purposes.

Of the complaints investigated and responded to by the CCG 11 related to the Continuing Health Care service; 3 related to Individual Funding Requests; 2 related to a medicines management issue.

5.8.11 Discharge of Statutory Functions

Arrangements put in place by the clinical commissioning group and explained within the corporate governance framework have been 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.

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 to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

5.8.12 Conclusion

No significant internal control issues have been identified as part of our review of our governance arrangements.

Signed:

Clare Parker
Accounting Officer
Date: 25 May 2016

REMUNERATION REPORT

6 Remuneration Report

6.1 Remuneration committee members and attendance

The Remuneration Committee is responsible for agreeing, with the Governing Body, the framework for the remuneration and conditions of service of CCG staff, including the Governing Body members, and reviewing the on-going appropriateness and relevance of the remuneration policy.

The Remuneration Committee meets in common across Central London, West London, Hammersmith and Fulham, Hounslow and Ealing Clinical Commissioning Groups. Membership comprises the Chair of each CCG and a lay member from each CCG. The committee met three times during 2015/16 and further details are set out in the Governance Statement at Section 5.

This remuneration policy includes clinicians, lay members, and executive directors.

6.2 Remuneration Policy

6.2.1 Chair and elected Governing Body members

The chair and elected Governing Body members have a contract of employment with the CCG. Where no end dates are shown individuals are currently still in post.

There is a rolling programme of elections to the Governing Body, and the post will continue for the initial period until the CCG's election process is completed.

Name	Role	Contract Start Dates	Contract End Date
Dr Nicola Burbidge	Chair	1 April 2013	31 March 2017
Dr Paul Shenton	vice chair	1 April 2013	31 March 2017
Dr Prashant Gupta	GP member	1 April 2013	31 March 2017
Dr Parvinder Garcha	GP member	1 April 2013	30 June 2016
Dr Indervir Dhandee	GP member	1 April 2013	30 June 2016
Dr Brigitte Unger-Graeber	GP member	1 April 2013	30 June 2016
Dr Shantha Sethurajan	GP member	1 April 2013	30 June 2016
Dr Richard Baxter	GP Member	1 July 2014	30 June 2016

Dr Ashok Gorasia	GP Member	July 2015	30 June 2017	
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6.2.2 Lay members

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

Name	Role	Contract Start Date	Contract End date	Term of Office Expires (if no end date)
Philip Young	Lay member (audit chair)	1 April 2013	31 March 2018	
Trevor Woolley	Lay member	1 April 2013	31 March 2017	
Javed Khan	Lay member	1 April 2013	31 March 2017	
Clive Chalk	Lay member	1 April 2015	31 March 2018	

6.2.3 Senior managers' performance-related pay

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

All pay progression and bonus payments for directors and senior managers employed on the Senior Manager Pay range are linked to annual appraisal of performance and the CCG achieving its strategic objectives in line with the Senior Manager Pay & Reward Policy. Performance awards for 2015/16 will be determined in the first quarter of 2016/17.

The performance of Elected Governing Body members and the Chief Officer is appraised by the Chair. The performance of CCG Officers of the Governing Body is appraised by the Chief Officer.

6.3 Compensation on early retirement or for loss of office (subject to audit)

There has been no compensation on early retirement or for loss of office (subject to audit).

6.4 Payments to past senior managers (subject to audit)

There have been no payments made to past senior managers.

6.5 Pay multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the

organisation's workforce. The mid-point of the banded remuneration of the highest paid Governing Body member in Hounslow CCG during the financial year 2015/16 was £165k (2014/15: £165k). This was 3.47 (2014/15: 2.67) times the median remuneration of the workforce, which was £47.6k (2014/15: £61.8k). The change in pay multiples is due to a number of posts that specifically relate to CWHHE transferring back from CSS (commissioning support services hosted by Brent CCG), the costs are then recharged to each of the CWHHE CCG's on a net accounting basis and included within salary costs..

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind and severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

To ensure a level of comparability, these figures are calculated on the full time equivalent measurement of staff and on an annualised basis to remove any fluctuations caused by staff turnover and only includes agency and other temporary employees covering staff vacancies.

In 2015/2016, no employee received remuneration in excess of the highest paid employees ranged from £16.6k to £165k (2014/15; £14.3k to £165k).

6.6 Senior Managers Definition

Senior managers are on the senior managers pay framework, have a permanent contract and are subject to a six month notice period except in the case of summary or immediate dismissal. Compensation for loss of office is based on the terms and conditions laid out under Agenda for Change. Details of the senior managers are stated below. Where no end dates are shown individuals are currently still in post.

Senior Executive Manager	Role	Contract Start Date	Contract End Date
Clare Parker	Accountable Officer	5 January 2015	n/a
Keith Edmunds	Chief Financial Officer	1 September 2015	n/a
Sue Jeffers	Managing director	1 April 2013	n/a
Ben Westmancott	Director of compliance	1 April 2013	n/a
Jonathan Webster	Director of patient safety and quality	1 April 2013	n/a

6.7 Senior managers – salaries and allowances

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

All pay progression and bonus payments for directors and senior managers employed on the Senior Manager Pay range are linked to annual appraisal of performance and the CCG achieving its strategic objectives in line with the Senior Manager Pay and Reward Policy. Performance awards for 2015/16 will be determined in the first quarter of 2016/17.

The performance of Clinical Directors and the Chief Officer is appraised by the Chair. The performance of CCG directors is appraised by the Chief Officer.

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

6.8 Salaries and allowances (subject to audit)

Salaries & Allowances (subject to audit)

Name & Title	Notes	2015-16						2014-15					
		Salary (bands of £5,000)	Expense payments (taxable) to nearest £00	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) to nearest £00	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
		£'000	£'00	£'000	£'000	£'000	£'000	£'000	£'00	£'000	£'000	£'000	£'000
Dr Richad Baxter - GP Member (from 1st July 2014)	6	50-55	0	0	0	35-40	90-95	30-35	0	0	0	0	30-35
Dr Nicola Burbidge - Chair	4	95-100	0	0	0	0-5	100-105	95-100	0	0	0	7.5-10	105-110
Dr Indervir Dhandee - GP Member		25-30	0	0	0	60-65	85-90	25-30	0	0	0	0-2.5	25-30
Dr Parvinder Garcha - GP Member		35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
Dr Ashok Gorasia - GP Member (from 1st July 2015)	4	15-20	0	0	0	0	15-20	0	0	0	0	0	0
Dr Prashant Gupta - GP Member		35-40	0	0	0	35-40	75-80	35-40	0	0	0	0	35-40
Dr Shantha Sethurajan - GP Member		35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
Dr Paul Shenton - Vice Chair (retired 2014)		40-45	0	0	0	0	40-45	40-45	0	0	0	0	40-45
Dr Brigitte Unger-Graeber - GP Member	6	40-45	0	0	0	20-25	60-65	35-40	0	0	0	0	35-40
Dr Annabel Crowe - GP Member (30th Oct 2014)		0	0	0	0	0	0	55-60	0	0	0	0	55-60
Dr Mohammed Muzaffer - GP Member (left 30th Jun 2014)		0	0	0	0	0	0	0-5	0	0	0	0	0-5
Clive L Chalk - Lay Member		10-15	0	0	0	0-5	10-15	0	0	0	0	0	0
Javed Khan - Lay Member		10-15	0	0	0	0.0	10-15	10-15	0	0	0	0	10-15
Trevor Woolley - Lay Member		10-15	0	0	0	0.0	10-15	10-15	0	0	0	0	10-15
Dr Alison Baker - Lay Member (left October 2014)		0	0	0	0	0.0	0.0	5-10	0	0	0	0	5-10
Sue Jeffers - Managing Director		110-115	0	0-5	0	55-60	170-175	100-105	0	0-5	0	30-32.5	140-145
Imran Choudhury - Director of Public Health	5												
Alan Adams - Director of Children's and Adult's services	5												
Daniel Elkeles - Accountable Officer (1st April 13 – 4th January 2015)		0	0	0	0	0	0	5-10	0	0-5	0	5-7.5	10-15
Clare Parker - Accountable Officer (from 5th January 2015)	1	25-30	0	0-5	0	12.5-15	35-40	10-15	0	0-5	0	2.5-5	10-15
Keith Edmunds - Chief Financial Officer (from 2nd Sept 2015)	1	10-15	0	0	0	0	10-15	0	0	0	0	0	0
David Tomlinson - Interim Chief Financial Officer (from 2nd Feb 2015 to 31st July 2015)	1	20-25	0	0	0	0	20-25	0-5	0	0	0	0	0-5
Helen Troalen - Acting Chief Financial Officer (from 1st Aug 2015 to 1st Sept 2015)	1,3	0-5	0	0-5	0	2.5-5	0-5	0-5	0	0-5	0	0-2.5	0-5
Jonathan Webster - Director of Nursing, Quality & Safety	1	15-20	0	0-5	0	2.5-5	15-20	5-10	0	0-5	0	0	5-10
Ben Westmancott - Director of compliance (adviser in attendance)	1	20-25	0	0	0	0-2.5	20-25	5-10	0	0-5	0	2.5-5	10-15
Philip Young - Lay Member	1	0-5	0	0	0	0	0-5	0-5	0	0	0	0	0-5
Dr Alan Hakim - Secondary Care Consultant	1,2	20-25	0	0	0	0-2.5	20-25	10-15	0	0	0	0	10-15

1. Paid by Central London CCG but their costs have been shared across Central, West, Hammersmith and Fulham, Hounslow and Ealing CCGs.
The average weighting for each CCG is as follows: Central London CCG 16%, West London CCG 25%, Hammersmith & Fulham CCG 14%, Hounslow CCG 19%, Ealing CCG 26%.
Their full year salary is shown in the table below.
2. Dr Alan Hakim was paid through Barts Health NHS Trust for April and May 2015. An amount of £90,067 was re-charged to the CWHHE collaboration for his services during 2015/16.
The split between CCGs was: Central London CCG 20%, West London CCG 31%, Hammersmith & Fulham CCG 17%, Hounslow CCG 23%, Ealing CCG 9%.
As the CCG does not make contributions direct to a pension scheme for this individual no pension values are required to be disclosed in the above table.
3. Acting Chief Financial Officer from 1st August 2015 to 1st September 2015.
4. Please note figures do not reflect true values as still awaiting further pension details from Greenbury
5. These are non voting members on the governing board and are paid by London borough of Hounslow.
6. These are also clinical leads

6.9 Senior Managers – salaries and allowances - joint appointments (subject to audit)

The following senior members of staff all work across Central London, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs and their costs have been shared across other organisations. The salaries and allowances table only show Hounslow CCG's share of the amount. This table gives their total salary and allowances.

Name and Title	Notes	2015-16						2014-15					
		Salary (bands of £5,000) £'000	Expense payments (taxable) to nearest £00 £'00	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000	Salary (bands of £5,000) £'000	Expense payments (taxable) to nearest £00 £'00	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
		Notes	Notes	Notes	Notes	Notes	Notes	Notes	Notes	Notes	Notes	Notes	
Daniel Elkeles - Accountable Officer (1st April 13 – 4th January 2015)	1	0	0	0	0	0	0	115-120		5-10		72.5-75	195-200
Clare Parker - Accountable Officer (from 5th January 2015)		145-150	0	5-10	0	77.5-80	230-235	130-135		5-10		52.5-55	195-200
Keith Edmunds - Chief Financial Officer (from 2nd Sept 2015)		75-80	0	0	0	0	75-80	0	0	0	0	0	0
David Tomlinson - Interim Chief Financial Officer (from 2nd Feb 2015 to 31st July 2015)		115-120	0	0	0	0	115-120	50-55		0		0	50-55
Helen Troalen - Acting Chief Financial Officer (from 1st Aug 2015 to 1st Sept 2015)	2	5-10	0	0-5	0	15-17.5	20-25	5-10		0-5		17.5-20	25-30
Jonathan Webster - Director of Nursing, Quality & Safety		110-115	0	0-5	0	22.5-25	135-140	100-105		0-5		0	105-110
Ben Westmancott - Director of compliance (adviser in attendance)		100-105	0	0	0	7.5-10	110-115	105-110		0-5		47.5-50	160-165
Philip Young - Lay Member		15-20	0	0	0	0	15-20	15-20		0		0	15-20
Dr Alan Hakim - Secondary Care Consultant		90-95	0	0	0	0	90-95	80-85		0		0	80-85

1. Chief Financial Officer from 1st April 2013 to 4th January 2015.

2. Acting Chief Financial Officer from 1st August 2015 to 1st September 2015.

Notes:

Any payment of performance awards for 2015/16 to senior managers will be determined in the first quarter of 2016/17.

The share is calculated on the relative population of each CCG and costs were shared.

Definition of Columns

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

6.9 (subject to audit) Senior Managers - Pensions benefits

Pension Benefits (subject to audit)

	Notes	2015-16							2014-15								
		Real Increase in pension at age 60	Real Increase in Lump sum at age 60	Total accrued pension at age 60 at 31 March 2016 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1 Apr 2015	Real increase in Cash Equivalent Transfer Value at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2016	Employer's contribution to stakeholder pension	Real Increase in pension at age 60	Real Increase in Lump sum at age 60	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 1 Apr 2014	Real increase in Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2015	Employer's contribution to stakeholder pension
		(bands of £2,500) £'000	(bands of £2,500) £'000	(bands of £5,000) £'000	(bands of £5,000) £'000	£'000	£'000	£'000	£'000	(bands of £2,500) £'000	(bands of £2,500) £'000	(bands of £5,000) £'000	(bands of £5,000) £'000	£'000	£'000	£'000	£'000
Dr Richad Baxter - GP Member (from 1st July 2014)	2	0-2.5	(2.5-0)	5-10	10-15	66	47	89	0	0-2.5	0-2.5	0-5	10-15	59	5.0	66	0
Dr Nicola Burbidge - Chair		0-2.5	(2.5-0)	20-25	40-45	345	17	365	0	0-2.5	0.0	15-20	40-45	310	22.6	345	0
Dr Indevir Dhandee - GP Member		2.5-5	2.5-5	5-10	5-10	58	67	102	0	0-2.5	0.0	0-5	5-10	61	5.7	58	0
Dr Parvinder Garcha - GP Member		0-2.5	0-2.5	15-20	50-55	360	3	378	0	0-2.5	0-2.5	15-20	50-55	340	0.8	360	0
Dr Ashok Gorasia - GP Member (from 1st July 2015)		0	22.5-25	10-15	30-35	0	0	146	0	0	0	0	0	0	0	0	0
Dr Prashant Gupta - GP Member		0-2.5	(2.5-0)	20-25	55-60	284	43	308	0	0-2.5	0-2.5	15-20	55-60	267	3.8	284	0
Dr Shantha Sethurajan - GP Member		0	0	0	0	0	0	0	0	77.5-80	232.5-235	85-90	255-260	177	0	0	0
Dr Paul Shenton - Vice Chair (retired 2014)	2	0-2.5	2.5-5	10-15	30-35	199	28	228	0	0-2.5	0-2.5	5-10	25-30	185	3.6	199	0
Dr Brigitte Unger-Graeber - GP Member		0	0	0	0	315	0	0	0	0-2.5	0-2.5	15-20	50-55	297	1.2	315	0
Dr Annabel Crowe - GP Member (30th Oct 2014)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dr Mohammed Muzaffer - GP Member (left 30th Jun 2014)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clive L Chalk - Lay Member		0-2.5	0	0-5	0	0	4	2	0	0	0	0	0	0	0	0	0
Javed Khan - Lay Member		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trevor Woolley - Lay Member		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dr Alison Baker - Lay Member (left October 2014)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sue Jeffers - Managing Director		2.5-5	7.5-10	45-50	135-140	923	71	1,014	0	0-2.5	5-7.5	40-45	125-130	831	46	923	0
Imran Choudhury - Director of Public Health	1																
Alan Adams - Director of Children's and Adult's services	1																
Daniel Elkeles - Accountable Officer (1st April 13 – 4th January 2015)		0	0	0	0	0	0	0	0	2.5-5	7.5-10	25-30	85-90	346	49	420	0
Clare Parker - Accountable Officer (from 5th January 2015)	3	2.5-5	5-7.5	35-40	105-110	459	55	520	0	2.5-5	7.5-10	30-35	95-100	393	56	459	0
Keith Edmunds - Chief Financial Officer (from 2nd Sept 2015)	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
David Tomlinson - Interim Chief Financial Officer (from 2nd Feb 2015 to 31st July 2015)	3,5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Helen Troalen - Acting Chief Financial Officer (from 1st Aug 2015 to 1st Sept 2015)	3,6	0-2.5	(2.5-5)	10-15	35-40	162	1	173	0	0-2.5	0-2.5	10-15	35-40	137	2	162	0
Jonathan Webster - Director of Nursing, Quality & Safety	3	0-2.5	5-7.5	35-40	110-115	587	31	626	0	0-2.5	0-2.5	35-40	105-110	554	18	587	0
Ben Westmancott - Director of compliance (adviser in attendance)	3	0-2.5	(2.5-5)	20-25	65-70	320	8	332	0	2.5-5	7.5-10	20-25	65-70	265	48	320	0
Philip Young - Lay Member	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dr Alan Hakim - Secondary Care Consultant	3,4	0-2.5	(2.5-5)	40-45	115-120	632	19	663	0	0	0	0	0	0	0	0	0

1. These are non voting members on the governing board and are paid by London borough of Hounslow.

2. These are also clinical leads

3. The disclosure for these individuals who are shared across organisations is the gross amount and not the individual Clinical Commissioning Groups share.

4. Dr Alan Hakim was paid through Barts Health NHS Trust for April and May 2015. As the CCG does not make contributions direct to a pension scheme for this individual no pension values are required to be disclosed in the above table.

5. David Tomlinson is paid through Green Park Interim & Executive Ltd. As the CCG does not make contributions direct to a pension scheme for this individual no pension values are required to be disclosed in the above table.

6. Acting Chief Financial Officer from 1st August 2015 to 1st September 2015.

Notes to pensions table:

Cash equivalent transfer values

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

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.

7 Staff Report

7.1 Number of Senior Managers by Band

Number	Band
3	VSM

7.2 Staff Numbers

The average number of people employed by the CCG is as follows:

	2015/16	2014/15
	No.	No.
Permanently Employed	62	30
Other	26	16
Total	88	46

Included within the above whole time equivalent staff numbers are 6 (2014/15: 4) relating to CSS in-housed services. The increase in staff numbers are due to full CCG staff establishment and Hounslow CCG's share of services transferring back from CSS that related specifically to CWHHE.

7.3 Staff Composition

	Female	Male
Governing Body	4	15
Other senior managers and clinical leads (not included in Governing Body figures) ¹	3	2
CCG staff (local)	31	13

¹ Includes staff on VSM (very senior manager) pay grades, but does not relate to whole time equivalents, i.e. clinical leads may only work for the CCG on an ad hoc sessional basis.

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

Staff Costs

A table is included in the Employee Benefit and Staff numbers Note 3 of the Financial Statements which provides details on staff costs.

7.4 Sickness Absence Data

A table is included in the employee benefits note (note 3.3) to the financial statements.

With a relatively small office based workforce, sickness absence is not a significant issue for the CCG. The management and reporting of sickness is supported by a comprehensive absence management policy and advice from the Human Resources team which covers the eight North West London CCGs. Human Resources have undertaken process training for CCG managers, including the efficient use of sickness absence management protocols to refresh knowledge and reminding managers of their role in the management of absence.

In April 2015 we moved to a new payroll provider and this has included the provision of a sickness reporting system.

7.5 Staff Policies

7.5.1 Equality

The CCG is committed to equality of opportunity for all employees and is committed to employment practices, policies and procedures which ensure that no employee, or potential employee, receives less favourable treatment on the grounds of the nine protected characteristics in line with the Equality Act 2010: sex, race, ethnic or national origin, sexual orientation, marriage and civil partnership, religion or belief, age, pregnancy and maternity and disability.

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

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

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

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

7.6 Expenditure on Consultancy

During the year Hounslow CCG incurred £19k on Consultancy services primarily in respect of Whole Systems Integrated and Care, £10k, and Hounslow's share of some CWHHE commissioned market analysis, £9k.

7.7 Off-payroll engagements

Table 1

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

	Number
Number of existing engagements as of 31 March 2016	4
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	2
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
For 4 or more years at the time of reporting	

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

Table 2

For all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	4
Number of new engagements which include contractual clauses giving the CCG the right to request assurance in relation to Income Tax and National Insurance obligations	4
Number for whom assurance has been requested	4
Of which:	
• assurance has been received	4
• assurance has not been received	
• engagements terminated as a result of assurance not being received	

Table 3

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016:

	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements	21

7.8 Exit Packages (subject to audit)

Hounslow CCG has not agreed any exit packages during the year.

7.9 Approval of Remuneration and Staff Report

The Remuneration and Staff Report has been approved by the Audit Committee on behalf of the Governing Body of Hounslow CCG.

Signed:

Clare Parker
Accountable Officer
NHS Hounslow CCGs

Date: 25 May 2016



*Hounslow
Clinical Commissioning Group*

Audit Opinion

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS HOUNSLOW CCG

We have audited the financial statements of NHS Hounslow CCG for the year ended 31 March 2016 on pages 1 to 24 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Members of the Governing Body of NHS Hounslow CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, 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 Governing Body of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 35, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for the regularity of expenditure and income. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

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

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

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

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

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes

intended by Parliament and the financial transactions conform to the authorities which govern them.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2016 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

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 other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We have to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We have nothing to report in respect of the above responsibilities.

Certificate

We certify that we have completed the audit of the accounts of NHS Hounslow CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Neil Hewitson for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

26 May 2016

Financial Statements

This year 2015/16

This year ended 31 March 2016

This year commencing: 1 April 2015

CONTENTS	Page Number
The Primary Statements:	
Statement of Comprehensive Net Expenditure for the year ended 31st March 2016	1
Statement of Financial Position as at 31st March 2016	2
Statement of Changes in Taxpayers' Equity for the year ended 31st March 2016	3
Statement of Cash Flows for the year ended 31st March 2016	4
Notes to the Accounts	
Accounting policies	5-10
Other operating revenue	11
Employee benefits and staff numbers	11-12
Operating expenses	13
Better payment practice code	14
Operating Leases	14
Property, plant and equipment	15
Intangible non-current assets	16
Trade and other receivables	17
Cash and cash equivalents	17
Trade and other payables	18
Provisions	18
Financial instruments	19-20
Operating segments	21
Pooled budgets	22
Related party transactions	23
Events after the end of the reporting period	23
Financial performance targets	24

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

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	3.1.1	7,008	4,203
Operating Expenses	4	332,762	300,611
Other operating revenue	2	(3,981)	(3,570)
Net operating expenditure for the financial year		<u>335,789</u>	<u>301,244</u>
Of which:			
Administration Income and Expenditure			
Employee benefits	3.1.1	3,123	1,862
Operating Expenses	4	2,651	4,134
Other operating revenue	2	(1)	0
Net administration costs before interest		<u>5,773</u>	<u>5,996</u>
Programme Income and Expenditure			
Employee benefits	3.1.1	3,885	2,341
Operating Expenses	4	330,111	296,477
Other operating revenue	2	(3,980)	(3,570)
Net programme expenditure before interest		<u>330,016</u>	<u>295,248</u>
Total comprehensive net expenditure for the year		<u>335,789</u>	<u>301,244</u>

The notes on pages 5 to 24 form part of this statement

**Statement of Financial Position as at
31-March-2016**

	2015-16	2014-15
Note	£000	£000
Non-current assets:		
Property, plant and equipment	68	102
Intangible assets	26	112
Total non-current assets	<u>94</u>	<u>214</u>
Current assets:		
Trade and other receivables	10,982	5,710
Cash and cash equivalents	103	86
Total current assets	<u>11,085</u>	<u>5,796</u>
Total assets	<u>11,179</u>	<u>6,010</u>
Current liabilities		
Trade and other payables	(48,263)	(36,024)
Provisions	(209)	0
Total current liabilities	<u>(48,472)</u>	<u>(36,024)</u>
Non-Current Assets plus/less Net Current Assets/Liabilities	<u>(37,293)</u>	<u>(30,014)</u>
Assets less Liabilities	<u>(37,293)</u>	<u>(30,014)</u>
Financed by Taxpayers' Equity		
General fund	(37,293)	(30,014)
Total taxpayers' equity:	<u>(37,293)</u>	<u>(30,014)</u>

The notes on pages 5 to 24 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 24th May 2016 and signed on its behalf by:

Clare Parker
Accountable Officer

**Statement of Changes In Taxpayers Equity for the year ended
31-March-2016**

	General fund £000
Changes in taxpayers' equity for 2015-16	
Balance at 1 April 2015	(30,014)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16	
Net operating expenditure for the financial year	(335,789)
Net funding	<u>328,510</u>
Balance at 31 March 2016	<u>(37,293)</u>

	General fund £000
Changes in taxpayers' equity for 2014-15	
Balance at 1 April 2014	(22,861)
Changes in NHS Commissioning Board taxpayers' equity for 2014-15	
Net operating costs for the financial year	(301,244)
Net funding	<u>294,091</u>
Balance at 31 March 2015	<u>(30,014)</u>

The notes on pages 5 to 24 form part of this statement

NHS Hounslow Clinical Commissioning Group - Annual Accounts 2015-16

**Statement of Cash Flows for the year ended
31-March-2016**

	Note	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(335,789)	(301,244)
Depreciation and amortisation	4	120	122
(Increase)/decrease in trade & other receivables	8	(5,272)	189
Increase/(decrease) in trade & other payables	10	12,239	6,848
Increase/(decrease) in provisions	11	209	0
Net Cash Inflow (Outflow) from Operating Activities		(328,493)	(294,085)
Cash Flows from Financing Activities			
Net Funding Received		328,510	294,091
Net Cash Inflow (Outflow) from Financing Activities		328,510	294,091
Net Increase (Decrease) in Cash & Cash Equivalents	9	17	6
Cash & Cash Equivalents at the Beginning of the Financial Year		86	80
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		103	86

The notes on pages 5 to 24 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention 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.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 30 to these financial statements.

1.5 Charitable Funds

There are no Charitable Funds held by the Clinical Commissioning Group.

1.6 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

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

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

- The clinical commissioning group's share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group's share of any liabilities incurred jointly; and,
- The clinical commissioning group's share of the expenses jointly incurred.

Notes to the financial statements

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

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

1.7.1a Corporate Recharge within the CWHHE Collaborative

NHS Central London CCG initially pays for a range of corporate costs which are incurred by all of the CCGs in the Collaborative (NHS Central London CCG, NHS West London CCG, NHS Hammersmith & Fulham CCG, NHS Hounslow CCG and NHS Ealing CCG). NHS Central London CCG then recharges the other CCGs. Each CCG is responsible for its proportionate share of total costs. The basis for calculating the recharges is as follows: each CCG has an agreed local structure and once the local structure is funded, the balance of the remaining running cost allowance is treated in a similar way to a pooled budget. Costs are recharged in the same proportion that the CCG contributes to the pooled budget. Services recharged on a different basis from this are Safeguarding and Office and Estates Services which is based on usage and occupancy and incorporates recharges to Brent CCG and NHS England for occupancy of 15 Marylebone Road. Recharges for support to the GP IT system and for telephony costs are also based on usage.

NHS Central London CCG initially pays for a range of corporate costs which are incurred by all of the CCGs in the Collaborative (NHS Central London CCG, NHS West London CCG, NHS Hammersmith & Fulham CCG, NHS Hounslow CCG and NHS Ealing CCG). NHS Central London CCG then recharges the other CCGs. The basis for calculating the recharges is as follows: each CCG has an agreed local structure and once the local structure is funded, the balance of the remaining running cost allowance is treated in a similar way to a pooled budget. Costs are recharged in the same proportion that the CCG contributes to the pooled budget. The split between CCGs for Admin was Central London CCG 16%, West London CCG 18%, Hammersmith & Fulham CCG 12%, Hounslow CCG 21%, Ealing CCG 32%. The split between CCGs for Programme was Central London CCG 17%, West London CCG 48%, Hammersmith & Fulham CCG 18%, Hounslow CCG 7%, Ealing CCG 10%. Services recharged on a different basis from the above are Safeguarding and Office and Estates Services which is based on usage and occupancy and incorporates recharges to Brent CCG and NHS England for occupancy of 15 Marylebone Road. Recharges for support to the GP IT system and for telephony costs are also based on usage.

1.7.1b Operating a Risk Share between the CWHHE Collaborative

The five CCGs in the CWHHE Collaborative established the principles of a risk share in June 2013 related to high cost activity which is difficult to plan for at an individual CCG level but is more predictable over the larger population of the five CCGs. The risk share was extended in January 2015 to cover the wider system risks emerging during the year and cover any pressures arising from the disaggregation of PCT budgets. The risk share is also flexed on an affordability basis. The risk share was re-affirmed by Governing Bodies in January 2016. Hounslow CCG contributed to the risk share in 2015/16.

1.7.1c Accounting for in-housed Commissioning Support Services

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

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

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

During 2015/16, a number of costs specifically relating to CWHHE which had been charged through the CSS previously were transferred to the host CCGs and therefore recharged net in line with other CWHHE collaborative recharges, i.e. costs are reported in each of the CCG's on a net accounting basis; expenditure incurred by the hosting entity have been netted down to reflect recharges to other CCGs on the expenditure line where the cost is incurred. Examples of this include Joint Commissioning teams for Tri-Borough and Hounslow, CWHHE Finance and the CWHHE Quality and Safety team. This approach was agreed by Finance & Performance committees in January 2016.

Notes to the financial statements

1.7.1d NHS 111 Shared Commissioning Arrangement - NHS Hounslow CCG Commissioned 111 service from Harmoni on behalf of NHS Brent CCG, NHS Harrow CCG and NHS Ealing CCG. This arrangement has been in place from 1 April 2013. The service cost is recharged out to CCGs based on the population size. This means that the costs are split in the following proportions: NHS Hounslow 23%, NHS Ealing CCG 29%, NHS Brent CCG 27%, NHS Harrow CCG 21%.

1.7.1e Urgent Care Centre recharges - Hounslow CCG commissions a UCC service from Hounslow and Richmond Community Trust on a gross basis which is based at West Middlesex University Hospital. Hounslow CCG then recharges non Hounslow CCG costs to the responsible commissioners. The recharge is based on activity information and invoices were raised on a quarterly basis.

1.7.1f **NWL Financial Strategy**

A shared financial strategy has been agreed across the North West London (NWL) Collaboration of CCGs. This comprises two elements -

Part A: The first (Part A) relates to a central budget which funds the Strategy and Transformation team which operates across North West London, as well as provider support for transformational change and other shared costs of transformation across the health economy. Hounslow CCG made a contribution to Part A in 2015/16. There was originally a Part B of the strategy but this has now ceased.

Part C: The second part (Part C) of the North West London Financial Strategy (NWLFS) relates to a transfer of funding between the CCGs to allow those CCGs with more financial flexibility to support those with a more constrained position in order to ensure all CCGs in North West London are able to invest in common commissioning strategies such as *Shaping a Healthier Future* and out of hospital services. Hounslow CCG received support from the NWL financial strategy under Part C in 2015/16. The allocation was transferred between CCGs using the revenue transfer process facilitated by NHS England and the central budget was hosted by Central London CCG. Central London, Hammersmith & Fulham, West London and Brent CCGs were contributors to the NWLFS Part C, with Hillingdon, Hounslow and Harrow as beneficiaries. Ealing CCG was neither a contributor nor a beneficiary of Part C.

1.7.2 **Key Sources of Estimation Uncertainty**

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

1.7.2.1 **Prescription Pricing Authority Expenditure**

Prescription Pricing Authority - The Prescription Pricing Authority (PPA) currently provides us with details of the monthly expenditure incurred by Independent Contractors in respect of Pharmacy contract payments and drug costs. There is approximately a two month delay in notifying the CCG of its expenditure for a particular month. The CCG has therefore applied estimation techniques based on previous trends, expenditure profiles, forecasts from PPA and local knowledge from our Prescribing Advisors. Cost data has been received up to the end of February for drugs.

1.7.2.2 **Acute Contracts Expenditure**

There is a monthly closedown of the acute contracts activity data and post reconciliation data gets rolled into the next monthly reconciliation data. Providers use the monthly reconciliation data to inform their monthly Service Level Agreement Monitoring (SLAM) reports. The latest available SLAM information, Month 11 SLAM data available at the beginning of April, has been used to estimate the full year activity levels and expenditure under service level agreements by including agreed activity to month 11 and pre-validated month 12 activity. In addition NHS creditors and accruals have been informed by the M12 Agreement of Balances exercise where forecast full year costs are agreed.

1.7.2.3 **Recognition of Expenditure**

The CCG has used various techniques to estimate the appropriate levels of expenditure to be included in the accounts. These include basing forecasts on actual expenditure incurred to date extrapolated to a full year, using internal databases (such as Continuing Care), local knowledge from managers and past experience.

1.8 **Revenue**

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

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

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Notes to the financial statements

1.9.2 Retirement Benefit Costs

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

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

1.10 Other Expenses

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

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

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost. Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.12 Intangible Assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost or the value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Notes to the financial statements

1.13 Depreciation, Amortisation & Impairments

Depreciation and amortisation are charged to write off the costs of equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.14 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.

1.14.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.15 Cash & Cash Equivalents

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

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

1.16 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.

1.17 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.

1.18 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.

1.19 Continuing healthcare risk pooling

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

Notes to the financial statements

1.20 Contingencies

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

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

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

1.21 Financial Assets

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Loans and receivables.

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

1.21.1 Loans & Receivables

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

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

1.22 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised 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.

1.23 Value Added Tax

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

1.24 Losses & Special Payments

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

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

1.25 Joint Operations

Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:

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

The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year.

2 Other Operating Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Education, training and research	219	0	219	158
Non-patient care services to other bodies	3,762	1	3,761	3,412
Total other operating revenue	3,981	1	3,980	3,570

3. Employee benefits and staff numbers

3.1.1 Employee benefits

	2015-16			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	6,307	3,103	3,204	2,689	1,886	803	3,618	1,217	2,401
Social security costs	294	294	0	186	186	0	108	108	0
Employer Contributions to NHS Pension scheme	407	407	0	248	248	0	159	159	0
Gross employee benefits expenditure	7,008	3,804	3,204	3,123	2,320	803	3,885	1,484	2,401

3.1.2 Employee benefits

	2014-15			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	3,840	1,767	2,073	1,640	1,002	638	2,200	765	1,435
Social security costs	148	148	0	92	92	0	56	56	0
Employer Contributions to NHS Pension scheme	215	215	0	130	130	0	85	85	0
Gross employee benefits expenditure	4,203	2,130	2,073	1,862	1,224	638	2,341	906	1,435

3.2 Average number of people employed

	2015-16			2014-15
	Total Number	Permanently employed Number	Other Number	Total Number
Total	88	62	26	46

3.3 Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	167	59
Total Staff Years	39	21
Average working Days Lost	4	3

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

3.4 Exit packages agreed in the financial year

The Clinical Commissioning Group has not agreed any exit packages during 2015-16 (2014-15 nil).

3.5 Pension costs

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

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

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

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

3.5.1 Full actuarial (funding) valuation

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

For 2015-16, employers' contributions of £407k were payable to the NHS Pensions Scheme (2014-15: £248k) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. The change in employer contribution took effect from 1st April 2015 and the employer contribution rate moved from 14.0% to 14.3%. These costs are included in the NHS pensions line in note 3.

4.0 Operating expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members*	6,717	2,846	3,871	4,018
Executive governing body members	291	277	14	185
Total gross employee benefits	7,008	3,123	3,885	4,203
Other costs				
Services from other CCGs and NHS England	9,335	1,183	8,152	7,919
Services from foundation trusts	99,701	4	99,697	36,472
Services from other NHS trusts	145,289	0	145,289	190,092
Services from other NHS bodies	0	0	0	12
Purchase of healthcare from non-NHS bodies	26,043	0	26,043	23,889
Chair and Non Executive Members	475	475	0	494
Supplies and services – clinical	25	0	25	0
Supplies and services – general	9,276	8	9,268	1,197
Consultancy services	18	0	18	352
Establishment	1,239	220	1,019	918
Transport	(0)	0	0	2
Premises	3,212	537	2,675	2,910
Depreciation	35	0	35	35
Amortisation	85	0	85	87
Audit fees	67	67	0	89
Prescribing costs	31,706	0	31,706	30,303
GPMS/APMS and PCTMS	4,464	0	4,464	4,699
Other professional fees excl. audit	194	151	43	273
Clinical negligence	1	1	0	0
Education and training	101	5	96	447
Provisions	209	0	209	0
CHC Risk Pool contributions	1,287	0	1,287	421
Total other costs	332,762	2,651	330,111	300,611
Total operating expenses	339,770	5,774	333,996	304,814

*On 1st October 2014 the CCG, in conjunction with the other seven CCGs in North West London, brought commissioning support services, which had previously been supplied by the NWL CSU, in-house. Each of the eight CCGs took an element of the service and hosted it on behalf of the other CCGs. It was agreed that a shared budget would be hosted by Brent CCG and each CCG would account on a gross basis for the locally hosted element.

Hounslow CCG pays £2.040m for commissioning support services in total and hosts £0.470m of the cost.

Excluding the hosted commissioning support service the employee benefits (note 4.1 and note 5) would be £6.538m and average staff numbers (note 4.2) would be 82.

4.1 Better Payment Practice Code

Measure of compliance	2015-16	2015-16	2014-15	2014-15
	Number	£000	Number	£000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,091	49,797	8,077	29,602
Total Non-NHS Trade Invoices paid within target	8,825	48,895	7,608	28,701
Percentage of Non-NHS Trade invoices paid within target	97.07%	98.19%	94.19%	96.96%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,087	260,017	3,666	237,665
Total NHS Trade Invoices Paid within target	2,980	257,664	3,391	229,098
Percentage of NHS Trade Invoices paid within target	96.53%	99.10%	92.50%	96.40%

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

The Clinical Commissioning Group did not have any late payment of commercial debt interest during 2015-16 (2014-15 nil).

5. Operating Leases

5.1 As lessee

The Clinical Commissioning Group pays NHS Property Services and Community Health Partnerships. These payments although not under a formal lease or contract have been determined under IFRIC 4 to be a lease arrangement.

5.1.1 Payments recognised as an Expense

Payments recognised as an expense	2015-16				2014-15			
	Land £000	Buildings £000	Other £000	Total £000	Land £000	Buildings £000	Other £000	Total £000
Minimum lease payments	0	1,930	29	1,958	0	2,882	0	2,882
Total	0	1,930	29	1,958	0	2,882	0	2,882

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

6.0 Property, plant and equipment

2015-16	Plant & machinery £000	Total £000
Cost or valuation at 01-April-2015	172	172
Cost/Valuation At 31-March-2016	<u>172</u>	<u>172</u>
Depreciation 01-April-2015	69	69
Charged during the year	35	35
Depreciation at 31-March-2016	<u>104</u>	<u>104</u>
Net Book Value at 31-March-2016	<u>68</u>	<u>68</u>
Purchased	68	68
Total at 31-March-2016	<u>68</u>	<u>68</u>
Asset financing:		
Owned	68	68
Total at 31-March-2016	<u>68</u>	<u>68</u>

6.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Plant & machinery	1	5

7.0 Intangible non-current assets

2015-16	Computer Software: Purchased £000	Total £000
Cost or valuation at 01-April-2015	286	286
Cost / Valuation At 31-March-2016	<u>286</u>	<u>286</u>
Amortisation 01-April-2015	175	175
Charged during the year	85	85
Amortisation At 31-March-2016	<u>260</u>	<u>260</u>
Net Book Value at 31-March-2016	<u>26</u>	<u>26</u>
Purchased	26	26
Total at 31-March-2016	<u>26</u>	<u>26</u>

7.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	1	2

8.0 Trade and other receivables	Current 2015-16 £000	Current 2014-15 £000
NHS receivables: Revenue	3,989	3,811
NHS prepayments	1,698	0
NHS accrued income	2,321	1,558
Non-NHS receivables: Revenue	2,851	145
Non-NHS prepayments	93	0
VAT	29	183
Other receivables	1	13
Total Trade & other receivables	<u>10,982</u>	<u>5,710</u>

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

8.1 Receivables past their due date but not impaired	2015-16 £000	2014-15 £000
By up to three months	1,617	933
By three to six months	41	0
By more than six months	662	182
Total	<u>2,320</u>	<u>1,115</u>

9.0 Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 01-April-2015	86	80
Net change in year	17	6
Balance at 31-March-2016	<u>103</u>	<u>86</u>
Made up of:		
Cash with the Government Banking Service	103	86
Balance at 31-March-2016	<u>103</u>	<u>86</u>

10.0 Trade and other payables	Current 2015-16 £000	Current 2014-15 £000
NHS payables: revenue	22,473	13,445
NHS accruals	3,672	2,123
Non-NHS payables: revenue	11,254	4,656
Non-NHS accruals	10,521	15,614
Social security costs	28	26
Tax	31	30
Other payables	284	130
Total Trade & Other Payables	<u>48,263</u>	<u>36,024</u>
Total current and non-current	<u>48,263</u>	<u>36,024</u>

Other payables include £42k outstanding pension contributions at 31 March 2016 (31 March 2015 £40k)

11.0 Provisions	Current 2015-16 £000	Current 2014-15 £000
Other	209	0
Total	209	0
Total current and non-current	<u>209</u>	<u>0</u>

The other provision relates to National Insurance and Tax costs associated with contractors engaged by Central London CCG and recharged across the five CCGs in line with work completed. These arrangements are subject to an investigation by HMRC and arrangements have changed going forward to ensure no future liability is incurred. The timing and exact value of any payment relating to historic practice is at this stage not agreed. As payment is made this would be declared under losses and special payments.

12.0 Financial instruments

12.1 Financial risk management

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

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

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

12.1.1 Currency risk

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

12.1.2 Interest rate risk

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

12.1.3 Credit risk

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

12.1.3 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.

12.0 Financial instruments cont'd

12.2 Financial assets

	Loans and Receivables 2015-16 £000	Total 2015-16 £000
Receivables:		
· NHS	6,310	6,310
· Non-NHS	2,851	2,851
Cash at bank and in hand	103	103
Other financial assets	1	1
Total at 31-March-2016	<u>9,265</u>	<u>9,265</u>

	Loans and Receivables 2014-15 £000	Total 2014-15 £000
Receivables:		
· NHS	3,812	3,812
· Non-NHS	145	145
Cash at bank and in hand	86	86
Other financial assets	13	13
Total at 31-March-2015	<u>4,056</u>	<u>4,056</u>

12.3 Financial liabilities

	Other 2015-16 £000	Total 2015-16 £000
Payables:		
· NHS	26,145	26,145
· Non-NHS	22,059	22,059
Total at 31-March-2016	<u>48,204</u>	<u>48,204</u>

	Other 2014-15 £000	Total 2014-15 £000
Payables:		
· NHS	15,568	15,568
· Non-NHS	20,401	20,401
Total at 31-March-2015	<u>35,969</u>	<u>35,969</u>

13 Operating segments

13. Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Acute	190,206	(1,331)	188,875	0	0	0
Mental Health	33,703	0	33,703	0	0	0
Continuing Care	10,013	0	10,013	0	0	0
Community	45,623	0	45,623	0	0	0
Prescribing	32,209	0	32,209	0	0	0
Primary Care	10,588	(219)	10,369	0	0	0
Corporate & Estates / Other	17,428	(2,431)	14,997	0	0	0
Unallocated	0	0	0	11,179	(48,472)	(37,293)
Total	339,770	(3,981)	335,789	11,179	(48,472)	(37,293)

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

14 Pooled budgets

The Clinical Commissioning Group has entered into a pooled budget with The London Borough of Hounslow under Section 75 of the NHS Act 2006, who are the host.

During 2015/16 the CCG entered into a pooled budget in respect of the Better Care Fund (BCF). The BCF was announced by the Government in the June 2013 spending round to drive the transformation of local services to ensure that the people receive better and more integrated care and support. The fund is to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups.

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

	2015-16	2014-15
	£000	£000
Income	0	0
Expenditure	15,288	0

The gross expenditure is reported in note 4 under the following headings:

Services from other NHS trusts	3,265
Purchase of healthcare from non-NHS bodies	1,977
GPMS/APMS and PCTMS	<u>1,429</u>
Expenditure incurred directly by the CCG as the lead Commissioner	<u>6,671</u>
Supplies and services – general	<u>8,617</u>
Expenditure incurred by London Borough of Hounslow as the lead Commissioner	<u>8,617</u>
Total BCF expenditure	<u>15,288</u>

15.0 Related party transactions

Members of the Governing Body are required to declare any interests that they hold, either directly or through family members, in organisations other than the Clinical Commissioning Group. Where the CCG receives income or incurs

During the year none of the Governing Body Members or members of the key management staff or parties related to them has undertaken any material transactions with Hounslow CCG except those listed below.

Clinical Commissioning Board Member	Name of related party	Nature of interest	Nature of transaction	Payments	Receipts	Amounts	Amounts
				to Related Party	from Related Party	owed to Related Party	due from Related Party
				£'000	£'000	£'000	£'000
Mr Philip Young	St David's Nursing Home	Trustee	Continuing health care payments	184	0	0	0
Dr Paul Shenton	Redwood Practice (P Shenton & Ptns)	Partner in practice	LES/OOH payments	96	0	48	0
Dr Shanitha Sethurajan	Grove Park Surgery	Partner in practice	LES/OOH payments	130	0	68	0
Dr Nicola Burbidge	Wellesley Road Practice	Partner in practice	LES/OOH payments	74	0	62	0
Dr Prashant Gupta	Brentford Group Practice	Partner in practice	LES/OOH payments	52	0	62	0
Dr Richard Baxter (Albany Practice)	Albany Practice	Partner in practice	LES/OOH payments	90	0	61	0
Dr Brigitte Unger-Graeber	Chiswick Health Practice	Partner in practice	LES/OOH payments	90	0	56	0
Dr Parvinder Garcha	Hounslow Family Practice	Partner in practice	LES/OOH payments	40	0	35	0
Dr Indervir Dhandee	Grove Village Medical Centre	Partner in practice	LES/OOH payments	132	0	48	0
Dr Ashok Gorasia	St Davids Practice	Partner in practice	LES/OOH payments	74	0	79	0
C Parker	Health Education England (HENWL)	Associate Finance Member	Training Funds	0	(219)	0	0
C Parker	West London Health Partnership Ltd	Director	Feasibility Study	10	0	10	0

The Department of Health is regarded as a related party and NHS England is regarded as parent entity. During the year Hounslow CCG has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

The entities with transactions greater than 1% of Hounslow CCG net operating cost for the financial year are:

	Income	Expenditure	Receivables	Payables
	£'000	£'000	£'000	£'000
A Trusts				
Hounslow & Richmond Community Healthcare NHS Trust	0	28,244	0	911
Imperial College Healthcare NHS Trust	0	31,008	(169)	909
London Ambulance Service NHS Trust	0	8,781	0	216
London North West Healthcare NHS Trust	0	7,184	(274)	100
West London Mental Health NHS Trust	0	24,462	0	1,440
West Middlesex University Hospital NHS Trust (Merged With Chelsea & Westminster FT w.e.f 01/09/2015)	0	40,582	0	0
B Foundation Trusts				
Ashford & St Peter's Hospitals NHS Foundation Trust	0	12,379	0	431
Chelsea And Westminster Hospital NHS Foundation Trust	(4)	68,775	(1,641)	6,752
The Hillingdon Hospitals NHS Foundation Trust	0	4,382	0	1,144
C Clinical Commissioning Groups				
NHS Central London (Westminster) CCG	(2,258)	5,566	(2,362)	9,061
D Local Authorities				
Hounslow London Borough Council	0	12,767	(2,705)	4,401

16.0 Events after the end of the reporting period

As at 22 April 2016, there are no post balance sheet events which will have a material effect on the financial statements of the Clinical Commissioning Group.

17.0 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:

	2015-16 Target	2015-16 Performance	2014-15 Target	2014-15 (Restated) Performance
Expenditure not to exceed income	346,081	339,770	311,743	304,814
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	342,100	335,789	308,173	301,244
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	6,734	5,773	6,602	5,996

Contact Details

Green Zone (Pavilion CG), Ground Floor,
Civic Centre
Lampton Road
Hounslow
TW3 4DN

Tel: 020 8538 2400

Email: houccg.contacts@nhs.net