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A Glossary of Terms is available on our website.
PART ONE:  ANNUAL REPORT
OUR SUCCESSES IN 2014/15

GP leadership and our GP networks have driven the development and implementation of our plans. As a result, we have achieved a range of service changes at a pace that would otherwise not have been possible.

Improving Quality
- Highest performing CCG in South London for our quality premium indicators in 2013/14
- A steady decline in patients with new pressure ulcers as well as a decrease in the number of falls
- Fewer venous thromboembolism (VTE) than expected
- Fewer Clostridium Difficile infections than expected
- Reduced number of fractured neck of femur through new falls prevention service
- Medication reviews in care homes
- 1 midwife to 28 births achieved

Achieving Financial Sustainability
- Delivered better than plan in the past two years
- £14m QIPP plan in 2013/14 and £11m in 2014/15

Transforming the way we deliver care
- 18 new care pathways developed and implemented through the clinical networks including cardiology, COPD, diabetes, MSK and falls, meaning patients have fewer unnecessary appointments
- Better access for people with mental health problems with new and enhanced mental health services including Home Treatment Crisis Service Enhancement, Dialectic Behavioural Therapy, Relapse Prevention
- 496 patients undertaken diabetes management course
- All GP practice have designated diabetes specialist nurse
- Paediatric asthma service implemented
- People with heart problems are seen and treated more quickly at community clinics: One stop heart failure clinic, Rapid Access Chest Pain Clinic

Transforming the way we deliver care
- Transforming Adult Community Services
  - 20,500 people referred to the new 24/7 Integrated Single Point of Assessment (SPA) have been triaged to the appropriate service
  - 864 people referred to new 24/7 Rapid Response service to support unwell patients to be cared for within the community
  - 193 patients supported away from hospital through increased number of Intermediate Care Bed from 6 to 12
  - 800 patients supported through dedicated case management through joint GP-led Primary, Community, Social Care and Mental Health multi-disciplinary teams (MDTs)
NHS Croydon Clinical Commissioning Group (Croydon CCG) has been established for two years and this is our second Annual Report.

We commission (plan and buy) most of the health services you will use in Croydon. We have three strategic aims:

- Maintaining and improving safety and quality of care
- Transforming the way care is delivered for the future
- Achieving financial sustainability

In April 2013, we inherited a very significant financial shortfall of £33.9m between the resources allocated to us and local demand for health services.

The legacy of our inherited financial position has been underinvestment in community services, primary care and mental health services - as a result there are variations in the quality and performance of our services leading to varying experiences of care and outcomes for our patients.

We have other challenges in Croydon; the population is growing and becoming more diverse. Life expectancy is increasing and we have an aging population but we are also expecting to see an increase in the number of younger people in the borough. These changes to our population affect the health needs of Croydon residents and impact on the types of services we need to commission.

We are determined to address these challenges – and to ensure we make the best use of our resources. We realised that we could not continue to deliver services in the same way as in the past. We have set out an ambitious transformation strategy for sustainable health services for the future, pushing organisational, contractual and transformational boundaries so that we can achieve the best possible, sustainable health care for the people of Croydon whilst achieving financial efficiencies to enable us to meet healthcare needs of the people of Croydon within the resources we receive.

2014/15 has been a busy year for Croydon CCG. Partnership working has been key to our progress. We have worked closely with our commissioning partners, our local providers, patients and local people – all of whom have been involved in the development of our plans. We have made significant progress against our objectives in a short time.

Our GP leadership and networks have driven the development and implementation of our plans and we have achieved service change at a pace which would not have been possible without their leadership.

To put this into context, our GP networks and clinical leaders have been integral in designing and rolling out 18 new care pathways, to improve care, services and outcomes for people using cardiology, chronic obstructive pulmonary disease (COPD) and diabetes services.

Through their commitment to working with provider clinicians, we have developed community services through the Transforming Adult Community Services (TACS) programme.
During 2015/16 we will continue to embed these new care pathways and services to ensure our patients gain the maximum benefit from them.

We have made significant investment during 2014/15 in mental health to increase access, although we need to further develop our models of care for mental health to achieve high quality, sustainable services to support people in the community and to provide safe, high quality care in times of crisis. We must also ensure we improve our performance against existing, and new targets particularly for increasing access to psychological therapies (IAPT) and dementia diagnosis for people over 65 years.

We have also developed firm foundations this year for changing the way we commission services for older people and are developing outcomes we want to commission for.

We launched our integrated commissioning unit (ICU) in partnership with Croydon Council in April 2014. The ICU has brought together a number of our commissioning support functions in relation to services for children, mental health, learning disabilities and vulnerable older people. The joint approach has meant that we can improve the quality of local services whilst at the same time using both organisations’ commissioning resources more efficiently and achieve better value for money. Most importantly, the ICU will significantly benefit local people as we are able to commission “end to end” services combining health and social care.

We have worked with other south west London CCGs and NHS England to retain and build upon local services, and developed plans for co-commissioning primary care services which we believe will deliver real improvements in delivering seamless integrated out of hospital services for local people across south west London.

The NHS had a very challenging winter period in 2014/15 – demands on urgent care and A&E increased significantly across the country. In Croydon a range of initiatives were implemented to help our local providers cope with the demands on their urgent care services, and we subsequently saw a reduction in A&E attendances.

The challenging winter period resulted in the CCG’s A&E four hour wait performance target not being achieved for 2014/15, and urgent care will be a focus for us in 2015/16 as we work towards delivery of a resilient and sustainable model of care.

We must also ensure in 2015/16 that we deliver a reduction in the variation in quality of primary care services. Again our GP networks are essential to drive this forward as they understand the needs of their patients and the health challenges in their local network.

In this report, you will find more detail on how we have built on the foundations we put in place last year and our plans going forward to deliver our vision of “longer healthier lives for all the people of Croydon”.

We are proud of our achievements this year and thank everyone who has worked with us. In 2015/16 we will continue to build on the progress we have made over the last two years.

Dr Tony Brzezicki
Chair
29 May 2015

Paula Swann
Chief Officer
29 May 2015
MEMBERSHIP REPORT

Member practices introduction

NHS Croydon Clinical Commissioning Group (Croydon CCG) is made up of all 58 GP practices in Croydon (there were 59 practices until October 2014). The GP Governing Body members for the CCG and the Clinical Leads are voted for by all the GPs practising within the borough of Croydon.

The six geographically based networks of practices, which are each led by a GP Clinical Lead and supported by network co-ordinators, work closely together meeting on a monthly basis to share ideas and good practice and to discuss areas of interest across the network. These meetings are also used to engage with the GPs and their practices in service redesign and commissioning plans to meet the needs of their local populations. The meetings also act as a vehicle to ensure the practices are up to date with other services in the borough available to their patients, such as secondary care, social care and services provided by the voluntary sector.

The GP networks have made good progress in delivering their practice plans to reduce variation in primary care during the last year supported by the primary care engagement team, finance, business intelligence, public health and medicines management.

Peer review has become successfully embedded in the practices and across the networks, providing support and sharing best practice to ensure consistently good quality primary care provision across Croydon.

Several GPs have taken on clinical roles within Croydon CCG, providing clinical input to a number of projects including cancer services, mental health, end of life care and diabetes. They are also providing valuable input into projects such as installing new hardware and software in all the practices. Clinicians have also led in developing three bids for the Prime Minister’s Challenge Fund to help improve access to primary care services.

The Council of Members, made up of GP practice representation from all practices in Croydon, has been engaged this year in the Transforming Primary Care agenda with the Governing Body.

There continues to be on-going programmes of training, through funding from Health Education South London, for clinicians, practice managers and administrative staff, supporting improvement of the patient experience of care in Croydon.

Dr Peter Boffa    Dr Bobby Abbot
Chairman      Clinical Lead
Council of Members   Development of practice networks
Membership Report

Croydon CCG is a clinically-led membership organisation bringing together 58 GP practices in the borough of Croydon into one commissioning organisation.

The CCG is made up of six, geographically based, localities each with a GP lead. The GP network lead is also a member of the Clinical Leadership Group (see below).

- East Croydon Network
- Mayday Network
- New Addington/Selsdon Network
- Purley Network
- Thornton Heath Network
- Woodside/Shirley Network

Network achievements

Clinical Leadership Group

The Clinical Leadership Group (CLG) was elected and established in 2012. Its purpose is to provide clinical and corporate support to the CCG’s Governing Body, by leading on agreed areas, engaging with member practices and providing clinical leadership in service redesign and commissioning improvement programmes. Each member of the CLG has an agreed portfolio of work and is supported by one of the GP Governing Body members.
• Dr Bobby Abbot
  Woodside/ Shirley Clinical Network Lead and also lead for public health, mental health, Prescribing and development of practice networks

• Dr Yinka Ajayi-Obe
  Mayday Network Clinical Network Lead and lead for COPD, MSK, Maternity and Diagnostics

• Dr Karthiga Gengatharan
  East Croydon Clinical Network Lead and lead for children’s health and public health

• Dr Agatha Nortley Meshe
  New Addington/Selsdon Clinical Network Lead and also lead for Cardiology, 111, A&E

• Dr Rajeev Sagar
  Thornton Heath Clinical Network Lead and lead for cardiology, urology and public health

• Dr Farhan Sami
  Purley Clinical Network Lead and also lead for planned care, long term conditions, children, anticoagulation and maternity

In addition there are a number of other GPs leading on areas such as diabetes training and education, end of life care, alcohol and substance misuse and mental health.

In 2015/2016, we will be appointing six deputy Network Clinical Leads to assist the current Network Clinical Leads. Each of the deputy leads will develop a portfolio of clinical areas.

Governing Body elections
In June 2014, we held elections and reappointed the Governing Body Chair and Governing Body Assistant Clinical Chair who are both in place until June 2017.

The current terms of office for elected members of the Governing Body are listed below. For the next election round in 2017 we will change the election term/cycle for the Chair and Assistant Clinical Chair roles so that the terms are staggered and do not end at the same time.

<table>
<thead>
<tr>
<th>Elected member</th>
<th>Appointment date</th>
<th>End of term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthony Brzezicki</td>
<td>July 2014 (Reappointment)</td>
<td>June 2017</td>
</tr>
<tr>
<td>Agnelo Fernandes</td>
<td>July 2014 (Reappointment)</td>
<td>June 2017</td>
</tr>
<tr>
<td>John Chan</td>
<td>November 2013</td>
<td>June 2016</td>
</tr>
<tr>
<td>Atif Hasan</td>
<td>November 2013</td>
<td>June 2016</td>
</tr>
<tr>
<td>John Linney</td>
<td>November 2013</td>
<td>June 2016</td>
</tr>
</tbody>
</table>

Declaration of interests
The result of the declaration of interests is attached at PART THREE: DECLARATION OF INTERESTS.
**Working with our members, patients, public and other stakeholders**

Over the past year, we have worked hard to develop the way we have worked with our members, and we continue to build strong and productive local relationships.

As part of this we have worked with members to improve both the quality of current services, and the way we work to jointly transform services for the future. Some examples of activity last year are listed below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Our members said …..</th>
<th>How we responded …..</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-commissioning</td>
<td>We aren’t convinced about plans for primary care co-commissioning</td>
<td>We recognise that our members and some partners have concerns, and we are keen to address these concerns. Good communication, clear and transparent processes, and management of potential conflicts of interests will be particularly important</td>
</tr>
<tr>
<td>Croydon Referral Support Service (CReSS)</td>
<td>Not all outpatient referrals should go through CReSS</td>
<td>A new tiered system is being introduced, more feedback opportunities have been provided, and we’ve provided more educational support to practices and patients</td>
</tr>
<tr>
<td>Mental Health</td>
<td>There are significant issues accessing Mental Health services</td>
<td>We worked with our members, providers, the public, patients, carers and our partners to produce a new mental health strategy with £5m of extra investment. We are piloting Mind’s ‘Somewhere to go, something to do’ programme in the Borough, we have increased access to IAPT (counselling services) and reduced waiting times and are working together to redesign services in the community</td>
</tr>
<tr>
<td>Redesigned care pathways</td>
<td>As clinicians we need to be kept up to date with decision making and have easily accessible information</td>
<td>We provided education sessions at our GP open meeting led by hospital and GP clinicians and are working to provide information on new pathways in more effective ways</td>
</tr>
<tr>
<td>Purley Hospital</td>
<td>We are happy with Purley War Memorial redevelopment but unhappy with changes to Minor Injuries Unit (MIU)</td>
<td>We have committed to regularly review the new service and work with local residents associations to communicate services and commission services that meet local need</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Patient education programmes should be delivered through GPs so patients don’t have to go to hospital</td>
<td>A new service has been developed by clinicians with education programmes available at home and services provided in primary care and community are being developed</td>
</tr>
<tr>
<td>Integration</td>
<td>Social care and health services need to be integrated more effectively to ensure residents are provided with joined-up support and treatment</td>
<td>We’ve co-developed and implemented the Transforming Adult Care Services programme with the local authority to provide joined-up care for patients. The Integrated Commissioning Unit has been launched bringing some key NHS and local authority commissioners into one team for the first time.</td>
</tr>
<tr>
<td>Finances</td>
<td>Underfunding by NHS England should not lead to cuts in services</td>
<td>We continue to run a reducing deficit budget in Croydon to protect services, whilst delivering quality-led savings to use our resources as effectively as possible to deliver financial sustainability over the longer term</td>
</tr>
<tr>
<td>Transforming Adult Care Services</td>
<td>We need to provide more support for patients to reduce avoidable emergency admissions</td>
<td>Our members have worked together with Croydon Hospital Trust and the local authority to develop the TACS service which is ensuring patients receive a wide range of support in their own homes, and rapid response teams to provide early intervention when things go wrong</td>
</tr>
<tr>
<td>Services for older people</td>
<td>We need to help older people stay in their homes for longer, keeping healthy and independent</td>
<td>We are working with our partners, including local people, to explore how an ‘outcomes based’ approach to commissioning services will benefit older people in the Borough</td>
</tr>
</tbody>
</table>
STRATEGIC REPORT

Who we are

NHS Croydon Clinical Commissioning Group (Croydon CCG) was established by the 2012 Health and Social Care Act. We received authorisation from NHS England in March 2013, and formally took responsibility for commissioning hospital, community and mental health services for local people in April 2013.

We are a clinically-led membership organisation bringing together all 58 GP practices in the borough of Croydon into one commissioning organisation. We also have a governing body which is responsible for overseeing our commissioning and statutory functions.

Governing Body

Croydon CCG is overseen by a Governing Body. The function of the Governing Body is to ensure strong and effective leadership, management and accountability for the CCG.

The Governing Body is currently comprised of the following members:

GP members
- Dr Anthony Brzezicki, Chair
- Dr Agnelo Fernandes, Assistant Clinical Chair
- Dr John Chan, GP Governing Body Member and Medical Director
- Dr John Linney, GP Governing Body Member
- Dr Atif Hasan, GP Governing Body Member

Clinical representatives
- Amanda Page, Chief Nurse
- Dr Jonathan Norman, Secondary Care Consultant

Lay members
- Roger Eastwood, Lay Member, Finance
- Helen Pernelet, Vice Chair and Lay Member, Governance and Patient and Public Involvement (PPI)

Executive members
- Paula Swann, Chief Officer
- Mike Sexton, Chief Financial Officer
- Sean Morgan, Director of Governance and Quality (Interim)*
- Stephen Warren, Director of Commissioning

(Note* Replaced Michelle Rahman in February 2015 who was interim Director of Governance and Quality covering Fouzia Harrington’s sabbatical.)

Attendees
- Paul Greenhalgh, Executive Director (Acting), People, Croydon Council*
- Dr Mike Robinson, Director of Public Health, Croydon Council
- Mark Justice / Vanessa Horsford (Interim), Healthwatch Chair

(Note* Replaced Hannah Miller in December 2014.)
Information on changes to the Governing Body during the year can be found in our governance statement at Appendix 1.

The CCG is managed in an open and accessible way, which enables local people to question what the CCG does and why. The Governing Body meets regularly in public and publishes board papers on Croydon CCG website. For further information visit: http://www.croydonccg.nhs.uk

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

What we do

Croydon CCG plans, buys and monitors most local health services, including:

- Outpatient appointments and planned operations (planned hospital care)
- Urgent and emergency care (including out of hours services)
- Rehabilitative care
- Maternity services
- Community health services (for example physiotherapy and district nursing)
- Mental health services
- Services for people with disabilities
- Prescribing by member practices

Our main local providers

The services we buy include hospital, community, mental health services and some primary care services. Some of the main providers locally are Croydon Health Services NHS Trust, St George’s Healthcare NHS Trust, The Royal Marsden NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, Care UK and Virgin Care.

- **Croydon Health Services NHS Trust**
  Croydon Health Services provide acute and community healthcare services across the borough of Croydon either in patient’s own homes or from clinics and specialist centres, including Croydon University Hospital and Purley War Memorial Hospital in Purley, which recently underwent an £11 million refurbishment and re-opened in the summer of 2013.

- **South London and Maudsley NHS Foundation Trust**
  The Trust provides the widest range of NHS mental health services in the UK. It also provides substance misuse services for people who are addicted to drugs and / or alcohol. It works closely with the Institute of Psychiatry, King’s College London and is part of King’s Health Partners Academic Health Sciences Centre.

- **Care UK**
  Care UK provides the NHS 111 service in Croydon. Care UK's NHS 111 service delivers the national requirements laid down by the Department of Health and incorporates NHS Pathways, through a software decision support tool which enables clinical assessment at the patient's first point of contact with the service. Care UK provide consistent, high quality clinical assessment and call handling / administration
services to support locally agreed care pathways. Care UK’s NHS 111 service model has six key components: access, assessment, signposting and booking of appointments, treatment, self-management and planning.

- **Virgin Care**
  We have commissioned Virgin Care to provide the Urgent Care Centre at Croydon University Hospital. Virgin Care provides over 270 services nationwide with a focus on community and primary healthcare.

Croydon CCG commissions healthcare services from acute hospitals, community healthcare providers and mental health providers. The table below sets out local providers and the services we commission from them.

**Main local NHS providers**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Acute Services</th>
<th>Community Services</th>
<th>Mental health Services</th>
<th>Cancer Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon Health Services NHS Trust</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>South London and Maudsley NHS Foundation Trust</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>St George’s University Hospital NHS Foundation Trust</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>King’s College Hospital NHS Foundation Trust</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The Royal Marsden NHS Foundation Trust</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

As a commissioning organisation it is vital for Croydon CCG to work closely with other commissioners and regulators. We have spent time developing relationships to ensure that we do not duplicate work, that the needs of all patients are known and provided for, and that the work of our stakeholders and partners is consistent with our ambitions.

Croydon CCG does not commission specialist services, such as bariatric surgery, renal dialysis, neonatal critical care and specialist mental health services. These are commissioned on a national basis by NHS England. ([https://www.england.nhs.uk/commissioning/spec-services/](https://www.england.nhs.uk/commissioning/spec-services/))
NHS England also contract with all GP practices in Croydon. Croydon CCG holds separate contracts with GPs to provide services which are in addition to the national GP contracts.
Our borough (health and wellbeing overview)

The Joint Strategic Needs Assessment (JSNA) identifies the big picture in terms of health and social needs of our local communities, picking out the key health and care issues in Croydon, to help focus commissioning and planning.

By mid-2013, the resident population of Croydon was estimated to be 372,000. 395,000 people are registered with a GP in Croydon. Croydon’s resident population is growing by about one per cent per year, and is projected to reach 400,000 by 2021.

Croydon is a diverse borough. Around half of Croydon’s population (49%) are from black and ethnic minority communities (BME) and the total BME population is forecast to grow to nearly 57% of the total population by 2015. Along with the four main minority languages of Tamil, Urdu, Gujarati and Polish, over 100 languages are spoken as a first language by patients registered with GPs in the borough.

![Graph showing population change by age group and ethnicity in Croydon]

Source: Greater London Authority 2013 SHLAA Capped Household Size-based ethnic group projections

Compared to other areas, Croydon has a relatively young population. The present high birth rate and effects of migration are expected to result in growth in some of the younger as well as older age groups in coming years. The latest projections suggest the number of people aged over 85 will increase by two thirds by 2030.

However, there are high numbers of care homes in Croydon relative to other London boroughs. Croydon has 144 care homes that are registered with the Care Quality Commission (CQC), with a maximum capacity to care for 2,796 people. Croydon Council only uses an estimated one third of these places, the remaining are either self-funded, from other areas, or health-funded. This places a great pressure on the local health system as well as the local Council.
Although Croydon is a relatively prosperous borough, with some parts of it in the least deprived 15% in the country, there are pockets of deprivation, with most of the poorer areas in the north of the borough, and some significant pockets of deprivation in the east, in areas such as Coulsdon and New Addington.

The health of people in Croydon is mixed compared to the England average:

- Life expectancy for both men and women is higher than the England average. However, life expectancy is 9.1 years lower for men and 7.7 years lower for women in the most deprived areas of Croydon than in the least deprived areas

- Deprivation in the borough is lower than average, however Croydon has become increasingly deprived in recent years at a faster rate than surrounding boroughs. 19,800 children (22%) in Croydon live in relative poverty

- Croydon has a growing population with more people having mental health support needs

- Obesity is a national and local concern, and an estimated 62% of Croydon adults are overweight or obese with a BMI of over 25

- An estimated 17% of adults in Croydon smoke and there are 390 deaths from smoking each year

- 21% higher spend on mental health inpatient services than comparative boroughs

- High numbers of looked after children including on average 400 unaccompanied asylum-seeking children

- Over the last 10 years all-cause mortality rates have fallen. Early death rates from cancer, heart disease and stroke have fallen. However, among under 75 year olds 27% of preventable deaths were due to cardio-vascular disease (including heart disease and stroke), 40% were due to cancer and 8% were due to respiratory disease

- The prevalence of diagnosed diabetes in Croydon is 6.5 % which is significantly higher than than in London (6%) and in England (6.2%)

- Breast and cervical cancer screening rates are both significantly worse than the national average

- It is estimated that 25% of older adults in the community have symptoms of depression that may require intervention, 11% will have minor depression and 2% major depression
Our challenges by GP Network

Thornton Heath
- Flu vaccine uptake
- High rate of emergency admissions for over 65s
- High rate of GP referrals to A&E
- Diagnosis rate for depression, CHD, atrial fibrillation, COPD and epilepsy
- Care and outcomes for depression and rheumatoid arthritis
- Breast and bowel screening; cancer reviews

Mayday
- Patient experience
- High A&E attendance rates
- High emergency admission rates
- Diagnosis of atrial fibrillation and epilepsy
- Childhood immunisations
- Cancer screening

East Croydon
- High rate of A&E attendances and emergency admissions particularly for over 65s
- Prescribing indicators
- Diagnosis rates for diabetes, depression, dementia and hypertension
- Care and outcomes for diabetes, severe mental illness and CKD
- Cancer screening

Woodside and Shirley
- Access and overall patient experience
- Prescribing indicators
- Diagnosis rates for dementia and CHD
- Flu vaccine uptake
- Childhood immunisations
- Care and outcomes for severe mental illness and sexual health
- High referral rates

New Addington and Selsdon
- Breastfeeding; smoking during pregnancy
- High emergency admission and A&E attendance rates in New Addington

Purley
- Flu vaccine uptake
- Care and outcomes for diabetes and depression
Our vision and priority areas

Our vision is for “longer healthier lives for all the people in Croydon”. We will deliver this vision by working with the diverse community of Croydon, using our resources wisely, to transform and provide safe, effective, high quality, patient centred services.

We have been transforming local healthcare services for two years through clinically-led, innovative re-design of services. We have been developing a model of care which is planned and co-ordinated around the needs of patients and their families. In the past commissioning has not always focussed on quality or been clinically driven. As an organisation led by GPs, we have moved to a commissioning model that is clinically led and quality driven to ensure the people in Croydon get the best possible health services that are efficient and sustainable.

In Croydon, health and social care face a number of challenges over the coming years. The overall population is growing. There is an expected increase in the number of younger people living in the borough, overall life expectancy is increasing and we have an ageing population which increases the demand on our services. Our population is also becoming more diverse, and so changing the health needs in Croydon.

There are variations in the quality and performance of our services, leading to varying experiences of care and outcomes for people. These challenges are set in the context of a significant financial shortfall as a result of an imbalance between our resources and our population needs.

Given our population needs, which are identified in the Joint Strategic Needs Assessment, and local service challenges our priority outcomes are:

- Reducing potential years of life lost through disease
- Ensuring people are seen in the right place at the right time
- Children and young people reach their full potential
- Increased independence
- Positive patient experience

Because of what we know about our local population we have a long term focus on:

- Cardiology
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Cancer
- Mental Health including Dementia
- Children and Young Adults

Our principles are:

- Prevention is better than cure; but
- When someone does become ill they are better able to manage their illness; and
- When a person does need care they are seen in the right place at the right time; and
- There is shared decision making between the patient and the health professional
Ensuring we make the best use of our resources means we cannot continue delivering services in the same way. We require transformational change through:

- Prevention, self-care, shared decision making
- Outcomes based commissioning
- Transforming Adult Community Services
- Improve integration of care
- Reducing unwarranted primary care variation
- Whole system redesign
Our transformation plans

We are determined that through the implementation of our transformation programme we will maximise the resources available to us to ensure we can continue to deliver quality health services and improve health outcomes for the people of Croydon.

Our GP leadership and networks have been driving change and ensuring delivery of plans. They have continued to develop Croydon wide plans with provider clinicians as well as being focused on their networks specific needs.

<table>
<thead>
<tr>
<th><strong>Prevention, self-care and shared decision making</strong></th>
<th><strong>Objective</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve patients' life expectancy and quality of life by helping them to look after themselves better, avoid illness where possible and, if they do become ill, get the best care</td>
<td><strong>We will</strong></td>
</tr>
<tr>
<td></td>
<td>• Help people feel empowered to look after themselves and their families better by making healthy lifestyle choices</td>
</tr>
<tr>
<td></td>
<td>• Put patients at the centre of their care, helping them to better manage their conditions</td>
</tr>
<tr>
<td></td>
<td>• Help patients understand their condition and treatment options so that, with their health professional, they can reach a healthcare choice together</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Primary and community care</strong></th>
<th><strong>Objective</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>More convenience and control for patients, with primary (GP), pharmacy and community services delivering more care closer to where people live</td>
<td><strong>We will</strong></td>
</tr>
<tr>
<td></td>
<td>• Harness the local experience of our GPs by planning our services around six area-based GP-led networks, targeting services where they are needed most</td>
</tr>
<tr>
<td></td>
<td>• Work with our GP networks to deliver a reduction in the variation in primary care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Long term conditions</strong></th>
<th><strong>Objective</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Help people maintain their independence and keep as well as possible for as long as possible</td>
<td><strong>We will</strong></td>
</tr>
<tr>
<td></td>
<td>• Support people with information and education about their condition so they understand what makes them ill and are better able to look after themselves</td>
</tr>
<tr>
<td></td>
<td>• Help patients to minimise the impact of their condition on their day-to-day lives and avoid the need for emergency treatment</td>
</tr>
<tr>
<td></td>
<td>• Identify people who are in most need of support from health and social care teams and ensure they get the help they need</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Urgent Care</strong></th>
<th><strong>Objective</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the reliance on urgent and emergency care services by improving access in primary and community care and helping patients use services more appropriately</td>
<td><strong>We will</strong></td>
</tr>
<tr>
<td></td>
<td>• Work with patients so that they know what services to use and when to use them</td>
</tr>
<tr>
<td></td>
<td>• Work with primary and community services to improve access and ensure that they are responsive to patients’ needs</td>
</tr>
</tbody>
</table>
### Making best uses of medicines

**Objective**
Support people to get the best benefit from their medicines and cut the amount of medicine wasted each year

**We will**
- Work with our GP practices, nurses and pharmacists to help people understand why they need to take their medicines and are able to raise any concerns
- Raise awareness of the best use of medicines and how to reduce waste

### Planned care

**Objective**
The right care in the right place – high quality services with more care delivered closer to people’s homes

**We will**
- Reduce emergencies by ensuring more care is planned, more convenient, accessible and a better use of resources
- Transfer hospital services where appropriate into community settings

### Children and young people

**Objective**
Support children and young people to achieve their full potential

**We will**
- Help ensure the best possible start in life for children by improving maternity services and increasing the number of midwives
- Work through our GP networks so that GPs and other health workers can identify and respond to local needs
Our achievements this year

Transforming the way we deliver care

We have a number of ongoing programmes of work aligned to our transformation plans for services in Croydon. These are detailed in our Operating Plan for 2015/16.

This report highlights key areas of progress during 2014/15.

Transforming Adult Community Services – Older People and Long Term Conditions

Our programme, 'Transforming Adult Community Services' (TACS), is an innovative and bold initiative which helps adults over 18 years with complex health and social needs. The aims of the TACS programme are to:

- Enhance care for people with long term conditions
- Reduce Unnecessary emergency admissions
- Provide high-quality, personalised care, as close to home as possible

The benefits for our patients of this integrated approach means that vulnerable patients with complex needs are able to get the care and support they need close to, or provided at, home so that they can live as independently as possible for as long as possible.

The programme has been running for over one year now and our progress is highlighted below.

Multi-disciplinary team working

Multidisciplinary teams (MDT) are groups of different health care professionals, for example nurses, physiotherapists and social workers, working together to identify vulnerable patients and develop tailored individual care plans for the patient. All GP practices have a named Community Matron, Social Services, and Mental Health link to support case management discussions.

Patients benefit from a named key worker who takes the lead on all aspects of the patient's health and social care needs, ensuring an integrated and coordinated approach to their care.

This year 800 patients have been supported through GP-led Primary, Community, Social Care and Mental Health MDTs

Rapid Response

Often the first service that people need is an urgent intervention. Our Rapid Response Service, staffed by nurses, physiotherapists, occupational therapists, social workers, mental health specialists, pharmacists, reablement workers and support workers sees people referred within two hours.

Patients benefit because services are provided in their own home, wherever possible, and the team’s involvement usually lasts for three days – during which time the appropriate care will be put in place (for example district nurse visits, help from the council’s housing department, or an ongoing care package).
Single point of assessment
GPs and other practitioners can speak with an experienced community nurse or social worker who will advise on community service options or refer the patient to the appropriate health or social care team for early intervention support through services to help care for people once they have been discharged from hospital (reablement), or for a community care assessment, as appropriate.

Patients benefit from an integrated and coordinated approach to their care, meaning that they can be cared for at home wherever possible, avoiding an emergency admission into hospital, and ensuring that they maintain their independence.

Case study
An 83 year old lady was referred to the single point of assessment (SPA) service by the London Ambulance Service. She was unable to stand up because of knee pain. She was reviewed by the community matron and physiotherapist within 30 minutes and a decision taken to admit her that day to a specialist nursing home for treatment and rehabilitation. She is now back safely at home and needs a minimal package of care.

Pathway redesign
18 new care pathways have been developed and implemented through the clinical networks. A care pathway is the journey a patient makes from being diagnosed with a condition to being treated and managing that condition effectively. Our aim is to help patients to understand what makes them unwell and are better able to look after themselves and manage their conditions. As a result of this, if they do become unwell, the impact of their condition on their day-to-day is minimised and the need for unplanned emergency treatment is avoided where possible.

We have highlighted below some examples of progress against service redevelopment and some of the benefits that these changes have made for patients.

Diabetes services
Diabetes is a major health issue with more than 19,000 people diagnosed in Croydon. The prevalence of diabetes in Croydon is increasing year on year at one of the fastest rates in south London. Many patients living with diabetes would benefit from improved education and support to manage their conditions better. There are significant numbers of patients who have undiagnosed diabetes.
During 2013/14 our diabetes services underwent a major, comprehensive review which resulted in the development of a new integrated care model for diabetes. We launched the new Croydon Community Diabetes Service on 1 April 2014. The service is provided by Bromley Healthcare (a social enterprise). Bromley Healthcare has extensive experience of delivering a very similar service in South East London.

Patients were involved throughout the development of the new service, participating in the working group and as part of the procurement panel. The new service has patients at its heart and they will continue to contribute to enhancements and refinement of the service over time. Our clinical networks have also been integral to the development of the service.

The new model of care has meant that:

- GPs are supported by the consultant-led community diabetes service that works directly with GPs and Practice Nurses providing advice and support to help them manage their patients
- The GPs have available to them a programme of education and development which increases their professional skills and knowledge in treating diabetes and enabling them to look after the majority of their patients within their practice
- All GP practices have named, specialist diabetes nurses and dieticians
- There is designated support to proactively work with GP practices to identify patients who are at risk of diabetes but are not accessing services. This includes those patients who are in nursing homes, have a mental health issue and other hard to reach groups. Those patients who have had a diagnosis some years ago and who are not accessing services have also been proactively targeted for review of their condition and support with education and self-management
- Those patients who are not able to be managed by their GP but do not need acute care can be seen in the community. This will be on a time limited basis to stabilise the patient and ultimately return them to the care of their GP
- The service also provides dedicated diabetes education for patients based on the nationally recognised DESMOND and DAFNE education programmes
- Croydon Health Service NHS Trust continues to provide specialist diabetes care for patients who need acute care – for example patients with renal problems, diabetes in pregnancy or severe vascular problems.

This has been a major service development which will continue to transform the way diabetes services are delivered in Croydon. It is a significant achievement for the CCG which will deliver real improvements for patients.
It also enables us to achieve our key aims of moving care to primary settings where appropriate and encouraging patients to look after themselves better through education and support thereby reducing the reliance on hospital based care.

**Cardiology service redesign**

Working closely in partnership with Croydon Health Services NHS Trust (CHS), the CCG continues with plans to transform the way patients receive cardiology services in Croydon.

New pathways for patients with heart failure, arrhythmia and chest pain have been rolled out across Croydon enabling patients to receive care at a local level where appropriate and faster diagnosis by reducing multiple visits to hospital.

A community Cardiology Service is in place for patients with Heart Failure, helping to keep these patients well and out of hospital, and a one-stop diagnostic and assessment service has been developed in Croydon University Hospital for patients with a sudden onset of chest pain.

Patients have been involved throughout the development of the service to ensure that it is built around their needs. They have participated in the project steering group and an independent survey of 214 cardiology patients was conducted. Patients overall experience of their appointments was described as ‘good’. Patients also felt involved in the decision making process and that the service they received was ‘reassuring, clear and professional. The CCG plan to continue to engage patients to collate their views to ensure that the service is improved and refined over time.

Service redesign is led by local GPs working in partnership with local Cardiology specialists, underpinned by detailed public health information to understand the needs of Croydon’s varied population.

- **12 lead Echocardiogram (ECG)**

  An innovative “12 lead ECG” service at GP surgeries was rolled out across Croydon in 2014/15, enabling patients with mild chest pain, palpitations or breathlessness to be seen by their GP and, if necessary, receive an ECG in the practice at the same time. The results are interpreted remotely and an electronic report is sent back to the GP within 20 minutes of the test.

- 55 out of 60 GP practices in Croydon have signed up to offer this service
- Over 5000 patients received this service in their own GP practice rather than having to wait to be seen in a hospital setting.
- In the last quarter of 2014/15, 98% of patients avoided an emergency admission.
- 97% of patients recently surveyed have rated the service as “very good”
- 100% of patients recently surveyed preferred to have the ECG at their GP practice
The service was commissioned in line with our focus on providing care at the “right time, right place” by increasing services available in the community providing care closer to home. It has improved the care patients receive at the same time as improving efficiency by avoiding an unnecessary outpatient referral for further tests.

Chronic Obstructive Pulmonary Disease (COPD)
There is a need to identify COPD patients early as the disease gets worse over time and whilst treatment cannot cure COPD, it can slow down its progression. Many patients with COPD remain undiagnosed and, potentially, unknown to healthcare providers. The prevalence of COPD in Croydon is under reported with 68.6% of expected COPD undiagnosed, compared to London (65%) and England (42%).

There are 4,133 people in Croydon on the COPD register. However, the estimated prevalence of people with COPD in the borough is 15,672 suggesting that there are potentially 11,538 people yet to be diagnosed.

Despite being a very distinct medical condition, COPD is also often misdiagnosed as asthma due to overlapping symptoms.

During 2014/15 we have been working on developing our new COPD improvement programme. Patients and members of the public have been involved in the redesign through engagement at our patient forums, Croydon Older People’s Network meetings, Breathe easy Croydon and the British Lung Association. Patients with COPD have been consulted on in-patient wards, via the pulmonary rehabilitation service and at the COPD “hot clinics”.

The East Croydon GP network will lead the development of the programme and oversee its progress.

The COPD Improvement Programme aims to help patients manage their condition and enable them to live healthier lives by:

- Increasing identification of people with COPD
- Increasing diagnosis and registration of people with COPD
- Optimising treatment and medication for people with COPD
- Smoking Cessation
- Pulmonary Rehabilitation
- Pharmacological Intervention
- Enhancing COPD annual reviews
- Providing support for practice staff in diagnosing and managing patients with COPD.

21 GP practices have signed up for the first wave of implementation.

Community Anticoagulation Service
During 2014/15, we procured a new community anticoagulation service with Boots UK Limited for patients with stable atrial fibrillation (AF). Boots will deliver the service across all the six GP Network and will offer enhanced access at weekends as well as an on-call advice service. Patients will also be given the choice to be treated at any one of the Boots’ sites offering the service. The service will initiate warfarin treatment for newly diagnosed patients with atrial fibrillation and provide on-going monitoring for those stable on treatment.
Patients who are on treatment but their conditions are not stabilised will continue to be cared for by Croydon University Hospital. GPs will refer new patients directly to the new service.

The service went live on 1 April 2015 and is being implemented in a phased approach until 31 December 2015. Boots are working very closely with existing community providers and Croydon University Hospital to ensure smooth and safe transfer of patients to the new service. Engagement events have been held with patients prior to the service transferring to Boots. Early feedback from Croydon University Hospital, for example, is that patients like the choice of site for their treatment offered by the new service.

Systematic feedback from patients will continue to be sought throughout the implementation phase and after that on a regular basis.

**Urgent Care**
The NHS had a very challenging winter period in 2014/15 with A&E attendances increasing significantly across the country. However, in Croydon a range of initiatives that have been implemented have reduced the number of A&E attendances.

The main objective for the Urgent and Emergency Care Strategy is to make sure that people have access to the right service, at the right time and in the right place. We host a System Resilience Group for Croydon made up of health and social care providers, which develops the priorities and initiatives to address local challenges.

The CCG’s A&E four hour wait performance target was a challenge in 2014/15, and we will be driving forward improvements in 2015/16 on:

- Better self-care
- Improving system access when patients realise something is wrong
- Improving patient flow in hospital
- Improving appropriate flow for patients leaving hospital
- Improving care clarifying options when returning to the community

Croydon CCG will also be working to support and align to national, London and south west London priorities for 2015/16.

**Mental Health Older Adults Redesign Project**
We inherited a position where our mental health services were under significant pressure. We are committed to working to stabilise services and transform community mental services to reduce inpatient need and improve access.

Our population in Croydon is growing and the number of people aged 65 years and over make up 13.8% of the Croydon population. This proportion of the population is projected to increase to 16.27%. The number of older people with mental health problems is also growing with a predicted increase of almost 10% by 2019.

A review of mental health services for older people highlighted a number of areas where services need to change to meet future demand but also to ensure that our services become more accessible with less reliance on inpatient treatment and take into account fully the needs of service users and their carers.
We have worked in partnership with adult social services colleagues at Croydon Council and have created a programme with four workstreams to look at how we can improve the quality of care for local older adults with mental health needs, particularly dementia. Our workstreams are:

- Raising awareness, information and training
- Prevention, wellbeing and early identification
- Specialist integrated community support
- Crisis management

All workstreams are interconnected. Raising awareness and improving training will lead to improved care and earlier diagnosis. Early identification of problems will help services users and carers access information and support earlier; helping manage their conditions better and understand how to live with their condition. Specialist, integrated community support means that care is improved because it is joined up. The development of a crisis management team will provide support to help patients in their homes in a crisis situation, helping to manage the situation at home rather than through an admission into hospital.

Work is to be completed by September with new services developed and rolled out next year.
Our ambition for next year

Our clinical leaders have been key in developing these plans and our GP networks crucial to successful implementation. GP networks are aligned with the operating plan based on the network’s population and service challenges.

<table>
<thead>
<tr>
<th>GP Network</th>
<th>Areas being considered (to be confirmed by June 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Croydon</td>
<td>Cancer Screening, Diabetes, Mental health including Dementia, Nursing/Care Homes, COPD</td>
</tr>
<tr>
<td>Mayday</td>
<td>Asthma, Diabetes, Cancer Screening, Obesity</td>
</tr>
<tr>
<td>New Addington / Selsdon</td>
<td>Cancer Screening, Nursing/Care Homes, Mental health including Dementia, Musculoskeletal Referrals, Anticoagulation</td>
</tr>
<tr>
<td>Purley</td>
<td>Care homes, Musculoskeletal Referrals, Dementia, Nursing Homes, Learning Disabilities</td>
</tr>
<tr>
<td>Thornton Heath</td>
<td>Admissions, COPD, Cancer Screening</td>
</tr>
<tr>
<td>Woodside / Shirley</td>
<td>Diabetes, Mental health incl. Dementia, Chronic Kidney Disease, Musculoskeletal Referrals</td>
</tr>
</tbody>
</table>

Across our CCG we will have a significant focus on

**Prevention, Self-Care, Shared Decision Making**

We want to empower patients by ensuring they are active participants in their health and social care and have the information they need to make healthy lifestyle decisions that help reduce the impact of the diseases and conditions that they may develop. Should they become ill, we want them to take more responsibility for their recovery, deterioration, and treatment options. During 2015/16 we will begin implementation of this long term strategy focusing on people with long term conditions.
We will be ensuring sustainability in

**Mental Health services**
In addition to the investments we made last year, £2.4m has been set aside for 2015/16 to increase the level of mental health provision further and to improve service performance and access and reduce waiting time. This investment is likely to include:

- Improving access to physiological therapy services
- Early intervention psychosis service – young people will access a new service designed to support early detection of psychosis.
- Older people’s community services: We will develop the Home treatment teams and Care Home intensive support team reducing the need for inpatient beds
- Child and adolescent mental health services: We will develop the service to increase access and reduce waiting times

**We will be preparing for**

**Urgent and Emergency Care redesign**
During 2015/16 we need to ensure that only our urgent and emergency services are able to cope with the differing demands throughout the year, ensuring people are seen in the right place, and only admitted when necessary.

We are also reviewing and redesigning our urgent care services (Urgent Care Centre at Croydon University Hospital, Edridge Road walk in centre and our minor injuries units in New Addington and Purley) because we need to reprocure our urgent care services by April 2017. This review has begun with wide ranging engagement with the public to understand what they expect from their urgent care services.

**Introduction of Outcomes Based Commissioning for Older People**
Our project with Croydon Council is exploring how both organisations could jointly buy services to incentivise proactive care that keeps people healthy and at home

We believe that by changing the way we commission and pay for services - linking payment to patients’ outcomes - we can ensure service provision is more focussed on prevention and providing support for people before they reach a crisis point

The initial, exploratory phases of the project have involved local clinicians, carers, and over 400 local residents.

In 2015/16 we will be starting the next phase of work with partners, service providers, patients and the public to determine how we will implement this new approach.

**We will be embedding:**

**18 new care pathways**
During 2014/15 we looked at the journey (known as a pathway) a patient takes from being identified with a condition to being treated and managing that condition effectively. Our GPs improved those pathways for 18 long term conditions.

As a result, we are identifying patients with conditions earlier and they are being treated more quickly and, in many cases, closer to home.
We are also starting to see a decrease in waiting times, less complications; and our patients experiencing more seamless care.

During 2015/16 we will be working with our GPs to make sure that they are all using the new pathways for their patients and we will continue to review the care patients receive to make sure that this is improving across all 18 pathways.

**Transforming Adult Community Services (TACS)**

Preventing avoidable emergency admission into hospital is one of the key aims of our major transformation project TACS. The TACS project is in its second year and our successes in 2014/15 are outlined earlier in this report.

During 2015/16, TACS will continue to be a major focus for expansion and development. For example, to enhance our existing rapid response team we will be introducing a “roving GP” service. The “roving GP” will provide skilled GP involvement with patients, taking over clinical responsibility and liaising with the rapid response team to ensure that the patients urgent care needs are responded to within one hour.
Our performance this year

The CCG plays a pivotal role in monitoring the performance of our providers and ensuring that Croydon residents receive the best possible healthcare. The CCG manages the performance of providers primarily through contract monitoring meetings and clinical quality review group meetings. These two forums report directly into the Senior Management Team which has oversight of performance across all commissioned services.

The CCG’s performance is measured against key performance indicators set out in the CCG Assurance Framework and against NHS Constitutional standards. The KPIs listed below cover a number of treatment waiting time targets as well as key patient safety and quality indicators.

In 2014/15 the CCG has achieved the requisite level of performance in a number of key areas.

Good Performance

Cancer waiting time standards
Overall all cancer standards are being met apart from the 62 day standard for GP referrals to first treatment. The two week, 31 day and 62 day standard for screening were all met for quarters 1 – 3 of 2014/15. The CCG continues to work closely with CHS as its main provider to maintain and improve performance against the 62 day standard following GP referral.

Improving performance

Referral to Treatment Times
Overall the CCG is meeting the national target which requires that 90% of admitted and 95% of non-admitted patients start treatment within 18 weeks of their referral. The 18 weeks waiting time starts on the day the hospital receives the referral letter or on the day the patient makes the booking for their first appointment, via the choose and book service. Despite missing the standard during the middle of the year, this was due to managed under performance across London providers enabling providers to focus additional resources on patients waiting over 18 weeks.

Both the CCG and CHS delivered all three RTT standards for January and will be in a better position to maintain this performance in 2015/16.

Diagnostic Test Waiting Times
The CCG’s performance against this target is largely determined by performance at CHS. The CCG has achieved this standard from August following a prolonged period of non-compliance at the start of the year.

As of February, 99.7% of Croydon patients referred for key diagnostic tests were able to access services in less than 6 weeks.
Priorities for improvement

A&E 4 hour wait standard
We did not achieve the A&E 4 hour wait target (95%) in 2014/15, apart from in Q2. The CCG’s performance for 2014/15, as an average, was 93.2%. CHS achieved the standard for Q1 and Q2, with a final performance for the year of 93.8%.

Nationally, performance has been below the 95% standard as an average for 2014/15. Croydon CCG is working with CHS to improve performance, however, due to the continued under performance at the outset of 2015/16 this is not expected to fully recover until June. A planned rebuild of the Trust’s A&E department scheduled for October will allow the Trust to better manage pressure related to the size of the department.

Cancer 62 Day Wait, GP Referral
There have been a number of issues that have resulted in shared breaches between CHS and the Royal Marsden (RMH) and St Georges (SGH) that have contributed to the CCG only achieving 62 day standard in Q3. CHS has undertaken a number of actions to improve performance, including improving the escalation process, review of workload of cancer MDT coordinators, undertaken a recruitment drive for the cancer team recruited an additional urology consultant in January 2015. As a result, CHS have achieved the standard in Q3 and is on track to meet it in Q4 also.

This standard will continue to be prioritised for action during 2015/16 to ensure the standard is achieved.

Improving access to psychological therapies (IAPT)
Using published data for Q1-Q2 and provisional data for Q3-Q4, the CCG has achieved a level of 6.1% for IAPT access against a local target of 5.0%. This means that a larger proportion of people with depression and/or anxiety are getting access to appropriate psychological therapies. Despite this being below the national target, the IAPT service has benefitted from additional investment, and will be further developed through the new mental health strategy.

Dementia Diagnosis Rate
Croydon CCG achieved its local target of 51.3% in February 2014/15 with performance rising to 51.83% in March and for the year. This represents the proportion of patients on the primary care dementia register from the estimated prevalence of dementia. Further work with primary care will continue in to 2015/16. The national target is 66.7%.

Healthcare Acquired Infections
The CCG was assigned three MRSA cases throughout the year against a target of 0. The learning from all cases has been reviewed and the CCG will continue to work with CHS to reduce incidents. The CCG have had 44 cases of Clostridium Difficile against a cumulative target of 59. Each case has been investigated fully and lessons are now being actioned. CHS continues to rigorously apply control measures with good outcomes.

Transforming Care for People with Learning Disabilities
NHS England charged CCGs with ensuring that all people with Learning Disabilities (LD) in inpatient wards have personalised care plans and move 50% of inpatients towards community based settings, where appropriate to do so, by the end of 2014/15. Whilst all people receiving inpatient care for LD, commissioned by the CCG, did indeed have personalised care plans, the CCG fell short of the 50% discharge target by the end of March. However, this is expected to be met by May 2015.
## NHS Constitution performance and plans

### Area Measure

<table>
<thead>
<tr>
<th>Measure</th>
<th>2015/16 National Standard</th>
<th>2015/16 Plan</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E waits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department – Croydon Health Services</td>
<td>95.3%</td>
<td>94.5%</td>
<td>96%</td>
</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes - Red 1</td>
<td>77.4%</td>
<td>77.8%</td>
<td>75%</td>
</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes - Red 2</td>
<td>75.3%</td>
<td>76.3%</td>
<td>75%</td>
</tr>
<tr>
<td>Category A calls resulting in an ambulance arriving at the scene within 19 minutes</td>
<td>97.9%</td>
<td>98.2%</td>
<td>95%</td>
</tr>
<tr>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>91.5%</td>
<td>91.9%</td>
<td>90%</td>
</tr>
<tr>
<td>Non-admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>96.4%</td>
<td>96.7%</td>
<td>95%</td>
</tr>
<tr>
<td>Referral To Treatment waiting times for non-urgent consultant-led treatment</td>
<td>93.3%</td>
<td>93.7%</td>
<td>94%</td>
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<td>Diagnostic test waiting lines</td>
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<td>Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral</td>
<td>96.5%</td>
<td>96.8%</td>
<td>95%</td>
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<td>Mixed Sex Accommodation</td>
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<td>Minimise breaches</td>
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<tr>
<td>Cancer waits - Two-week wait</td>
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</tr>
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<td>Maximum one month (31-day) wait for first definitive treatment for all cancers</td>
<td>98.3%</td>
<td>98.7%</td>
<td>96%</td>
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<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
<td>97.9%</td>
<td>98.5%</td>
<td>95%</td>
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<td>Cancer waits - Three-week wait</td>
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<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen</td>
<td>99.8%</td>
<td>100%</td>
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<td>Cancer waits - Six-week wait</td>
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<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
<td>97.8%</td>
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<td>Cancer waits - Nine-week wait</td>
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<td>Cancer waits - Twelve-week wait</td>
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<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
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<td>97.9%</td>
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<tr>
<td>Cancer waits - Six-month (62-day) wait from urgent GP referral to first definitive treatment for cancer</td>
<td>76.4%</td>
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<td>Area</td>
<td>Measure</td>
<td>14/15 Outturn /Forecast Year End Position</td>
<td>13/14 Year End Position</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------</td>
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<td>Infection</td>
<td>Number of C. Difficile infections</td>
<td>56†</td>
<td>51</td>
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<td>Care Programme Approach (CPA)</td>
<td>The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period</td>
<td>97.5%†</td>
<td>97.3%</td>
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<tr>
<td>Dementia</td>
<td>Per centage diagnosis rate *</td>
<td>51.8% (Local target 51%)†</td>
<td>43.9%</td>
</tr>
<tr>
<td>IAPT</td>
<td>IAPT Access proportion *</td>
<td>6.1% (Local target 5%)†</td>
<td>3.76%</td>
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<td>IAPT Recovery Rate</td>
<td>42.9%†</td>
<td>44%</td>
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<td>Mental Health Access</td>
<td>Proportion of patients waiting 6 weeks from referral to entering a course of IAPT treatment</td>
<td>75%</td>
<td>-</td>
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<tr>
<td></td>
<td>Proportion of patients waiting 18 weeks from referral to entering a course of IAPT treatment</td>
<td>95%</td>
<td>-</td>
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<tr>
<td>Direct Commissioning Primary Care</td>
<td>Satisfaction with the quality of consultation at the GP practice</td>
<td>398.96</td>
<td>401.43</td>
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<tr>
<td></td>
<td>Satisfaction with the overall care received at the surgery</td>
<td>82.8%</td>
<td>83.4%</td>
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<tr>
<td></td>
<td>Satisfaction with accessing primary care</td>
<td>72.6%</td>
<td>73.5%</td>
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</table>

†M11 Forecast Outturn
**Achieving the national standards**

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<thead>
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</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>Per centage diagnosis rate (over 65s)</td>
<td>60%</td>
<td>67%</td>
<td>-</td>
<td>67%</td>
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<tr>
<td>IAPT</td>
<td>IAPT Access proportion</td>
<td>8.16%</td>
<td>11.5%</td>
<td>15%</td>
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Quality overview

Quality Improvements
One of the CCG’s key objectives is ‘to commission safe, high quality services in the right place, in the right time’. This is a commitment to ensure high quality patient centred care.

The CCG continuously seeks assurance about the safety of services, and proactively seeks opportunities to improve the quality of the services provided by its contracted providers. The CCG establishes quality expectations in its contracts with providers, monitors them regularly, and holds providers to account for their performance. When errors occur, the CCG works with the providers to ensure that reasons are identified through a formal process of root cause analysis and lessons are learned to reduce the risk of recurrence.

Supporting the Quality Agenda

The Commissioning for Quality Framework
The CCG’s Commissioning for Quality Framework provides the framework from which the CCG will deliver its duty to secure continuous improvement for the benefit of patients.

The Framework brings together national quality frameworks and the conclusions from the Francis review, detailing:

- The arrangements for informing our priorities for continuous improvement
- Providing early warning for action; and
- Delivering assurance on quality

The CCG will be reviewing and updating the framework during the early part of 2015/16.

Improving Quality

- Highest performing CCG in South London for our quality premium indicators in 2013/14
- A steady decline in patients with new pressure ulcers as well as a decrease in the number of falls
- Reduced number of fractured neck of femur through new falls prevention service
- A reduction in the number of venous thromboembolism (VTE)
- A significant reduction in the number of community MRSA cases
- Medication use reviews carried out in care homes
- Ratio of 1 midwife to 28 births achieved
Francis Report Recommendations
The CCG undertook a review of the recommendations from the Francis Report into the events at Mid Staffordshire NHS Foundation Trust. An action plan was developed to address the recommendations of the report, and builds on the quality and safety agenda already identified within the CCG. The CCG review considered all the recommendations, including actions recommended for commissioners and providers. Many of the recommendations related directly to providers and therefore the CCG reviews periodic updates from providers at the CQRGs.

The CCG agreed to evaluate progress against its action plan. The draft 2014/15 review shows that good progress has been made across all recommendations. Many actions have been fully implemented, and it will be important to continue to review these areas to ensure they are being applied effectively.

The CCG will continue to implement our Francis Report and Winterbourne Action Plans to ensure those that are most vulnerable receive the necessary high quality of care. Our focus is not only the national priorities but local priorities such as pressure ulcers and the quality of the provision in nursing homes.

Clinical Quality Review Groups
Regular programmes of Clinical Quality Review Groups (CQRGs) are held with acute, urgent care and mental health providers. CQRG meetings are chaired by CCG Clinical Leads, and provide a robust mechanism where commissioners and providers work together to identify opportunities for improvement that will ensure delivery of safe and effective services, and drive up quality. Relationships have become well established to support local accountability and respond to local needs and requirements.

Commissioning for Quality and Innovation
The CCG has monitored every provider’s quarterly performance against the Commissioning for Quality and Innovation (CQUIN) requirements. Good progress has been made by all providers in relation to achievement of their CQUIN in 2014/15, with most being fully met.

Infection Prevention and Control
The CCG remains strongly committed to reducing Healthcare Associated Infections (HCAI), particularly working with providers to target a reduction in Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (CDI). Post Infection Review is undertaken on all these infections to understand the cause and ensure that learning from incidents can be identified and built into practise.

The CCG was assigned three cases of MRSA during 2014/15, up to the end of February 2015, which is a reduction from the seven in 2013/14. These cases were judged to have been unavoidable ([DN: TBC]. The CCG will continue to work with providers and other stakeholders to understand patterns of infection and target prevention.

The CCG has been assigned 51 cases of CDI during 2014/15, up to the end of February 2015, against a year end trajectory of 59. The year-end figure for 2013/2014 was 51.
Patient Experience

The CCG recognises that across a number of health services in Croydon, patients are reporting a poorer experience than those received elsewhere. In our local acute hospital, our community services, and mental health services, the reported patient experience is often below the national average. Satisfaction with our primary care services is just below the national average, although it has improved and is better than the average across the rest of London.

Provider patient experience is monitored through national data including the Friends and Family Test and National Patient Surveys, in conjunction with locally sourced information from Complaints and from the Patient Advice and Liaison Service (PALS). Providers report on patient experience in their quality reports to the CCG, and quality monitoring is also informed through quality visits by CCG staff, which includes specific assessment on feedback about patient experience.

Improving Patient Experience
- Rolling out Friends and Family Test in acute and mental health trusts and GP practices
- CQUIN initiatives for acute and community services to incentivise service improvements focused on urgent care access, including greater presence of emergency medicine consultants in ED, increased usage of out-of-hospital options and to facilitate earlier, safer discharge
- 18 new patient pathways that will mean patients are seen in the right place at the right time

Information on safer staffing, infection rates, serious incidents and feedback from the Friends and Family Test is displayed on boards in each ward. This also includes actions taken to address comments made through the Friends and Family Test.

Joint commissioning of primary care services with NHS England means the CCG will now be able to set our ambition for improvement with primary care. We will use the Friends and Family test, now being used in primary care to help set this and to monitor progress. For our local acute, community and mental health services we continue to track progress and their developments for delivery. Our transformation plans, also aim to improve the patient experience of the patient pathway.

Patient Safety

The CCG actively seeks to reduce harm to patients. We review of a range of information which enables us to address local issues for a range of providers including quality of care home provision. National priorities such as infection control or the new sepsis and acute kidney injury standards are managed locally with our providers. The 2015/16 contracts with acute providers include the national CQUINs on sepsis and acute kidney injury.

Patient Safety – Reducing harm
- A steady decline in patients with new pressure ulcers as well as the number of falls
- Reduced venous thromboembolism (VTE)
- Fewer Clostridium Difficile infections than the 59 annual trajectory
- Reduced number of Fractured neck of femur
- Medication reviews undertaken in care homes
- 1 midwife to 28 births ratio achieved
**Never Events**

Never Events are serious patient safety incidents that should not occur if known best practice guidance has been followed. Croydon Health Services NHS Trust reported two Never Events in 2014/15. The lessons from these incidents are reviewed by the CQRG.

**Serious Incidents**

The CCG performance manages serious incidents relating to any NHS or independent provider with which it has a contract. Incidents are managed in line with the national Serious Incident Framework. The CCG has managed 310 serious incidents occurring within their healthcare providers in 2014/15, 293 at Croydon University Hospital and 17 at South London and the Maudsley.

**Safeguarding adults and children**

The CCG continues to invest in its safeguarding service in order to improve outcomes for vulnerable children and adults at risk across the health economy. There is an executive lead for safeguarding and this responsibility currently sits with the Chief Nurse.

The safeguarding team now consists of a designated nurse and deputy, a designated doctor and a named GP for safeguarding children and a lead nurse and practitioner for adult safeguarding. In addition, the expertise of the designated nurse for looked after children has been secured for one day a week and the designated doctor for looked after children is available for expert advice and guidance. The whole safeguarding team is supported by administrative staff.

There have been a number of developments over the last year including a successful second bid to NHSE (London) for funding to further support the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards project in Croydon. This is now under way with significant levels of work completed in order to raise awareness and increase understanding across the borough.

Funding has recently been agreed by the CCG for a project to improve health outcomes for women and girls affected by female genital mutilation (FGM). While this will have a very strong health focus, the necessity to take a whole systems approach with collaborative working across the partnerships and communities is recognised.

There has been significant development in arrangements to support health practitioners within primary care. These include the embedding of the case reflection model (designed by the deputy designated nurse for children) in GP practices and the provision of GP safeguarding leads workshops. While these were initially child focussed, the recognition of the need to include adults and develop whole family thinking has broadened the agenda to incorporate the needs of all patients who may be vulnerable or at risk. The workshops include presentations from multi agency facilitators in order to disseminate messages from the partnership.

Work going forward will include the need to respond to the Care Act 2014 and its implications for adult safeguarding, the further development of the Prevent agenda and the need to address issues relating to radicalisation and the prevention of terrorism.

The CCG Safeguarding Strategy sets out its vision for safeguarding arrangements which includes the robust quality assurance processes for provider services. This is continually reviewed in order to meet the demands of new developments. Work is in progress to develop a model which ensures that safeguarding is embedded in all commissioning.
processes from procurement through to the contract stage. This model is a joint initiative across health and the local authority and seeks to meet the requirements of the integrated commissioning unit.

The CCG safeguarding team work in partnership with statutory and voluntary agencies, providing expert opinion on strategic matters, consultation, advice and support on more operational issues. This work also includes significant contribution to safeguarding reviews (serious case reviews for adults and children, domestic homicide reviews and case reviews) and arrangements to ensure that appropriate responses are made to findings. In addition, contribution is made to the significant level of safeguarding audit activity.

Croydon CCG continues with its commitment to the Domestic Abuse and Sexual Violence Strategy and has oversight of the health economy contribution via the Croydon safeguarding children and adult boards sub groups.

Complaints
The CCG encourages feedback, positive and negative, so that we can make improvements based directly on the concerns of patients and the public. During 2014/15, there were 86 complaints, of these 36 were for areas outside the CCG’s area of responsibility and were handed on to the relevant organisation.

Complaints about care – following the Ombudsman’s principles
The Health Service Ombudsman is responsible for handling complaints from the public that relate to maladministration and has set out the six principles which underpin this work, which are to:

- get it right
- be customer focused
- be open and accountable
- act fairly and proportionately
- put things right
- seek continuous improvement.

The CCG continues to work hard to meet the standards set within these principles, working closely with partner agencies such as Healthwatch, hospital trusts and NHS England to ensure a robust service which reflects the principles of being open and enabling continuous improvement to meet the needs of residents within the borough.

Patient Advice and Liaison Service
The CCG provides a Patient Advice and Liaison Service (PALS) to respond to information requests, issues and concerns raised by patients and members of the public. There have been 178 PALS enquiries received in 2014/15. This reduction is primarily a result of handing over responsibility for all primary care PALS enquiries to NHS England. Of the 178 PALS queries, 44 were redirected to NHS England as they related to primary care services. 39 PALS enquiries related to acute hospital and community services.

The PALS office works closely with the CCG directly commissioned services to ensure that concerns are dealt with promptly and services are improved.
Working in partnership

Patient and Public involvement (PPI) – engaging with partners and the public

The CCG is dedicated to commissioning the best possible services for the people of Croydon. A key component of our work is ensuring that we communicate and engage with our patients, the wider health and social care community, and our local stakeholders. We are keen to hear from as many local people as possible, and use service user experience when developing and redesigning pathways, so that we can truly understand the story behind the data. The CCG has established a framework for patient and public engagement that will ensure patient and community views are integral to the commissioning work of the CCG.

Our vision for engagement:

- We want to be an open and listening organisation that has the needs of local people at its heart and delivers real benefits through collaborative and partnership working.
- When communicating or engaging with any audience our key messages will be set in the context of:
  - Aiming to achieve high quality, safe and effective services in the context of a significant financial challenge. We must use our resources wisely and to greatest effect.
  - Tailor messages specifically related to our audiences and for the project we are working on.

We are updating our communications and engagement strategy and work plans for 2015/2016. We aim to strengthen and build upon the engagement work during our first year, and to help ensure patients, public and stakeholders:

- Recognise the CCG as a credible local health leader for commissioning and monitoring the delivery of health services.
- Understand the CCG priorities and the context in which they are set.
- Are engaged in a meaningful way in our planning.

To do this we must be open and honest in all our communications and we must actively seek ways to reach diverse communities and a range of stakeholders.

Quarterly Patient and Public Forums

The quarterly patient and public forum was established in September 2013. These are open invitation meetings and in addition to patients and the public, the forums are attended by members of the Governing Body, clinicians, commissioning managers, Healthwatch and representatives from community and voluntary groups. Over the past year, stakeholders were engaged in a variety of topics and had the opportunity to contribute to our strategic planning processes including:

- The prevention, self-care and self-management strategy
- Shared Decision making
- The NHS England national ‘Call to Action’ consultation
- Care.data
- Development of the CCGs engagement and Involvement work plan
The Forums are advertised using routine communications channels including the CCG website, social media, via partners’ networks and patient and public participation groups and their networks.

**Patient and Public Reference Group**
The establishment of a Patient and Public Involvement Reference Group will play a key role in our engagement activities.

The Group was developed to quality assure the levels of patient and public engagement activity undertaken. It is chaired by the Lay Representative for Patient and Public Involvement, with a membership comprising representatives from Healthwatch, community and voluntary groups, engagement leads from community and acute providers, Croydon Council and patients and the public.

**PPI in commissioning programmes**
To ensure stakeholders views are embedded in the entire commissioning process, project managers are required to have a Patient and Public Involvement implementation plan signed off by the Senior Management Team.

This will be further embedded, by working with our partners, such as members of the PPI Reference Group, other PPG members and our community and voluntary sector to help us deliver on and monitor the effectiveness of our engagement activities.

During 2013/2014, we successfully included Patient and Public Involvement in a number of our proposals for service redesign.

We formed working groups or steering groups aligned to specific projects, to ensure our service users were given a genuine opportunity to influence the redesign of services they use. We invited people to join the Groups on the basis that they are ‘experts by experience’ i.e. they all had used the services directly, or indirectly - in the capacity of carer, relative or friend. We also hosted larger events which concentrated on broader themes including improving services for older people, self-care, and shared decision making.

There are many benefits to establishing these groups, most notably, to enable integration of the service user perspective in the planning and development of future services. The CCG is keen to engage with service users, and their carers and to listen to their experiences. To get involved email getinvolved@croydonccg.nhs.uk.

**Patient Participation Groups**
The CCG recognises the importance of establishing a strong network of Patient Participation Groups (PPGs) across the borough, and the value they can bring by helping to engage and involve local people across all areas of the borough.

Currently there are variations in the number and effectiveness of PPGs, and in order to help address this, the CCG has funded membership of the National Association for Patient Participation (N.A.P.P.) for all Practices. N.A.P.P. can provide practical advice and support to establish and develop PPGs.
**Stakeholder database**
A database of stakeholder and patient representative contacts has been created and is regularly updated with details of individuals who would like to be involved in the CCGs work.

**Forward plans**
Our plans for the next year will primarily focus on improving and embedding our patient and public involvement infrastructure and on strengthening our relationships with our local stakeholders.

We have updated our engagement work plan in which we have identified the following four objectives that are underpinned by detailed actions and outcomes.

- **Objective 1:**
  Better engagement with more people, from more diverse communities

- **Objective 2:**
  Ensure that the views of public, patients and carers are at the centre of every decision that we make

- **Objective 3:**
  Work collaboratively with other groups and organisations.

- **Objective 4:**
  Deliver engagement work that contributes effectively to improving quality of services.

The work plan will be reviewed on a quarterly basis by the Patient and Public Involvement Reference Group to ensure our activities continue to deliver against the needs of patients, public and carers.

**Community, Voluntary and Faith Sector Organisations (including Carers support)**
The CCG is developing relationships with Croydon’s many local support groups as part of its voluntary sector strategy. The CCG’s clinicians are working closely with the voluntary sector and community groups to ensure we are utilising the services provided by these groups as effectively as possible.

**Croydon Healthwatch**
Croydon Healthwatch is the independent champion of local people working to improve health and social care services.

Croydon Healthwatch is a member of our Patient and Public Involvement Reference Group, has made contributions to our proposals on the future of urgent care services and has sat on our working group to develop and implement our prevention, self-care and shared decision making strategy.

We will continue to establish a close working relationship with Croydon Healthwatch particularly working with them to develop and deliver our Patient and Public Involvement work programme and, to use information and knowledge they have gathered regarding the patient experience of our local residents, to help improve the commissioning, design and delivery of services.
Croydon Healthwatch plays a pivotal role, working with NHS Croydon Clinical Commissioning Group (CCG) to improve health services in Croydon. As well as being an active member of the CCG’s Patient and Public Involvement Reference Group and Croydon’s Transforming Care Board, Healthwatch has over the last year contributed to proposals on; Outcomes Based Commissioning for Older People, the future of urgent care services and participated in the working group to develop and implement the prevention, self-care and shared decision making strategy.

Healthwatch representatives regularly attend CCG Governing Body meetings and contribute to the Governing Body’s discussions. The CCG values this input and will continue to nurture this close working relationship. Healthwatch have been particularly valuable in supporting the CCG to develop and deliver its Patient and Public Involvement work programme. Additionally, Healthwatch shares information it gathers from residents on their experiences of local healthcare services, which informs the CCG's work on the commissioning, design and delivery of services.

South West London Collaborative Commissioning

The six south west London CCGs (Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth) and NHS England, who commission specialised and primary care services in south west London, came together in April 2014 to work together under the umbrella name of South West London Collaborative Commissioning (also known as the SWLCC). The programme replaced the Better Services Better Value (BSBV) Programme which the CCGs inherited.

The six CCGs are working together as SWLCC on a long term plan to improve the quality of care in South West London for the benefit of patients and those living in South West London.

SWLCC developed a case for change document for the NHS in SW London which is available on the programme website http://www.swlccgs.nhs.uk/the-case-for-change/

The ‘case for change’ document sets out the challenges that the NHS faces in south west London and the reasons why we need to change.

The key reasons for change are:

- We want all patients to get the best possible care but the quality and safety of our health services varies enormously depending on where and when people are treated.

- The needs of our patients have changed so we need to deliver health services differently.

- We do not have the money or staff to go on as we are.

Development of the South West London Strategy

In April 2014 the SWLCC started to consider how the local NHS was going to address the challenges identified in the ‘case for change’ document.

Clinicians from the Trusts, SWLCCGs and NHS England across south west London worked together to develop the 5 year strategic plan, which sets out an ambitious vision for the transformation of our local health economy. During its development the CCGs were
also keen to engage with local patients, the public and the voluntary/community sector to
discuss the 5 year strategy from the beginning. A “Listening and Learning” event was help
in May 2014, the outputs of which were fed into the 5 year strategy.

Hospital and Community Providers will play a key role in advising commissioners on the
best way to implement this strategy; our aspiration is to agree on an approach which will
be shared and owned by both commissioners and providers, working with local people to
codeign solutions.

The CCGs have also been working with local NHS trusts, GPs and others about the role
each part of the NHS plays and how we can work more closely with each other and with
social care (local Authorities) to respond to the challenges and what changes we need to
make to deliver the strategy. Once we have identified what the potential solutions are, we
will talk to local people about them. If major service changes are proposed, there will be a
formal public consultation.

**Commissioning Intentions 2015/16**

In August 2014, for the first time, the six south west London CCGs jointly developed
commissioning intentions for providers for 2015/16, to focus on the priority work areas
which were outlined in the five year strategy. The Joint Commissioning Intentions were
agreed by each CCG governing body and were published in September 2014. This was an
important step towards demonstrating a commitment from the CCGS to work together for
the benefit of patients and the NHS in South West London.

**Co-commissioning arrangements for Primary Care**

Each GP practice works to a core contract which NHS England plans and commissions.
Practices can provide additional services and Croydon CCG has contracts with some local
practices.

From April 2015 in addition to the services we currently commission, CCGs will begin to
work together as a larger group to plan and develop their local primary care health
services - NHSE will still have some involvement. This is because the NHS wants local
clinicians and local communities to have more influence over how primary care services
are developed.

This is part of the NHS’ vision to improve the quality of services for patients, provide
greater value for money and address any local health inequalities (such as mortality rates)
and will result in a more responsive health service.

CCGs and NHSE working together in this way to plan and deliver primary care services is
called ‘co-commissioning’.

The joint commissioning model in conjunction with south west London CCGs was
considered to be the most appropriate model as it enables us to better protect Croydon’s
interests.

- We can influence Croydon services without bearing any financial risk which is held by
  the statutory commissioner (NHS England)
- We can build capacity and knowledge locally which can be a stepping stone to fully
deleagated budgets
• We can bring local knowledge and develop localised commissioning and incentives

• Sustainable/resilient local services can be developed in primary care, bringing services closer to patients and shifting resource essentially developing integrated out-of-hospital services based around the needs of our local population

• Risks associated with identifying and managing conflicts of interest and capacity/capability can be mitigated

**Better Health for London**
The Mayor of London Boris Johnson, NHS England, Public Health England, London Councils and the 32 GP-led clinical commissioning groups have come together to outline how, individually and collaboratively, they will work towards London becoming the world’s healthiest major city.

The new partnership has been established in response to the challenges set out in the London Health Commission’s *Better Health for London* report and the *NHS Five Year Forward View*. The aim is to work together at all levels to make the best use of resources and build on best practice to improve the health and well-being of all Londoners, wherever they live in the capital. The plan is a good basis to explore how London could benefit from more autonomy to improve the future of the capital’s health.

NHS England and the London’s CCGs Commissioning System Design Group that has jointly set and agreed priorities for transformation, with pan-London activities supporting local action where this has the potential to add value.

**The transformation programmes**
The 13 transformation programmes for collaboration are set out below.

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<thead>
<tr>
<th>Clinical programmes</th>
<th>Enabler programmes</th>
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<tbody>
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<td>Urgent and emergency care</td>
<td>Primary Care</td>
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<td>Children and young people</td>
<td>Business intelligence and interoperability</td>
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</tbody>
</table>

All programmes were selected on the basis that working collaboratively would lead to added value in supporting the delivery of local transformation priorities, including drawing on the learning from work already underway or developing in different parts of London.
Croydon Council

Health and Wellbeing Board

The Health and Wellbeing Board considers matters relating to the provision of public health services and the commissioning of adult social services and children’s services across health and social care and the impact of these on the health and wellbeing of the local population.

Leaders from across the community have come together to form Croydon’s Health and Wellbeing Board. The Board’s focus is on improving health and wellbeing so that individuals and communities are able to live healthier lives, have better health outcomes, and have a better experience of using the health and care system. Health and wellbeing is more than the absence of disease; it is the ability for everyone to fulfil their potential, make a contribution and to be resilient to life’s challenges.

The health and wellbeing strategy sets out the Board’s vision and the long term improvements in people’s health and wellbeing that they want to achieve. It also sets out priorities for action and indicators that will help measure progress.

The CCG works with partners to align the objectives and aims of the health and wellbeing strategy with our aims and objectives as a CCG and deliver better health outcomes, a better experience for patients and service users and better value for money. The health and wellbeing strategy can be found at www.croydon.gov.uk/

In 2014/15 we shared our commissioning intentions and operating plan with the Health and Wellbeing Board, ensuring our plans are aligned, and asked for feedback on programmes of work for example on mental health, and child and adolescent mental health.

Public Health

From April 2013, the London Borough of Croydon became responsible for commissioning most public health services. The CCG works collaboratively with the public health commissioners in Croydon Council to deliver joint priorities as set out in the health and wellbeing strategy and ensure the best health outcomes for local people.

This includes working together to:

- Reduce the prevalence of smoking through primary prevention focused on schools and youth settings, enforcing tobacco control measures, and providing a range of services to help people quit
- Tackle overweight and obesity through promoting physical activity and a healthy diet across the life course and ensuring that appropriate weight management and treatment services for obesity are in place
- Improve sexual and reproductive health by provision of advice, prevention and promotion, testing and treatment (including promotion of opportunistic testing and treatment in healthcare settings), and provision of high quality termination of pregnancy services.
The Council is also responsible for commissioning adults’ and children’s social care services.

**Joint Strategic Needs Assessment**

We are also working with our partners in Public Health and the London Borough of Croydon to respond to the Joint Strategic Needs Assessment (JSNA), which analysed the health needs of our local population. We are using the JSNA to inform and guide our planning and funding of health and well-being services in the borough. The JSNA can be found at [http://www.croydonobservatory.org/jsna/](http://www.croydonobservatory.org/jsna/)

**Outcomes based commissioning**

A Croydon CCG and Croydon Council joint project is developing an ‘Outcomes Based Commissioning’ approach to buying health and social care services for over 65s. This project explores ways both organisations could jointly buy services in a way that would incentivise a focus on proactive care that keeps people healthy and at home.

We believe that by changing the way we pay for services - by linking payment to a patient’s outcomes rather than the number of procedures they received - then we can deliver services which are more focused on prevention and providing support for people before they reach a crisis point.

The initial exploratory phases of the project have involved local clinicians, carers, and over 400 local residents. Meetings of Croydon Council’s cabinet and CCG Governing Body in October 2014 approved the next phase of work with partners, service providers, patients, and the public to explore implementation of this new approach. This third and final implementation phase is expected to take about a year to complete.

**Better Care Fund**

The Better Care Fund (BCF) was created to ensure a transformation in integrated health and social care. The BCF is a single pooled budget supporting health and social services to work more closely together in local areas. Local areas are required to develop plans for the use of this fund, overseen by Health and Wellbeing Boards.

In Croydon we developed the BCF jointly with Croydon Council, with consultation with other stakeholders including acute healthcare providers, health and social care teams, and local residents. It will build on existing joint working (for example re-enablement and service transformation) and will be reinforced through the Integrated Commissioning Unit.

The BCF for Croydon will total £21.5m for 2015-16.

**Integrated Commissioning Unit**

Croydon Clinical Commissioning Group and the London Borough of Croydon have established an Integrated Commissioning Unit to exploit opportunities to jointly commission services to improve outcomes for Croydon people.

The Integrated Commissioning Unit will progress jointly agreed initiatives, including, for example:

- Children and young people
- Vulnerable adults
• Mental health
• People with learning disabilities

During 2014/15, priority areas of focus for the CCG have included:

• Rebalancing acute and community services in mental health, strengthening recovery and mental health reablement

• Improved capacity in psychological therapies in primary and secondary care

• Re-view and re-commissioning of mental health services for older adults including dementia diagnosis and services

• Requirements and actions from the Winterbourne View Concordat for people with complex learning disabilities

• Preparing for Care Act implementation, especially the development of improved universal information and advice, support to carers, and developing a more systematic approach to market management and quality outcomes

• Strengthen emotional wellbeing and mental health of children and young people

• Improving health outcomes for children looked after

• Strengthening early intervention for children aged 0-5s through the Best Start model and through health improvement services for children and young people aged 5-19

• Improving health and education outcomes for children with special educational needs and disabilities

**Equality and diversity**

The CCG developed an Equality and Diversity Strategy to support delivery of their legislative responsibilities as a public body, an employer and a commissioner of services. The Strategy was designed in response to the requirements of the Equality Act 2010 and builds on the previous actions and objectives that were contained in the former Single Equality Scheme. It is also designed to meet the requirements the Human Rights Act and the NHS Equality Delivery System (EDS). The Strategy will be refreshed in 2016.

The action plan supports the implementation of the strategy and outlines how the CCG proposes to meet its equality duties. Key objectives are focused around: putting appropriate governance arrangements in place, providing equality and diversity training, ensuring equality analysis assessments are conducted on all documents and services, development of patient participation groups to represent communities, utilising the JSNA and other data sources to identify gaps in service provision and ensuring Human Resources (HR) and employment policies are in line with the Equality Act 2010 and implementing the EDS.

The following equality and diversity objectives have been grouped into the following key areas that will support Croydon CCG’s vision:
Croydon CCG is committed to:

- Promoting equality and diversity
- Ensuring that all commissioned and contracted services deliver better outcomes for our population as a whole and those with protected characteristics.
- Empowered, engaged and included staff

During 2014 Croydon CCG and SECSU staff steadily worked together to achieve success in delivering the Equality Objectives and Action Plan.

The Executive Equality Lead for the CCG is developing Equality Objectives for 2015 with the support of the Equality and Diversity Lead for NHS South East Commissioning Support Unit.

Equality Delivery System (EDS)

In 2011, the Department of Health introduced a new tool for monitoring equality outcomes called the Equality Delivery System.

The EDS enables the CCG to:

- Analyse its performance against the EDS Goals and Outcomes
- Identify any gaps or areas that require improvement
- Identify any high risk areas as priorities for setting objectives

During 2014, engagement was carried out with local stakeholders and staff in order to verify the process. The results and grading of our findings, key objectives and accompanying action plan can be found with the CCG’s Annual Equality PSED Report January 2015 on the equality and diversity pages of our website (www.croydonccg.nhs.uk).

The Governing body are extremely supportive of the Equality work undertaken and lay members regularly challenge the work of the CCG to ensure that people from protected groups have been considered in all decision making.

During 2014 Governing Body and Senior Directors demonstrated strong and sustained commitment to promoting equality, within and beyond the CCG and they regularly took account of and managed equality related risks.

Public engagement with local communities improved during the year with positive effects. For example, our local BME community’s input into the review and redesign of our local diabetes service and musculoskeletal service has helped improve access to these services and provide better patient outcomes.

Key staff from the CCG have undertaken Equality Analysis training provided by the South East Commissioning Support Unit (SECSU). Regular training sessions are planned to ensure that Equality Analysis assessments are conducted on all policy documents and the commissioning of services.
The CCG is supported by a Human Resources Business Partner from SECSU who has been working with the CCG to develop training packages and review HR policies.
Sustainability

Sustainability is a new area of development for Croydon CCG, and we do not currently have the performance reporting for the last two business years. We will be working to the Sustainability Development Unit (SDU) guidance to capture information in the future, so we have a baseline from which to measure our sustainability efforts. We are currently exploring how to capture and record information in the future.
Our staff

Communicating and Engaging
There are a number of ways in which the CCG communicates and engages with its staff. These include:

- A south west London Staff Partnership Forum where managers and staff from the six south west London CCGs meet to discuss and consult on issues.

- A number of CCG away days have been held throughout the year which includes all the Governing Body members, Management Team and staff.

- There are regular team briefings with the staff and Executive Management Team

We have appointed a team from the South East Commissioning Support Unit to work with us on an important piece of Organisational Development (OD) work. It will run across the next 12 months and focus on four key areas:

- Vision and values, behaviour and culture
- Leadership and people development
- Communications, staff engagement and clinical engagement
- Recruitment, retention, performance and reward

Training and Development
There is a statutory and mandatory training policy in place and reporting procedures for staff to undertake statutory and mandatory training which has been provided both on line via e-learning from Skills for Health and in house. Training is reported back to the CCG.

All staff have regular 1:1s and we are working towards all staff having appraisals, objectives and Personal Development Plans (PDPs) in place.

Employee Consultation
Organisational Change is managed in accordance with the principles and procedures contained within the CCG's Organisational Change Policy. The CCG also informally communicates and consults with employees via a monthly newsletter and regular staff briefings.

Policy on Disabled Employees
Disabled employees are protected under the "protected characteristics" of the Equality Act 2010, one of which is disability. The CCG's Equality & Diversity Strategy supports the CCG in ensuring that the requirements and reasonable adjustments necessary for employees with disabilities are taken into account during their employment and that people with disabilities are not discriminated against on the ground of their disability at any stage of the recruitment process or in their employment with the CCG.

The CCG's Sickness Absence Policy confirms that where an employee becomes disabled as a result of sickness, the CCG will make any necessary reasonable adjustments, as required, and in accordance with the Equality Act to enable the employee to return to work. The types of adjustments may include adjustments to work base, working hours, redeploying the employee to another suitable position and providing any necessary equipment to assist the employee to perform their role.
Equalities for Staff
The CCG’s Equality & Diversity Strategy supports the promotion of a working environment in which all parties and procedures relating to recruitment, selection, training, promotion and employment are free from unfair discrimination, ensuring that no employee or prospective employee is discriminated against, whether directly or indirectly on the grounds of age; disability; gender reassignment; pregnancy and maternity; race including ethnic or national origins, colour or nationality; religion or belief; sex (gender); sexual orientation; marriage and civil partnership; trade union membership; responsibility for dependents or any other condition or requirement which cannot be shown to be justifiable.

<table>
<thead>
<tr>
<th>At the end of the financial year (31 March 2015)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of persons of each sex who were the Governing Body</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>The number of other senior manager of each sex who were a grade Very Senior Manager</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>The number of persons of each sex who were employees of the CCG</td>
<td>9</td>
<td>39</td>
</tr>
</tbody>
</table>

Sickness Absence
The CCG Sickness Absence per centage rate is presented monthly as part of the KPIs. The HR Business Partner works closely with managers to ensure that sickness absence cases are being managed in a timely way and in accordance with the CCGs Sickness Absence policy.

An Occupational Health (OH) service is available to provide professional medical advice to the CCG. Staff can access OH for a self-referral and can access the OH Counselling service.

The CCG also has access to an Employee Assistance Programme which is provided by Right Management, which offers confidential access to emotional and practical support, 24 hours a day, 7 days a week, including legal and financial advice.
Emergency Preparedness Resilience and Response

We are a Category 2 responder organisation under the Civil Contingencies Act 2004 (CCA) and the Health and Social Care Act 2012. We need to work with NHS England (the category 1 responder organisation) to cooperate and support them.

We have the following EPRR responsibilities:

- Ensure contracts with provider organisations contain relevant emergency preparedness, resilience (including business continuity) and response elements
- Support NHS England in discharging its EPRR functions and duties locally
- Provide a route of escalation for the Local Health Resilience Partnership (LHRP) should a provider fail to maintain necessary EPRR capacity and capability
- Fulfil the responsibilities as a Category 2 responder under the CCA including maintaining its own business continuity plan
- Be represented on the Local Health Resilience Partnership

Emergency Planning Resilience & Response (EPRR) Assurance

NHS England has included Clinical Commissioning Groups in its annual EPRR assurance process for the first time in 2014. This is to make sure that all NHS organisations are prepared to respond to an emergency, and have sufficient resilience in place to continue essential operations during a major incident or business continuity event. NHS Croydon CCG’s overall compliance level for 2014/15 is, “substantial”. The definition of substantial compliance is: “The plans and work programme in place do not appropriately address one or more of the core standard themes that the organisation is expected to achieve.”

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

Paula Swann

Paula Swann
Accountable Officer
29 May 2015
Our Finances

The Economic Environment

The government’s 2014 Budget set out action to secure financial recovery over the following 5 years. Although the UK economy was forecast to continue to grow, further reductions in public expenditure were outlined.

Whilst the government committed to real terms growth in NHS expenditure from 2013/14 – 2015/16, rising demand for health services (e.g. ageing population), increase in supply through new technologies and drugs and resource transfers to social care such as the Better Care Fund, mean increasing financial pressure on NHS budgets.

Moreover, the wider austerity measures on welfare, income and housing benefits, and reductions in local government funding, will place additional pressure on local NHS services, for example demand for mental health services and greater challenges to ensure timely discharges from hospitals.

Funding for Croydon CCG Patients

In December 2013, NHS England published target and actual allocations for all CCGs in England. This analysis confirmed that, on establishment in April 2013, the CCG was funded £46m (10.3%) below the needs based funding target for its population. The acknowledgement of this position was an important step to understanding the financial position of Croydon CCG, and addressing the position.

The 2015/16 allocations to CCGs were published in December 2014. At the end of 2015/16, the position has improved and Croydon CCG is 6.8% below target (£28m). The planning guidance further commits to move the CCG to 5% below target by 2016/17. Current NHSE funding policy indicates the CCG would only receive average levels of growth funding from 2017/18, and therefore remain 5% below target funding levels.

In 2014/15, the CCG was funded £1,030 (2013/14 £1,000) per patient for its GP registered population of 394,560 (2013/14 392,000).

Inherited Financial Position

On establishment in April 2013, the CCG inherited a challenging financial position from its predecessor organisation, Croydon PCT. Based on meeting NHS financial planning requirements, the CCG inherited an underlying annual deficit of £30m – that is expected demand for health services exceeded allocated resources by £30m. Although the CCG inherited only 60% of the PCT’s commissioning portfolio, it inherited 90% of the underfunding.

Benchmarking of expenditure levels, in comparison with CCGs of similar populations, indicates that the efficiency opportunity is not sufficient in itself to close the deficit position. Improvement in the funding position was also required. In light of the inherited underfunding and expenditure position, the Croydon CCG Directions 2013 were issued requiring NHS England to approve the CCG’s clear and credible integrated plans and to oversee and supervise the CCG’s savings and efficiency programme.
The CCG has made significant progress in addressing the inherited financial position, reporting an improved financial position in 2013/14 (£18.2m deficit) and 2014/15 (£14.7m deficit). This has been achieved after delivering efficiency improvement in 2013/14 (£14.0m) and 2014/15 (£11.0m).

Our largest provider, Croydon Health Services, is also facing significant financial challenges during 2014/15. The CCG continues to work closely with the Trust to improve the quality of care and to ensure the provider is appropriately funded under the national “Payment by Results” framework.

**Financial Outlook**

The CCG agreed a 5-Year Financial Plan that reduces the annual in-year deficit from 2014/15 to 2018/19. This required savings and efficiency targets of £35.5m to be delivered over the first three years of the CCG (2013/14 £14.0m, 2014/15 £11.0m, and 2015/16 £10.5m). Whilst underlying inflation assumptions are low in line with the 2014 Budget public sector pay expectations, growth in the demand for services continues to be high.

Based on the 2015/16 planning guidance, the CCG is focused on delivering a reduced deficit of £11.9m for 2015/16 including delivery of a £10.5m efficiency target.

The CCG is exploring new approaches to commissioning services locally, in particular we are developing an innovative outcomes and capitation based approach to commissioning health and social care services for older people in Croydon, in collaboration with Croydon Council.

Given the indicative funding settlement up until 2018/19, local health economy forecasts, and the benchmarked efficiency opportunities, the CCG will not be in a position to repay the predicted accumulated deficit.

**Financial Performance in 2014/15**

In the context of the inherited underfunding position, Croydon has successfully delivered ahead of expectations recording a £14.7m deficit against the £17.0m deficit plan in 2014/15. The delivery of £11m (2.5%) efficiency savings has been an achievement given the level of efficiency savings previously delivered. The financial benefits are the product of a clinically led initiative to improve services for patients. During the year the CCG managed additional acute activity and continuing health care pressures through releasing activity reserves and underspends in other budget areas.
Financial Targets
Each year the financial performance of the CCG is judged externally against a range of financial duties and targets. A summary of the CCG’s duties is as follows:

<table>
<thead>
<tr>
<th>Target</th>
<th>Statutory / Non-Statutory</th>
<th>Plan</th>
<th>Actual</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue Resource Limit (Breakeven)*</td>
<td>Statutory</td>
<td>£0.0m</td>
<td>£14.7m deficit</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(£32.9m cumulative)</td>
<td></td>
</tr>
<tr>
<td>Capital Resource Limit</td>
<td>Statutory</td>
<td>£0.0m</td>
<td>£0.0m</td>
<td>Yes</td>
</tr>
<tr>
<td>Maximum Cash Drawdown (MCD)</td>
<td>Statutory</td>
<td>£437.7m</td>
<td>£430.4m</td>
<td>Yes</td>
</tr>
<tr>
<td>Cash Balance as at 31/3/15</td>
<td>Statutory</td>
<td>£0.5m</td>
<td>£0.1m</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue Resource Limit (Control Total set by NHSE)*</td>
<td>Non-Statutory</td>
<td>£17.0m deficit</td>
<td>£14.7m deficit</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(£35.2m cumulative)</td>
<td>(£32.9m cumulative)</td>
<td></td>
</tr>
<tr>
<td>Running Cost</td>
<td>Non-Statutory</td>
<td>£9.1m</td>
<td>£8.1m</td>
<td>Yes</td>
</tr>
<tr>
<td>QIPP Savings</td>
<td>Non-Statutory</td>
<td>£11.0m</td>
<td>£11.0m</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Note*: NHS England accept that the statutory requirement of breakeven was not achievable and agreed a planned deficit.)

Expenditure
Total costs incurred in 2014/15 were £437.8m (2013/14 £425.1m) split as detailed below. Key providers (annual contract value greater than £3m) account for 61% of the 2014/15 total expenditure.
Revenue
The CCG attracts low levels of income. The key areas are training income from Health Education South London (HESL), recharge to London Borough of Croydon for the joint funding element on commissioning of voluntary mental health services and the recovery of office accommodation costs occupied by South London Commissioning Support Unit staff that are based locally with the CCG.

Capital Investment
The CCG did not directly incur capital expenditure in 2014/15.

Productivity and Efficiency
The CCG successfully managed to deliver £11.0m (2.5% of the CCG’s Revenue Resource Limit) of efficiency savings in the year and looks to build on this position in 2015/16 (£10.5m). The Trust continues to work in partnership to commission effective and efficient services for the local health economy. The CCG continues to review its benchmarked opportunities to improve efficiency across primary care, prescribing, mental health services, continuing care and acute hospital services.

Better Payment Practice Code
The Better Payment Practice Code requires the CCGs to aim to pay all 95% undisputed invoices by the due date or within 30 days or receipt of goods or a valid invoice, whichever is later. In 2014/15 the CCG improved its performance and paid 85.5% by value and 90.4% by number of non-NHS trade invoices and 99.3% by value and 87.0% by number of NHS invoices within the required timescale.

External Auditors
The CCG’s external auditors for the financial year 2014/15 were Grant Thornton LLP. Their fees amounted to £114k which was for services provided to conduct the statutory audit.
Late Payment of Commercial Debts
There were no claims for interest payable under the late payment of Commercial Debts (Interest) Act 1999.

Pension Liabilities
The treatment of pension liabilities is detailed in the notes to the financial statement.

Changes in Accounting Policies
The CCG has adopted accounting policies, where applicable, based on the International Financial Reporting Standards deemed relevant for public sector reporting by the Treasury. There are no changes to the accounting policies from the prior year.

Managing our risks
Full details of Croydon CCG’s approach to risk management can be found in the Annual Governance Statement in Part Two.

Pension liabilities
Information on how pension liabilities are treated and relevant pension schemes are found in the remuneration report.

Sickness absence data
Sickness absence data is provided in note 4 of the financial statement.

Paula Swann
Accountable Officer
29 May 2015

Mike Sexton
Chief Finance Officer
29 May 2015
Remuneration Report

The Remuneration Committee comprises of 4 members and has met on 1 occasion during the past year. The Chair of the committee is Roger Eastwood. A full list of members, their roles and the number of meetings each attended is below.

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Role</th>
<th>Date joined committee</th>
<th>Date left committee (if applicable)</th>
<th>No of committee meetings attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roger Eastwood</td>
<td>Chair</td>
<td>September 2014</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>David Hughes</td>
<td>Chair</td>
<td>1 April 2013</td>
<td>August 2014</td>
<td>1</td>
</tr>
<tr>
<td>Helen Pernelet</td>
<td>Lay Member/ Vice Chair</td>
<td>1 April 2013</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Jon Norman</td>
<td>Secondary Care Consultant</td>
<td>1 April 2013</td>
<td>N/A</td>
<td>-</td>
</tr>
<tr>
<td>Tony Brzezicki</td>
<td>Governing Body Chair</td>
<td>1 April 2013</td>
<td>N/A</td>
<td>1</td>
</tr>
</tbody>
</table>

In addition to the members listed above, the following CCG employees provided the Committee with services and/or advice which was material to the Committee's deliberations.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Swann</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>Gail Tarburn</td>
<td>Head of Human Resources, SECSU</td>
</tr>
</tbody>
</table>

Gail Tarburn, HR Business Partner from the South East Commissioning Support Unit (SECSU), provided HR advice at the Remuneration Committee meetings, as they are the CCG’s appointed HR advisers. The advice did not incur any extra fee as it was part of the SECSU contract.

Remuneration Policy

The Committee's deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures.

It has been agreed that the Remuneration Committee will give consideration to benchmarking data provided by the SECSU in respect of pay for the coming year for Governing Body members.

No national guidance has been issued for Very Senior Manager (VSM) pay awards for the forthcoming year. The Committee meets as frequently as is necessary to advise the Governing Body on the appropriate remuneration and terms of service for the Chief Officer and the Chief Finance Officer who are remunerated under the Very Senior Manager Pay Framework.

Senior Managers’ Performance Related Pay

The CCG does not have any Senior Manager Performance Related Pay.
**Senior Managers’ Service contracts**

Each of the senior managers listed below have substantive contracts, which can be terminated by either party by giving 3 months written notice. The CCG can request that the senior manager either works his or her notice or be paid an amount in lieu of notice.

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

<table>
<thead>
<tr>
<th>Senior Manager</th>
<th>Role</th>
<th>Contract Date</th>
<th>Leave Date</th>
<th>Notice Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Swann</td>
<td>Chief Officer</td>
<td>1 April 2013</td>
<td></td>
<td>3 Months</td>
</tr>
<tr>
<td>Mike Sexton</td>
<td>Chief Finance Officer</td>
<td>1 April 2013</td>
<td></td>
<td>3 Months</td>
</tr>
<tr>
<td>Stephen Warren</td>
<td>Director of Commissioning</td>
<td>1 April 2013</td>
<td></td>
<td>3 Months</td>
</tr>
<tr>
<td>Fouzia Harrington*</td>
<td>Director of Quality &amp; Governance</td>
<td>1 April 2013</td>
<td>31 January 2015</td>
<td>3 Months</td>
</tr>
</tbody>
</table>

(Note*: Fouzia Harrington was on sabbatical from 19 May 2014 until 31 December 2014. The post was covered by Michelle Rahman who was seconded to the CCG from the SECSU. From 1 February 2015, the post has been filled on an interim basis by Sean Morgan, who has also been seconded to the CCG from the SECSU.)

None of the service contracts for Senior Managers make any provision for early termination compensation outside of the national pay and remuneration guidelines or NHS Pension Scheme Regulations.

Clinical and lay members of the Governing Body, and Clinical Network Leaders are office holders and do not have service contracts. They are appointed by the CCG for a set period and at rates agreed by the Remuneration Committee. Travel and subsistence fees (where incurred in respect of official business) are in accordance with national Agenda for Change rates.

For GPs only, the Governing Body and Clinical Network Leader roles are pensionable under the NHS Pension Scheme. For all other office holders the remuneration is not pensionable.

The appointments became effective on the following dates:

---

1 Fouzia Harrington took a new role in the CCG from 1 February 2015 and consequently resigned from her Director role on 31 January 2015.
### Governing Body Members

<table>
<thead>
<tr>
<th>Member</th>
<th>Role</th>
<th>Appointment Date</th>
<th>Date member left organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Anthony Brzezicki</td>
<td>Chair</td>
<td>1 April 2013*</td>
<td></td>
</tr>
<tr>
<td>Dr Agnelo Fernandes</td>
<td>Assistant Clinical Chair</td>
<td>1 April 2013*</td>
<td></td>
</tr>
<tr>
<td>Dr John Chan</td>
<td>GP Governing Body Member and Medical Director</td>
<td>1 November 2013**</td>
<td></td>
</tr>
<tr>
<td>Dr John Linney</td>
<td>GP Governing Body Member</td>
<td>1 November 2013**</td>
<td></td>
</tr>
<tr>
<td>Dr Atif Hasan</td>
<td>GP Governing Body Member</td>
<td>1 November 2013**</td>
<td></td>
</tr>
<tr>
<td>Dr Jonathan Norman</td>
<td>Secondary Care Consultant</td>
<td>1 April 2013</td>
<td></td>
</tr>
<tr>
<td>Amanda Page</td>
<td>Chief Nurse</td>
<td>1 April 2013</td>
<td></td>
</tr>
<tr>
<td>David Hughes</td>
<td>Lay Member, Finance</td>
<td>1 April 2013</td>
<td>August 2014</td>
</tr>
<tr>
<td>Roger Eastwood</td>
<td>Lay Member, Finance</td>
<td>1 April 2013</td>
<td>September 2014</td>
</tr>
<tr>
<td>Helen Pernelet</td>
<td>Vice Chair and Lay Member, Governance and Patient and Public Involvement (PPI)</td>
<td>1 April 2013</td>
<td></td>
</tr>
</tbody>
</table>

### Clinical leaders

<table>
<thead>
<tr>
<th>Member</th>
<th>Role</th>
<th>Appointment Date</th>
<th>Date member left organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Bobby Abbot</td>
<td>Clinical Network Leader</td>
<td>1 April 2013*</td>
<td></td>
</tr>
<tr>
<td>Dr Yinka Ajayi-Obe</td>
<td>Clinical Network Leader</td>
<td>1 November 2013**</td>
<td></td>
</tr>
<tr>
<td>Dr Karthiga Gengatharan</td>
<td>Clinical Network Leader</td>
<td>1 April 2013*</td>
<td></td>
</tr>
<tr>
<td>Dr Agatha Nortley Meshe</td>
<td>Clinical Network Leader</td>
<td>1 November 2013**</td>
<td></td>
</tr>
<tr>
<td>Dr Brian Okumu</td>
<td>Clinical Network Leader</td>
<td>1 April 2013</td>
<td>30 June 2014</td>
</tr>
<tr>
<td>Dr Rajeev Sagar</td>
<td>Clinical Network Leader</td>
<td>1 April 2013*</td>
<td></td>
</tr>
<tr>
<td>Dr Farhan Sami</td>
<td>Clinical Network Leader</td>
<td>1 April 2013*</td>
<td></td>
</tr>
<tr>
<td>Dr Kamran Khan</td>
<td>Leader for education and training</td>
<td>1 April 2013</td>
<td>30 June 2014</td>
</tr>
</tbody>
</table>

(Note*: Re-elected on 1 July 2014)

(Note**: Appointment extended by Council of Members on 9 January 2014)
## Payments to Past Senior Managers

There have been no payments to past Senior Managers during the financial year.

### a. Senior Managers’ Salaries and Allowances (Audited)

<table>
<thead>
<tr>
<th>Name and title</th>
<th>(a) Salary (bands of £5,000)</th>
<th>(b) Expense payments (taxable) to nearest £100 £</th>
<th>(c) Performance pay and bonuses £000</th>
<th>(d) Long term performance pay and bonuses (bands of £5,000) £000</th>
<th>(e)² All pension-related benefits (bands of £2,500) £000</th>
<th>(f)³ TOTAL (a to e) (bands of £5,000) £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Swann, Chief Officer</td>
<td>120-125</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>50.0-52.5</td>
<td>175-180</td>
</tr>
<tr>
<td>Mike Sexton, Chief Financial Officer</td>
<td>100-105</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>50.0-52.5</td>
<td>155-160</td>
</tr>
<tr>
<td>Stephen Warren, Director of Commissioning</td>
<td>95-100</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>42.5-45.0</td>
<td>140-145</td>
</tr>
<tr>
<td>Fouzia Harrington, Director of Quality and Governance (pro rata)</td>
<td>35-40</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>32.5-35.0</td>
<td>70-75</td>
</tr>
<tr>
<td>Michelle Rahman, Interim Director of Quality &amp; Governance (pro rata)</td>
<td>70-75</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>70-75</td>
</tr>
</tbody>
</table>

² All pension related benefits means the annual increase in cumulative pension entitlement. This amount is not paid to senior managers in the year. This is influenced by length of service, employer and employee contributions and any pay award for the period.

³ The total included within column f is a notional calculation that adds 2014/15 employment benefits with changes in accumulated benefit under the NHS pension scheme. This total is not the total payments made to senior managers during the financial year and should not be quoted as such.
<table>
<thead>
<tr>
<th>Name and title</th>
<th>(a) Salary (bands of £5,000)</th>
<th>(b) Expense payments (taxable) to nearest £100</th>
<th>(c) Performance pay and bonuses (bands of £5,000)</th>
<th>(d) Long term performance pay and bonuses (bands of £5,000)</th>
<th>(e) All pension-related benefits (bands of £2,500)</th>
<th>(f) TOTAL (a to e) (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sean Morgan, Interim Director of Quality &amp; Governance⁴</td>
<td>20-25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20-25</td>
</tr>
<tr>
<td>Dr Anthony Brzezicki, Chair</td>
<td>100-105</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100-105</td>
</tr>
<tr>
<td>Dr Agnelo Fernandes*, Assistant Clinical Chair</td>
<td>70-75</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>70-75</td>
</tr>
<tr>
<td>Dr John Chan, GP Governing Body Member and Medical Director</td>
<td>35-40</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>35-40</td>
</tr>
<tr>
<td>Dr John Linney, GP Governing Body Member</td>
<td>25-30</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25-30</td>
</tr>
<tr>
<td>Dr Atif Hasan, GP Governing Body Member</td>
<td>25-30</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25-30</td>
</tr>
<tr>
<td>Dr Jonathan Norman, Secondary Care Consultant</td>
<td>10-15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10-15</td>
</tr>
<tr>
<td>Mrs Amanda Page, Chief Nurse</td>
<td>40-45</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25.0-27.5</td>
<td>70-75</td>
</tr>
</tbody>
</table>

⁴ The Interim Director of Quality & Governance post was filled by both Michelle Rahman and Sean Morgan who were seconded to the CCG from SECSU. The amounts disclosed above represent amounts paid to the CSU for the period in post.
<table>
<thead>
<tr>
<th>Name and title</th>
<th>(a) Salary (bands of £5,000)</th>
<th>(b) Expense payments (taxable) to nearest £100</th>
<th>(c) Performance pay and bonuses (bands of £5,000)</th>
<th>(d) Long term performance pay and bonuses (bands of £5,000)</th>
<th>(e) All pension-related benefits (bands of £2,500)</th>
<th>(f) TOTAL (a to e) (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Hughes, Lay Member, Finance (pro rata)</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Roger Eastwood, Lay Member, Finance (pro rata)</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Helen Pernelet, Vice Chair and Lay Member, Governance and Patient and Public Involvement (PPI)</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Dr Bobby Abbot, Clinical Network Leader</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Dr Yinka Ajayi Obe, Clinical Network Leader</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Dr Karthiga Gengatharan, Clinical Network Leader (pro rata)</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Dr Agatha Nortley Meshe, Clinical Network Leader</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

*Note: The table is not fully visible. The text continues with details for each person, including their title and salary ranges.*
<table>
<thead>
<tr>
<th>Name and title</th>
<th>(a) Salary (bands of £5,000)</th>
<th>(b) Expense payments (taxable) to nearest £100</th>
<th>(c) Performance pay and bonuses (bands of £5,000)</th>
<th>(d) Long term performance pay and bonuses (bands of £5,000)</th>
<th>(e)** All pension-related benefits (bands of £2,500)</th>
<th>(f)** TOTAL (a to e) (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Brian Okumu* Clinical Network Leader</td>
<td>5-10</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5-10</td>
</tr>
<tr>
<td>Dr Rajeev Sagar Clinical Network Leader</td>
<td>25-30</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25-30</td>
</tr>
<tr>
<td>Dr Farhan Sami* Clinical Network Leader</td>
<td>20-25</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20-25</td>
</tr>
</tbody>
</table>

(Note*: NHS organisations are required to disclose the pension benefits for those persons disclosed as senior managers of the organisation, where the clinical commissioning group has made a direct contribution to a pension scheme. Due to the nature of clinical commissioning groups, some GPs have served as office holders of Croydon CCG. However, for GPs who work under a contract for services with the CCG, they are not considered to hold an officer pensionable post and so no pension disclosure is required. This has been confirmed with the NHS Pensions Agency. It should be noted that clinical leader roles are not members of the Governing Body.)


**GP and Executive Director expenses**

Governors and Directors are entitled to claim for certain expenses incurred whilst undertaking their role at the CCG, under the rates payable to staff employed on the Agenda for Change terms and conditions.

The table below outlines the expenses paid to Governing Body members in 2014/15 (rounded to nearest £).  

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Travel (incl parking) £</th>
<th>Other £</th>
<th>Total £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Swann</td>
<td>Chief Officer</td>
<td>611</td>
<td>-</td>
<td>611</td>
</tr>
<tr>
<td>Mike Sexton</td>
<td>Chief Finance Officer</td>
<td>806</td>
<td>-</td>
<td>806</td>
</tr>
<tr>
<td>Dr Anthony Brzezicki</td>
<td>Chair</td>
<td>558</td>
<td>-</td>
<td>558</td>
</tr>
<tr>
<td>Amanda Page</td>
<td>Chief Nurse</td>
<td>124</td>
<td>-</td>
<td>124</td>
</tr>
<tr>
<td>Dr Agnelo Fernandes</td>
<td>Assistant Clinical Chair</td>
<td>91</td>
<td>-</td>
<td>91</td>
</tr>
<tr>
<td>Roger Eastwood</td>
<td>Lay Member</td>
<td>28</td>
<td>-</td>
<td>28</td>
</tr>
</tbody>
</table>

No other senior managers received payments for expenses, other than those disclosed in table above.
### Senior Managers' Pension Benefits (Audited)

<table>
<thead>
<tr>
<th>Name and title</th>
<th>(a) Real increase in pension at age 60</th>
<th>(b) Real increase in pension lump sum at age 60</th>
<th>(c) Total accrued pension at age 60 at 31 March 2015</th>
<th>(d) Lump sum at age 60 related to accrued pension at 31 March 2015</th>
<th>(e) Cash Equivalent Transfer Value at 1 April 2014</th>
<th>(f) Real increase in Cash Equivalent Transfer Value</th>
<th>(g) Cash Equivalent Transfer Value at 31 March 2015</th>
<th>(h) Employer's contribution to stakeholder pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Swann, Chief Officer</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>0-2.5</td>
<td>5-7.5</td>
<td>45-50</td>
<td>135-140</td>
<td>693</td>
<td>58</td>
<td>770</td>
<td>17</td>
</tr>
<tr>
<td>Mike Sexton, Chief Financial Officer</td>
<td>0-2.5</td>
<td>5-7.5</td>
<td>20-25</td>
<td>70-75</td>
<td>331</td>
<td>44</td>
<td>384</td>
<td>14</td>
</tr>
<tr>
<td>Stephen Warren, Director of Commissioning</td>
<td>0-2.5</td>
<td>5-7.5</td>
<td>35-40</td>
<td>110-115</td>
<td>674</td>
<td>57</td>
<td>749</td>
<td>13</td>
</tr>
<tr>
<td>Fouzia Harrington, Director of Quality and Governance</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>20-25</td>
<td>65-70</td>
<td>312</td>
<td>32</td>
<td>352</td>
<td>12</td>
</tr>
<tr>
<td>Amanda Page, Chief Nurse</td>
<td>1 – 1.5</td>
<td>3 – 3.5</td>
<td>35-40</td>
<td>105-110</td>
<td>615</td>
<td>41</td>
<td>673</td>
<td>6</td>
</tr>
</tbody>
</table>
Pay Multiples (Audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid director in the financial year 2014/15 was £123k (2013/14, £118k). This was 2.6 times (2013/14, 2.4 times) the median remuneration of the workforce, which was £47k (2013/14, £49k*).

In 2014/15, no permanent employee received remuneration in excess of the highest paid member of the Governing Body (2013/14, nil). Annual remuneration ranged from £19k to £123k (2013/14 £9k–£118k). There were three instances where the cost, including agency fees, of engaging interim staff exceeded the highest paid member of the Governing body.

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

There has been an increase in the number of the general workforce as a result of recruitment to vacant posts throughout the year.

(Note*: During the year the CCG reorganised its commissioning support and brought in house a number of functions which significantly changed the CCG’s staffing mix and whole time equivalents.)

Off-payroll Engagements

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

<table>
<thead>
<tr>
<th>Total number of existing engagements as of 31 March 2015</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new engagements or those that reached six months in duration between 1 April 2014 and 31 March 2015.</td>
<td>1</td>
</tr>
<tr>
<td>Number of the above which include contractual clauses giving the CCG the right to request assurance in relation to Income Tax and National Insurance obligations.</td>
<td>1</td>
</tr>
<tr>
<td>Number for who assurance has been requested.</td>
<td>1</td>
</tr>
<tr>
<td>Of which, the number:</td>
<td></td>
</tr>
<tr>
<td>• For whom assurance has been received.</td>
<td>1</td>
</tr>
<tr>
<td>• For whom assurance has not been received.</td>
<td>-</td>
</tr>
<tr>
<td>• That has been terminated as a result of assurance not being received.</td>
<td>-</td>
</tr>
<tr>
<td>Number</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>---</td>
</tr>
<tr>
<td>Number of off-payroll engagements of Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year</td>
<td>-</td>
</tr>
<tr>
<td>Number of individuals that have been deemed “Governing Body members, and/or, senior officials with significant financial responsibility”, during the financial year (this figure includes both off-payroll and on-payroll engagements)</td>
<td>21</td>
</tr>
</tbody>
</table>

Paula Swann

Paula Swann
Accountable Officer
29 May 2015
Governing Body Profiles

Profiles for current Governing Body Members are noted below.

**GP members**

**Dr Anthony Brzezicki, Chair**
Dr Brzezicki has been a GP at The Queenhill Medical Practice in Croydon since 1983. His special interests are in prescribing and cancer. He was part of the first wave of the Prescribing Collaborative and chaired the third wave for England. He worked in the Breast Unit at Croydon Health Services for 10 years, and has been a MacMillan GP, Primary Care Lead for South West London, and worked in the common cancer group developing the Case for Change for Cancer in London. He co-Chairs the Cancer Commissioning Board and is clinical lead for the Transforming Cancer Team for London, chairing the Early Diagnosis work stream. He is also a GP member of the London Cancer Alliance clinical board.

**Dr Agnelo Fernandes, Assistant Clinical Chair**
Dr Fernandes has been a GP in Thornton Heath, Croydon for 25 years. His interests include minor surgery, dermatology, teaching and quality improvement of health services through innovation and transformation. He is a GP Trainer, an Educational Supervisor of GP Trainees out of hours, a GP appraiser, a member of the Croydon Local Medical Committee and a Governor at Royal Russell School, Croydon. He was awarded the MBE for “services to Medicine and Healthcare” by Her Majesty the Queen (2004) and the Fellowship of the Royal College of General Practitioners (2006), and his practice attained the highest honour of the Royal College of General Practitioners “Quality Practice Award” (2010).

In his role as the Assistant Clinical Chair of the CCG he chairs the System Resilience Group which includes urgent care in Croydon, the Transforming Care Board, the Prevention, Self-Care & Shared Decision Making steering group, Intermediate services Clinical Quality Review group, and is a member of Croydon’s Health & Wellbeing Board.

Agnelo is also the Chair of the NHS England’s pan-London NHS 111 Clinical Governance group, the National GP Lead for Urgent & Emergency Care for the Royal College of General Practitioners (UK), Chair of the National Intercollegiate Clinical Governance group for NHS Pathways, and a member of the national CQC advisory group on urgent and emergency care.

**Dr Atif Hasan, GP Governing Body Member**
Dr Hasan trained at Guy’s King’s & St Thomas’ School of Medicine and is currently a GP Partner at the Keston Medical Practice in Croydon. He has worked in Croydon for the last eight years. He has been part of the CCG in its current form since 2013. His clinical interests include ophthalmology and child health. Dr Hasan is involved in medical education and clinical development and is currently a GP trainer and GP appraiser. In addition to his governing body role, Dr Hasan has been involved in the redesign for Adult Care and Ophthalmology services in Croydon for which he is the clinical lead.

**Dr John Chan, GP Governing Body Member and Medical Director**
Dr Chan has lived and worked in Croydon for over 20 years and is a partner at Eversley Medical Centre, Thornton Heath. He has a background in clinical education and is currently, a Programme Director for GP specialty training for over 10 years and previously, GP clinical tutor with responsibilities for the planning and implementation of continuing
professional development activities for GPs and other primary care health professionals in Croydon; and Appraisal Lead, overseeing the appraisal and revalidation process for Croydon GPs. He is a longstanding member of the Croydon Local Medical Committee and has served in various capacities in predecessor commissioning organisations including the PCT (Primary Care Trust), PBC (Practice Based Commissioning) and GP clinical commissioning consortia representing the voice of patients and local general practice.

Dr John Linney, GP Governing Body Member
Dr Linney has been a GP at Woodcote Medical Practice in Croydon since 1983 until retiring from the practice last year. He was on Croydon South PCG Board and acted as Prescribing Lead, participating in the introduction of practice visits in the early 2000s. Whilst in practice he was a GP trainer for 22 years and a GP Appraiser for nine years; he also acted as Lead GP for the provision of primary care services from 200-13 to the Forensic Medium Secure [Mental Health Unit] initially at Cane Hill and more recently to River House at SLaM. He has been a member of the local area prescribing committee for more than 10 years, including working on mental health and local microbiology guideline groups.

Clinical representatives

Dr Jonathan Norman, Secondary Care Consultant
Dr Norman is the secondary care consultant on the Governing Body. He is a specialist in pain management based in Kent and has been a consultant since 2005. He qualified from Newcastle in 1993 and trained in medicine and anaesthetics before becoming a pain specialist. He has worked across the north east, north west and west midlands before moving to Kent. His special interest is in cancer pain; he also still works as an anaesthetist.

Amanda Page, Chief Nurse
Amanda Page brings many years of experience as a professional leader in delivering clinical pathway redesign and major organisational improvement to ensure patients experience high quality care and clinical outcomes. Her passion is driving change in pathways to confidently know that people, especially older people, will have a better experience when they are at their most vulnerable. Amanda is also our Executive Safeguarding Lead and has ensured sound governance systems and processes are in place to assure the Governing Body and our public that our provider organisations meet their statutory responsibilities in relation to safeguarding.

Lay members

Roger Eastwood FCA, Lay Member, Finance
Brought up in Croydon, Roger is a Chartered Accountant and has worked with a range of financial services organisations but mostly with mutual life insurers for over 30 years. He has held a number of non-executive and lay roles and is currently Chair of a social housing and care organisation based in East Sussex.

Helen Pernelet, Vice Chair and Lay Member, Governance and Patient and Public Involvement (PPI)
Helen Pernelet worked in the City for nearly 20 years, firstly as a solicitor and then as an investment banker with a number of leading financial institutions in the UK and France. Helen currently holds two other public appointments: she is a non-executive director within the Ministry of Defence, where she sits on two boards and chairs an audit committee, having previously been a member of the Army audit committee. She also is the Chair of
the National Society for Epilepsy, and an external adviser to the investment committee of the Dunhill Medical Trust.

**Executive members**

**Paula Swann, Chief Officer**
Paula was appointed Chief Officer of Croydon CCG on 1 April 2013, after previously being appointed to the role of Croydon Borough Managing Director in June 2012. Paula is a qualified accountant (FCCA) and holds an MBA and has significant experience of strategic and operational planning and delivery, performance improvement as well as financial leadership and expertise. Paula was formerly Director of Finance for Wandsworth PCT for five years and has over 25 years practice in senior management, financial management, audit and consultancy services within the NHS and 'not for profit' organisations.

**Stephen Warren, Director of Commissioning**
Stephen has a wide range of experience of NHS Management including several years in Acute and Mental Health Services having joined the NHS in 1983 through the NHS Management Training Scheme, having graduated with a Politics Degree from Nottingham University and achieving Graduateship of the Institute of Personnel Management. Stephen then went on to work in commissioning from 1990 in a number of roles covering all aspects of commissioning in south west London across the Boroughs of Merton, Sutton and Wandsworth. More recently Stephen was Head of Commissioning at Wandsworth Primary Care Trust until taking up the post of Director of Commissioning for Croydon CCG from September 2012.

**Mike Sexton, Chief Financial Officer**
Mike was appointed as Chief Finance Officer on the establishment of the CCG in April 2013. He is a chartered accountant having qualified in New Zealand and in the UK. Before joining Croydon CCG, Mike spent 11 years in the role of Deputy Director of Finance at Sutton & Merton Primary Care Trust (turnover £0.6bn), including experience as Acting Director of Commissioning and Acting Director of Finance. Mike holds a Bachelor of Management Studies (Waikato, New Zealand) and started his career in the New Zealand health service.

**Sean Morgan, Director of Governance and Quality (Interim)**
Sean is an experienced NHS general manager with a background in performance management, business intelligence, planning and commissioning. Sean has worked in Director roles at Southwark Primary Care Trust (in a joint role with Southwark Council) and previously at North Central London Strategic Health Authority. Sean joined South East Commissioning Support Unit from the South East London Cluster where he was Head of Performance and Information. At the South East Commissioning Support Unit Sean was initially Head of Business Intelligence and for the last year has been the account lead for five CCGs in south west London.

**Attendees**

**Dr Mike Robinson, Director of Public Health, Croydon Council**
Dr Mike Robinson is currently Director of Public Health for the London Borough of Croydon, where he has worked since October 2012. Mike has previously held Director of Public Health posts at the NHS Hounslow/London Borough of Hounslow, NHS Wakefield District/Wakefield Metropolitan Borough Council and East Leeds Primary Care Trust. Mike has a long standing interest in training, most recently as Head of the School of the London Kent Surrey and Sussex Speciality School of Public Health based at the London Deanery.
Before training in Public Health, Mike undertook vocational training in general practice and continues in part time clinical practice as a sessional GP.

**Paul Greenhalgh, Executive Director, People, Croydon Council**
Paul is 'Executive Director, People' for Croydon Council, responsible for a portfolio that includes adult social care, children’s services, housing need and welfare support, along with services such as libraries and adult learning. He previously spent a decade as Executive Director for Children’s Services (in Croydon and Southend). His background was in education, through range of local authority roles, after teaching both in mainstream schools and in specialist provision for children with emotional and behavioural difficulties. His book, 'Emotional Growth and Learning' (Routledge, 1994) won the 1994 Times Educational Supplement/National Association of Special Educational Needs Academic Book of the Year award.

**Profiles for Governing Body Members during 2014/15 who were not part of the Governing Body at 31/3/2015.**

**Hannah Miller, Executive Director Adult Services, Health and Housing and Deputy CE, Croydon Council**
Hannah was appointed as Director of Social Services for Croydon Council in 1998 and from February 2007, following the division of adults and children’s social care services, she became Director of Adult Social Services. Following a major restructure of council services, Hannah was appointed to the post of Executive Director Adult Services and Housing on 1 July 2008. With the move of Public Health from the NHS to local authorities on 1 April 2013, this role was retitled Executive Director Adult Services, Health and Housing (DASHH). Prior to taking up her role in Croydon, Hannah was Director of Social Services at Islington Council. She was awarded an OBE in the 2009 New Year’s honours list for her services to the welfare of children.
PART TWO: STATEMENTS BY ACCOUNTABLE OFFICER
Statement of Accountable Officer’s responsibilities

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

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

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

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter, except for the breach of the Revenue Resource Limit as reported in the s19 letter dated 23 April 2014.

Paula Swann

Paula Swann
Accountable Officer
29 May 2015
Annual Governance Statement

Introduction

NHS Croydon Clinical Commissioning Group (Croydon CCG) is a membership organisation made up of 58 GP practices in the London Borough of Croydon.

We were established in April 2011 as a shadow organisation and received authorisation from the NHS Commissioning Board (now NHS England) in March 2013. On 1 April 2013, we became legally responsible for commissioning healthcare services for the residents of Croydon. During the last two years we have successfully submitted evidence to NHS England supporting the removal of all but two of the outstanding financial conditions of authorisation placed on us; which are reflective of the challenging financial position we face.

We manage local healthcare budgets in excess of £425 million and commission a range of healthcare services, including hospital, community and mental health services.

We serve over 350,000 people across the very diverse borough of Croydon.

The Clinical Commissioning Group has an important role, and we must work with our local partners to ensure our local health services continue to offer high quality care, are responsive to local needs and support improved health outcomes.

We know that our partnerships continue to be important and have maintained effective joint working arrangements with the London Borough of Croydon along with other local partners. We have established a partnership relationship with the other CCGs in South West London (the South West London Commissioning Collaborative) which puts us in a strong position to work together to deliver change on a broader system-wide basis. In addition, we have strong relationships with other commissioning organisations such as NHS England’s specialist commissioning and primary care teams.

Scope of Responsibility

As Accountable Officer, I am responsible for maintaining a sound system of internal control that supports the achievement of the CCG’s policies, aims and objectives, whilst safeguarding the public funds and assets for which I am held personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money.

I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter. I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the Corporate Governance Code

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

The CCG’s Governance Framework

The National Health Service Act 2006 (as amended ), at paragraph 14L (2) (b), advises us that the main function of the governing body is to ensure that the group has made
appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

The Clinical Commissioning Group

The CCG is a clinically led membership organisation currently made up of 58 member practices. The membership has powers as set out within the scheme of delegation. The CCG has granted authority to act on its behalf to:

- A Council of Members, comprised of representatives appointed by each Member Practice;
- The Governing Body; and
- Committees of the Governing Body, namely a Remuneration committee, an Integrated Governance and Audit Committee, a Finance Committee and a Quality Committee.

The Council of Members

The Council of Members is a forum of one representative appointed by each Member Practice. The Council has specific powers to act on behalf of the CCG Membership and on the advice of the Governing Body. The CCG is therefore constituted and empowered by its membership.

During 2014/2015 the Council of Members met three times and:

- Agreed the strategic direction of the CCG’s 5-Year Strategy and noted the 2 Year Operating Plan.
- Agreed the 2013/14 Annual Accounts subject to approval by the Governing Body and the draft Annual Report.
- Agreed the changes in Constitution to recognise the reduction in the number of NHSE commissioned General Practices from 61 to 58.
- Ratified the outcome of elections for the Governing Body Chair, Assistant Clinical Chair and Clinical Leaders.
- Agreed to make an application to jointly co commission Primary Care medical services in conjunction with NHS England and the other 5 SWL CCGs, in addition to constitutional amendments enabling the formation of a Joint Committee to support Primary Care Co Commissioning.

The Governing Body

The role of the Governing Body is to ensure that the Clinical Commissioning Group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. The Governing Body meets on at least alternate months and in public. The names of all members present are recorded in the minutes of the group’s meetings and kept by the Board Secretary. All meetings have declarations of interests as an agenda item, where made, and recorded where relevant.

In 2014/15, the Governing Body met on ten separate occasions and:
• Agreed the CCG Delivery Strategy (including 2 Year financial plan and updated 5 year financial model)

• Agreed the Annual Report and Accounts 2013/14

• Agreed the full implementation of the clinically and quality led QIPP savings programme to minimise the financial deficit and risks and agreed the continued implementation of the remedial Action Plan

• Approved the collaborative approach for developing a 5-year strategy and the proposed governance arrangements for South West London Collaborative Commissioning and the Draft South West London 5-Year Strategic Plan

• Discussed and approved the Transformation of Croydon Adult and Older Adults Mental Health Service and the Outcomes Based Commissioning Strategy

• Agreed to proceed to phase 3 of the “Improving Health and Social Care Outcomes for over 65s Programme”, based on the 8 principles set out in the paper and agreed that the test for continuation of the project, at each checkpoint, is that the scheme continues to offer improvements in outcomes for patients and delivery of system wide efficiencies, making care more affordable than the current system

• Approved the Adults Mental Health and Mental Health Older Adults Business Cases

• Approved the Reducing Variation in Primary Care Strategy, Effective Commissioning Initiative (ECI) Policy and the Draft Participation Duty Report

• Approved the application to jointly co-commission primary care medical services in conjunction with NHS England and SWL CCGs and to amend the CCG’s constitution to enable the CCG to form a SWL joint committee

The membership of the Governing Body for 2014/2015 is as follows:

**Non-Executive Members**

• Dr Anthony Brzezicki (Chair)
• Dr Agnelo Fernandes (Assistant Clinical Chair)
• Dr John Chan (GP Governing Body Member and Medical Director)
• Dr John Linney (GP Governing Body Member)
• Dr Dev Malhotra (GP Governing Body Member to 1 July 2014)
• Dr Atif Hasan (GP Governing Body Member)
• Dr Jonathan Norman (Secondary Care Consultant)
• Helen Pernelet (Vice Chair and Lay Member, Governance and PPI)
• David Hughes (Lay Member – Finance to 26 August 2014)
• Roger Eastwood (Lay Member – Finance from 2 September 2014)
• Hannah Miller (Executive Director Adult Services, Health and Housing Croydon Council, to November 2014 – no voting rights)
• Paul Greenhalgh (Executive Director Adult Services, Health and Housing Croydon Council, from November 2014 – no voting rights)
• Dr Mike Robinson (Director of Public Health, Croydon Council – no voting rights)
Executive Members

- Paula Swann (Chief Officer)
- Mike Sexton (Chief Financial Officer)
- Stephen Warren (Director of Commissioning)
- Amy Page (Chief Nurse)
- Fouzia Harrington (Director of Quality and Governance to 16 May 2014)
- Michelle Rahman (Interim Director Quality and Governance from 19 May 2014 to 30 Jan 2015)
- Sean Morgan (Interim Director Quality and Governance from 2 Feb 2015)

The minutes of the Governing Body meeting are recorded and attendance is logged.

Governing Body Effectiveness Assessment

With the completion of each AGS our Governing Body has carried out an assessment on our collective performance and effectiveness against the principles outlined in the UK Corporate Governance Code. In undertaking this year’s survey the Governing Body has reported improved perceptions of the organisation’s effectiveness in areas such as Leadership, Effectiveness and Accountability. The Governing Body considers that it is effective in making decisions based on quality and evidence-based practice and regularly engages in challenge of executive proposals; thus ensuring that the decision making process is open and transparent. However our group also concluded that there remains scope for Governing Body members to more constructively challenge each other and to engage more fully with the wider membership.

The Governing Body was unanimous in its agreement that the CCG’s governance, risk management and internal control processes provide an appropriate and effective framework to ensure that they are sufficiently informed and supported in the discharge of their duties; and that appropriate relationships are maintained with internal and external stakeholders and partner organisations. It was noted, however that there was room for improvement in stakeholder engagement in general and even more engagement with our membership in particular. These challenges we have set ourselves are addressed through the CCG Membership Engagement plan and Organisational Development Strategy. Overall the responses are positive with the majority of respondents agreeing that developments had been made over the last year. The Governing Body as a whole feels that it has had the necessary time to discharge its responsibilities and was supported through access to relevant information, of an appropriate quality, and in timely fashion.

Governing Body Committees and Sub-committees

The Integrated Governance and Audit Committee is constituted as a standing committee of the CCG’s Governing Body. The Committee is responsible for ensuring effective internal control including compliance with such generally accepted principles of good governance as are relevant to it.

Reporting directly to the Governing Body, it provides a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the CCG’s activities (clinical and non-clinical). The Finance Committee and the Quality Committee report directly to the Governing Body but also provide scrutiny of issues and highlight risks to the Integrated Governance and Audit Committee.

During 2014/15, the Integrated Governance and Audit Committee met seven times and:
• Approved appointment of Internal Auditors for 2014/15

• Had oversight of the internal audit programme for 2014/15, including reviewing internal audit reports and recommendations, and receiving assurance on follow up actions

• Undertook an assessment using The HFMA Audit Committee Self-Assessment Tool to facilitate the review of IGAC performance against best practice.

• Agreed the Letter of Representation provided to the Auditors

• Agreed a detailed review on contract management of the Commissioning Support Unit, for 2015/16

• Agreed an extension to the Phlebotomy Enhanced Services contract to 1 October 2015 pending a review of the current service

• Regularly receives and reviews reports on Information Governance compliance, risk and anti-fraud initiatives

The membership of the Integrated Governance and Audit Committee for 2014/15 is as follows:

• Helen Pernelet (Chair / (GB Vice Chair and Lay Member, Governance and PPI)
• David Hughes (Lay Member – Finance to 26 August 2014)
• Roger Eastwood (Lay Member – Finance from 2 September 2014)
• John Linney (GP Governing Body Member)
• John Chan (GP Governing Body Member and Medical Director)

The meetings of the committee are minuted and attendance logged. Minutes and annual committee reports are sent to the Governing Body for noting.

The Finance Committee ensures a robust financial strategy is in place and oversees the organisation system of financial control. During 2014/2015, the Finance Committee met eleven times and:

• Reviewed and recommended the 2014/15 Financial Plan and the development of 2015/2016 plans

• Provided oversight to CCG activities related to population growth trends and links to funding

• Reviewed monthly synopses of the Finance Reports from Croydon Health Services NHS Trust and South London and the Maudsley NHS Foundation Trust.

• Monitored and challenged development of the 14/15 QIPP initiatives and reviewed summary forecasts for each scheme.

• Provided oversight of the development of a SW London CCGs risk share agreement and agreed the amendments to the 2013/2014 agreement
• Challenged implementation and delivery of the Transforming Adult Community Services agenda

The membership of the Finance Committee for 2014/15 is as follows:

• Roger Eastwood (Chair/Lay Member – Finance from 2 September 2014)
• David Hughes (Chair/Lay Member – Finance to 26 August 2014)
• Jon Norman (Secondary Care Consultant)
• Atif Hasan (GP Governing Body Member)
• John Linney (GP Governing Body Member)

The meetings of the committee are minuted and attendance logged. Minutes and annual committee reports are sent to the Governing Body for noting.

The Quality Committee has been established to oversee the application of quality in commissioning activity. It provides advice to the Integrated Governance and Audit Committee and assurance to the Governing Body that commissioned services are safe and of high quality and that there are adequate plans in place to respond to any issues of poor quality that may arise. During 2014/2015, the Quality Committee met six times and:

• Agreed Terms of Reference reflecting its assurance role.
• Agreed the Terms of Reference for the Safeguarding Group
• Regularly received and reviewed Quality and Safeguarding Reports
• Approved the Annual Equality Report incorporating the Equality Delivery System
• Established a Quality Risk Register, linking into the Corporate Risk Register and Assurance Framework
• Agreed a process to embed Safeguarding considerations in the contract review process
• Instigated an analysis on CHS staffing levels at times of falls to ensure patient safety

The membership of the Quality Committee for 2014/15 is as follows:

• Amy Page (Chair/Chief Nurse)
• Helen Pernelet (GB Vice Chair and Lay Member, Governance and PPI)
• Jon Norman (Secondary Care Consultant)
• Atif Hasan (GP Governing Body Member)
• John Chan (GP Governing Body Member and Medical Director)

The meetings of the committee are minuted and attendance logged. Minutes and annual committee reports are sent to the Governing Body for noting.

Remuneration Committee

A Remuneration Committee has been established and constituted in accordance with the ‘Codes of Conduct and Accountability’ for NHS Boards’ issued by the Secretary of State in April 1994, and accompanying guidance. The Committee assists the CCG Governing Body to meet its responsibilities to ensure appropriate remuneration, allowances and terms of service for the GB members, Clinical Leads, Chief Officer, Chief Financial Officer and senior staff. Recommendations are made to the GB all aspects of remuneration and related terms and conditions for CCG staff not covered by Agenda for Change. During 2014/15 the Remuneration Committee approved the Local Pay Framework for Governing Body members, Clinical Leaders and Very Senior Managers. It also reviewed the remuneration of key Executive Directors.
The membership of the Remuneration Committee for 2014/15 is as follows:

- Roger Eastwood (Chair/Lay Member – Finance from 2 September 2014)
- David Hughes (Chair/Lay Member – Finance to 26 August 2014)
- Helen Pernelet (GB Vice Chair and Lay Member, Governance and PPI)
- Jon Norman (Secondary Care Consultant)
- Tony Brzezicki (GB Chair)

The meetings of the committee are minuted and attendance logged. Minutes and annual committee reports are sent to the Governing Body for noting.

**Risk Management Framework**

Croydon CCG has put in place a robust governance structure to embed a high-level of both management and Governing Body assurance that will enable effective tracking of internal controls and provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies. The CCG’s Risk Management Strategy was developed in line with key Department of Health publications and has been recently revised to ensure that there is a clear description of management and committee responsibilities and oversight of risk portfolios.

**Risk Assessment**

The CCG Risk Assessment Framework is based on the National Patient Safety Agency (NPSA) guidance and the Australia New Zealand Standard AS/NZS 4360:1999 which provides guidance on identifying, evaluating and controlling risks. This is a generic risk assessment method which is applied in various contexts to assess any type of risk in a consistent manner. The way these principles are applied by the CCG are detailed elsewhere within this statement.

Risk assessments are carried out by all services/departments to identify the significant risks arising from all CCG activities; and their potential to cause injury, litigation, damage to the environment or property, or result in delays or impact upon reputation.

All officers, as part of both the Senior Management Team and Governing Body, have responsibility for identifying and managing strategic risks for the organisation. Additionally, the executive directors are accountable for managing operational risks associated with their areas of responsibility.

Each Director is responsible for ensuring that the Assurance Framework reflects key risks, controls and assurances related to strategic objectives, and that these are reviewed regularly.

The Assurance Framework provides a comprehensive method for effective and focused management of the principal risks that arise in meeting the CCG’s objectives and ensures that:

- The Governing Body is confident that its principal objectives can be achieved
- Has a process in place for identifying, minimising and prioritising risks that may prevent the achievement of principal objectives
- Strategic controls are in place to manage those risks
• Governing Body receives satisfactory assurance that these controls are effective and risks are managed appropriately

The Governing Body oversees the CCGs arrangements for risk management and assurance. In keeping with this role the Governing Body determines the CCG’s overall risk appetite. This supports a consistent approach when developing operational policies and provides assurance to the Governing Body and management that objectives are pursued within reasonable risk limits.

The Integrated Governance and Audit Committee (IGAC) reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across all organisational activities, both clinical and non-clinical, which support the achievement of the CCG’s objectives.

The Corporate Risk Register (CRR) is regularly updated as the nature and severity of risks change over time. The register provides the basis for reporting on the status of risks within the CCG. Portfolios of risks are reviewed and tested by the relevant committee. The risk registers are used to inform priorities for resources and supporting the case for capital bids.

The Quality Committee provides advice to IGAC and assurance to the Governing Body that commissioned services are safe and of high quality, and that there are adequate plans in place to respond to any issues that may arise. The committee reviews and discusses the identification and management of quality, patient safety and safeguarding risks.

The Finance Committee provides IGAC with advice and a means to exercise its role of independent and objective review of financial, quality, corporate governance, assurance processes and risk management across the whole of the CCG’s activities (clinical and non-clinical). It also provides assurance to the Governing Body that there are adequate plans in place to respond to any relevant issues that may arise. The committee reviews and discusses the identification and management of finance, performance and Quality, Innovation, Productivity and Prevention Performance (QIPP) risks.

The Assurance Framework (AF) and Corporate Risk Register are intrinsically linked. The high risk areas captured by the AF can be further drilled down to identify operational details captured in the Corporate Risk Register e.g. if poor implementation of a strategy is identified as a principal risk in the AF, then operational risks which may have an impact on the implementation of that strategy e.g. compliance risks, governance risks or clinical risks, are added to the Corporate Risk Register along with control measures and actions to be taken.

We update Corporate Risk Register (CRR) regularly, as the nature and severity of risks change over time. The register provides the basis for reporting on the status of risks within the CCG. Portfolios of risks are reviewed and tested by the relevant committee. The risk registers are used to establish priorities for resources and supporting capital bids.

Incident reporting processes have been communicated to all staff via briefings and information on the CCG file sharing structures. A non-clinical incident reporting policy has been implemented along with processes to ensure learning from incident reports is captured and fed into the risk management process. The process for internal reporting is
supplemented by the CCGs arrangements for receiving GP Ambers Alerts, a quality early warning system, which assists and supports risk management in the commissioning process.

Croydon CCG adopted the Equality Delivery System for the NHS (EDS) in 2011. The CCG successfully completed the EDS2 process during 2014 and implemented its Equality Objectives published in October 2013. The EDS enabled Croydon CCG to meet the aims of the Equality Act 2010 which is a legal requirement of all public organisations to take the necessary actions to achieve:

- Elimination of unlawful discrimination.
- Advancement of equality of opportunity.
- Fostering of good relations between individuals and communities.


When making decisions about the services to be commissioned Croydon CCG ensures that equality and diversity intelligence informs its decisions by routinely using the Joint Strategic Needs Assessment (JSNA) and by carrying out Equality Impact Assessments (EIA). EIA training, guidance and support is available to CCG staff.

The CCG has committed to commissioning the best possible services for the people of Croydon. A key component to help achieve this is effective communication, engagement and involvement with our patients, the wider health and social care community and our local stakeholders.

We are developing our framework for patient and public involvement. This supports our duties to engage and involve our local communities in the planning, design and delivery of services allowing them to highlight any concerns or issues and will involve:

- Strengthening the role of our Patient and Public Involvement Reference Group, whose members will help us prioritise, review and evaluate the effectiveness of our engagement activities; and

- Working more closely with our GP Networks to establish more Patient Participation Groups, to encourage better involvement at locality level.

The public are actively engaged in the decision making and policy development processes of the CCG and its partners. Policy development and implementation involves GP Networks who in turn link with their patients. The CCG holds a Public and Patient Involvement (PPI) Forum each quarter, and engagement events are held on specific topics during the course of the commissioning cycle. Views from such engagement influence and shape the CCG’s planning and prioritisation processes. Our implementation of EDS and alignment of this model with our QIPP programmes means that we seek to optimise patient voice and the patient perspective in our decision making.

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Developing an effective framework will help us embed patient and public involvement in all stages of the commissioning cycle.

**Key Risk Controls**

To maintain a robust system of assurance, the CCG ensures that Governing Body is actively involved in the development of its principal objectives. The risks to achieving these objectives are identified and recorded on the Assurance Framework.

A full review and reassessment of the strategic risks affecting the CCG was completed in November 2014. A new Assurance Framework, including an improved format and new content has been developed. The risks have been revised to reflect the latest position in the Governing Body Assurance Framework (GBAF). Key controls intended to manage these risks are reported on the GBAF. We will continue to develop the framework to ensure that the Governing Body receives a comprehensive view of the strategic risks facing the CCG and how we are managing them.

The existence of assurances to mitigate risk to delivery of these objectives is evaluated and any gaps identified and managed. Senior Management Team, Integrated Governance and Audit Committee and Governing Body receive regular reports detailing risk movement and trends and monitor all risks to the achievement of their principle objectives. All directors discuss risk on a monthly basis with the Risk Manager.

The CCGs risk and governance arrangements are reviewed regularly and the progress in implementing Internal Audit recommendations is tracked by the Integrated Governance and Audit Committee to ensure compliance.

Internal sources of assurance on the effectiveness of the CCG’s key controls include management reports to committees and Governing Body such as monthly, quarterly or annual reports and Internal Audit arrangements. At the mid-point of the year our arrangements were assessed by our Internal Auditors to provide us with adequate assurance. Since this point we have continued to develop and enhance our approach.

**2014/15 Significant Risks to Strategic Objectives**

Key financial risks affecting our objective “To achieve financial balance over five years” identified by the CCG in 2014/15, relate to the recognition that, taking account of the increased allocation in the Chancellor’s Autumn Statement and also the cost pressures from the national tariff, we would not be in a position to plan for a break-even position in 2015/16. We engaged proactively with NHSE and there is now recognition that we will put in place a deficit plan and ensure that everything possible is done to minimise the deficit. We are also considering more effective ways of delivering our targets and planning guidance in collaboration with providers and partners to improve efficiency and optimise our resources.

Other risks relating to each of the CCG’s corporate objectives were:

- **Capacity to deliver transformation of QIPP programme at the pace required**
  The clinically-led QIPP programme is instrumental to improving patient care and is designed to reduce the need for high-cost in-patient care, creating substantial financial benefits of up to £12.2m. Our target is to deliver £11m in savings. However, there is a risk around clinical engagement in the design and delivery of the schemes, capacity and capability and the availability of provider data to evidence the QIPP programme.
In order to mitigate the risk, we have:

- Developed a reward scheme to incentivise GPs in delivery of QIPP schemes, including adoption of improved patient pathways.
- Improved the uptake of new pathways by prioritising initiatives such as: Peer review programme/ Identification and supporting of outlying practices (understanding implementation issues)
- Closer working relationships with Croydon Health Services at all levels: clinical, management, and director level.
- Recruited to project management and commissioning vacancies; developed a competency framework and personal development plan (PDP) aligned to the development needs.

- The potential transfer of specialised commissioning from NHSE, impacts on our strategic objective, “To have collaborative relationships to ensure integrated approach”
  
  With regard to the transfer of specialised commissioning there was a consensus from London commissioners to treat 2015/16 as a shadow year with all responsibility for financial transfers happening in 2016/17. Although, NHS England’s position on this has since changed, we continue to seek opportunities to develop our capabilities by jointly commissioning services with our South West London colleagues to mitigate any potential risk arising from the transfer of responsibility in the next financial year.

- The possibility that the capability and capacity of our provider organisations may have an effect on the quality of the service they deliver on behalf of the CCG has also been considered. This would impact on our strategic objective “To commission integrated, safe, high quality service in the right place at the right time”
  
  We are actively collaborating with partner organisations to address this issue are reviewing innovative overseas recruitment strategies and creative advertising to promote Croydon and careers in healthcare professions.

- The most significant risk to our objective, “To develop as a mature membership organisation” is the risk that more Clinical Leadership time and resource is employed in implementing the Transforming Primary Care Agenda and on taking forward collaborative working through a federated model than on the delivery of commissioning priorities and QIPP outcomes.
  
  In mitigation, the CCG is actively supporting the development of provider collaboration locally, linking this to the wider South West London Provider Collaboration under the leadership of the CCG’s Medical Director.

**Internal Control Framework**

The CCG’s Internal Control framework is made up of processes and procedures designed to ensure it delivers its policies, aims and objectives. Our internal controls are an integral part of our governance system. They are designed to strengthen our ability to identify, prioritise and evaluate risks and their 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 CCG has followed national guidance and recommendations in establishing its systems of control and governance. It has complied with all legal requirements to address the criteria for authorisation and has, over the last 2 years reduced to 1 direction and 2 conditions, from the initial 7, placed on it, through rigorous application of internal controls. The Constitution of the CCG was developed with input from the CCG leadership and Governing Body and has been reviewed in line with national guidelines.

Our governance structures are used to ensure effective oversight of operational and strategic decisions and compliance with the NHS regulatory environment. Details of the Governing Body responsibilities and those of its committees are described above.

The CCG has in place a reliable governance framework with robust plans and processes to enable effective delivery of its strategic priorities and secure sound financial health. The Governing Body, committees and groups of the CCG are structured effectively to provide assurance over the wide range of business activities covered by the CCG.

**Croydon CCG Governance Structure**

In particular, the Finance Committee serves to provide an overview of financial activity and a sound understanding of costs, performance and achieving efficiencies through reliable and timely financial reporting that meets the needs of internal users, stakeholders and local people.

Effective risk management, financial management and compliance with statutory duties are high on the list of Governing Body priorities. We have implemented policies, systems and processes to reduce exposure in these areas and to ensure that we are legally compliant. Each committee and group oversees risks and policies relating to their area of responsibility, for example quality and safety risks are reviewed by the Quality Committee, whilst Integrated Governance and Audit Committee oversees risk management processes and the development of policies relating to financial management, security, counter fraud and governance and provides assurance of CCG compliance to the Governing Body.
Clinicians and management work in partnership through the commissioning cycle, adding value and delivering outcomes to ensure the procurement of quality services that are tailored to local needs and deliver sustainable outcomes and value for money.

The CCG has established an effective organisational structure with clear lines of authority and accountability which guards against inappropriate decision making and delegation of authorities enabling us to meet our statutory duties and follow best practice guidelines. Work to ensure that we promote and demonstrate the principles and values of good governance and the review of governance related risks takes place at Senior Management Team meetings and assurance is provided to the Integrated Governance and Audit Committee. We have considered the effectiveness of our governance framework and processes and raised no significant concerns on governance related matters this year.

Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect personal and corporate information. We have established an information governance management framework and have embedded information governance leadership, processes and procedures in line with the IGT requirements. This is evidenced through our IGT submission showing all requirements to be at level 2 or above and the substantial assurance provided by our auditors on this submission.

The information governance framework includes the use of an information risk register which is owned by the Senior Information Risk Owner and is reviewed and agreed regularly by the Information Governance Steering Group (IGSG). This ensures appropriate management of all information risks within the CCG. In addition, the Caldicott Guardian also owns a log, which records all sharing and use of Personal Confidential Data (PCD) requests, this document is owned by the Caldicott Guardian, but again reviewed and agreed regularly by the IGSG. These processes ensure that all risks associated with the use of PCD are managed appropriately.

We have ensured all staff undertake appropriate IG training and have implemented staff awareness materials including a staff information governance handbook, and undertaken a staff survey to ensure staff are aware of their information governance roles and responsibilities.

We have established processes in place for incident reporting and investigation of Serious Incidents Requiring Investigation (SIRI). No SIRIs have been reported during 2014/15.

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

The CCG is committed to ensuring the economic, effective and efficient use of our resources. The significance of this duty is heightened in the context (i) that the CCG is funded 7% less than its needs-based fair-share of national resources, (ii) that the CCG was established with Directions in respect of Financial Planning and QIPP Programme
Management, and (iii) that the CCG has set and delivered deficit financial plans in 2013/14 and 2014/15.

To determine the opportunities for the improved use of resources, the CCG has annually independently benchmarked its expenditure levels against other similar CCGs and has had this independently reviewed. The latest benchmarking report was finalised in March 2015. It should be noted that the benchmarked opportunity for financial savings is less than the level of underfunding, meaning the CCG would need to deliver better than benchmark to deliver its statutory duties.

Within a peer group of 11 CCGs with similar demographic profiles, the CCG is shown to benchmark favourably on prescribing, GP first outpatient attendances, elective admissions, continuing care and mental health expenditure.

Within the same peer group, the most significant issue is the level of emergency admissions. There is also opportunity on follow-up outpatient appointments and consultant-to-consultant outpatient referrals.

The CCG is following the national approach to improving the use of resources which focuses on four domains: Quality, Innovation, Productivity and Prevention (QIPP). The CCG developed and delivered a £11m (2.5% of allocation) QIPP savings programme for 2014/15, in line with our stated plans. This programme covered all aspects of the CCG’s commissioning expenditure, including acute hospital services, continuing care, prescribing and mental health services.

The CCG has also continued to develop an innovative approach to commissioning older people services across health and social care which will focus on outcomes, rather than the number of interventions.

Review of the Effectiveness of Governance, Risk Management & Internal Control
As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

Capacity and capability
Our mechanisms for internal control ensure that the CCG’s business activities are efficient and proficient, financial reporting is reliable and that applicable laws, regulations and internal policies are followed.

The CCG Governing Body has approved operating principles of internal control, which have been prepared in accordance with NHS requirements. We are not required to comply with the UK Corporate Governance Code. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice. Our operating principles include the main features of risk management process, assurance frameworks, control objectives and common control points for financial reporting as well as roles and responsibilities in executing and monitoring internal control.

As detailed comprehensively elsewhere within this statement the Governing Body and the Integrated Governance and Audit Committee, appointed by the Governing Body, supervise internal control and risk management. The Chief Officer and Chief Financial Officer are...
jointly responsible for implementing the internal control and risk management frameworks together with the CCG senior management team, finance managers and heads of services.

The Senior Information Risk Officer (SIRO) is responsible for:

- Understanding how the strategic business goals of the CCG may be impacted by information risks; acting as an advocate for information risk on the Board and in internal discussions
- Ensuring the Board is adequately briefed on information risk issues
- Overseeing the development of an Information Risk Policy, and a Strategy for implementing the policy within the CCG’s Information Governance Framework
- Reviewing the annual information risk assessment to support and inform the Annual Governance Statement
- Taking ownership of risk assessment processes for information risks, supported by the Information Governance Manager, Information Security lead, and the Records Manager
- Reviewing and agreeing action in respect of identified information risks
- Providing a focal point for the resolution and/or discussion of information risk issues

A number of risk training and awareness raising sessions have been offered and provided for staff. Risk management guidance has also been developed and distributed. Our Risk Management Policy and Strategy has been reviewed and revised and is applied by the CCG. We have a monthly cycle of process application designed to identify capture and regularly review and update the administration of risks within the CCG. A system, 4risk, is available and deployed to assist with this task. These arrangements are embedded within the culture of the organisation as detailed in earlier sections of this statement.

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 CCG 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 audit findings report and other reports.

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

I have confidence that the systems we deploy ensure that I would be aware of and would therefore respond to the implications of the deficiencies in effectiveness of the system of internal control by the CCG and through its operation the work of the Governing Body, the Integrated Governance and Audit Committee (IGAC) and the Quality, Finance and Remuneration Committees.

The CCG has in place a reliable governance framework with robust plans and processes to enable effective delivery of its strategic priorities and secure sound financial health;
The Governing Body, committees and groups of the CCG are structured effectively to provide assurance over the wide range of business activities progressed by the CCG. In particular, the Finance Committee serves to provide an overview of financial activity and a sound understanding of costs, performance and achieving efficiencies through reliable and timely financial reporting that meets the needs of internal users, stakeholders and local people.

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.

**Internal Audit Opinion**

The Head of Internal Audit, based on work undertaken up to 13 April 2015, concluded that:

“Based on the work undertaken in 2014/2015, **significant assurance** can be given that there is a sound system of internal control which is designed to meet the organisation’s objectives, and that controls are being consistently applied in all the areas reviewed.

During 2014/15 we have not issued any ‘no assurance’ (Red) opinions which is comparable to last year. In addition, we have not issued any red/amber opinions that the CCG would have considered in the formulation of the AGS, that may have been pertinent around internal control weaknesses.”
Data Quality

Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained. The CCGs primary provider of business intelligence services, SECSU, is at level 3 in this requirement. We receive notification of any relevant issues and reports on what has been done to resolve any issues discovered, as part of audits or routine monitoring – ensuring that issues are flagged and managed as they arise, with confirmation of an appropriate process via the audit. The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience.

Business Critical Models

Business critical models are driven by data analysis and the models used by the CCG are provided by external consultants and therefore subject to external quality assurance.

Data Security

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

Discharge of Statutory Functions

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

In light of the Harris Review, the Clinical Commissioning Group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, 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.
Conclusion
In conclusion, as required, I confirm that our systems of internal control have identified no significant issues of internal control.

Paula Swann

Paula Swann
Chief Officer
Croydon Clinical Commissioning Group
29 May 2015
### GOVERNING BODY - GP MEMBERS

<table>
<thead>
<tr>
<th>Details</th>
<th>Roles and Responsibilities held within member practices</th>
<th>Shareholding</th>
<th>Directorship/Ownership</th>
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</thead>
<tbody>
<tr>
<td>Anthony Brzezicki</td>
<td>Queenhill Medical Practice: Salaried GP From January 2015</td>
<td>Croydon PBC Limited: Shareholder (Ceased 27 October 2014)</td>
<td>A Brzezicki Consultancy: Director</td>
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<tr>
<td></td>
<td>Queenhill Medical Practice: Partner (Ceased 27 October 2014)</td>
<td>Croydon and Surrey Specialists Limited: Shareholder (Not trading)</td>
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<th>Update</th>
<th>Position of Authority in an organisation in the field of health and social care</th>
<th>Other</th>
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<tbody>
<tr>
<td>None</td>
<td>Transforming Cancer Services Team (TCS) hosted by South East Commissioning Support Unit (SE CSU): GP Member</td>
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<td></td>
<td>London Cancer Alliance Clinical Board: GP Member</td>
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<td></td>
<td>Early Diagnosis Cancer Implementation Group Chair</td>
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<tr>
<td></td>
<td>Royal Marsden Clinical Quality Review Group (London wide): Member</td>
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<td></td>
<td>Cancer Clinical Liaison Advisory Group: GP Member</td>
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<tr>
<td></td>
<td>London Cancer Commissioning Board Co-Chair</td>
<td></td>
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<td></td>
<td>Joint NHSE and London CCGs Transformation Programme Clinical Lead</td>
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Updated March 2015
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<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Partnerships/Committees</th>
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</thead>
<tbody>
<tr>
<td>John Chan</td>
<td>GP Governing Body Member and Medical Director</td>
<td>Eversley Medical Centre: GP Partner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
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<td></td>
<td></td>
<td>Communitas Clinics Limited Practice is a shareholder</td>
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<td></td>
<td></td>
<td>Croydon Local Medical Committee: Member</td>
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<td></td>
<td></td>
<td>Health Education England: GP Specialty Programme Director</td>
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<td></td>
<td></td>
<td>NHS England: Appraisal lead for Croydon (Ceased 31 March 2014)</td>
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<td></td>
<td></td>
<td>Zoteforms Limited: Medical Advisor</td>
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<tr>
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<td>Harris Academy Schools: Medical Adviser to some Harris Academy Schools</td>
</tr>
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<td></td>
<td></td>
<td>Family Member: Consultant in drug licencing and development</td>
</tr>
<tr>
<td>Agnelo Fernandes</td>
<td>Assistant Clinical Chair</td>
<td>Pachmore Partnership: Partner</td>
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<td>Ealing Park Medical Practice: Partner</td>
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<td>South Norwood Medical Practice: Partner</td>
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<td>None</td>
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<td></td>
<td>NHS England (South London): GP Appraiser</td>
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<td>London School of General Practice: GP Trainer</td>
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<td></td>
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<td>Croydon Local Medical Committee: Member</td>
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<td></td>
<td>Royal College of General Practitioners: National Lead for Urgent and Emergency Care</td>
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<td>Royal College of General Practitioners - Centre for Commissioning: National Clinical Commissioning Champion</td>
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<td>National NHS Pathways</td>
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<td>Community Phlebotomy Service: Pachmore Partnership provides premises for this service.</td>
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<td>Community Anti-Coagulation Service: Pachmore Partnership provides premises for this service. Will cease 1 April 2015</td>
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<tr>
<td></td>
<td></td>
<td>Community Minor Surgery Service: Pachmore Partnership provides premises for this service</td>
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<td></td>
<td></td>
<td>Virgin/London School of General Practice: Educational Supervisor of GP</td>
</tr>
</tbody>
</table>
**Governance Group:**
Chairman

National NHS Pathway Programme Board (NHS England/Health & Social Care Information Centre): Member

National Urgent and Emergency Care Steering Group - NHS England: Member

National Intercollegiate Committee for Children’s services in A&E, Royal College of Paediatrics and Child Health: Member

National intercollegiate Committee for Children’s services in A&E, Royal College of Paediatrics and Child Health: Member

Trainees Out of Hours Russell School Trust (Royal Russell School): Governor

Community Diabetes Service - Bromley Healthcare: (Parchmore Partnership provide the premises for this service)

Guy’s, King’s and St Thomas’s Medical School Partnership Medical Learning Centre

St George’s Hospital Medical School: Parchmore Partnership is a teaching practice for the medical school

Dr ABC First Aid Training Company: Wife-owner. Provides training for schools/nurseries and some GP practices (there is no link to the CCG or contracting)

Quintos Works Limited - Physiotherapy (non NHS): Parchmore partnership provides the premises for this service

Community Diagnostics Service – Inhealth: Parchmore partnership provides premises for this service *(Ceased October 2014)*
| **Atif Hasan**: GP Governing Body Member | **Keston Medical Practice**: GP Principal | **Avicenna Medical Limited**: (Company used to facilitate locum work): Director | None | None | **London Deanery**: GP Trainer.  
Sessional Out of Hours GP  
**Keston Medical Practice**: Tenants in Purley Hospital  
**King’s College Medical School**: Keston Medical Practice is a teaching practice for the medical school  
**NHS England**: GP Appraiser  
**CReSS**: Triager (Ceased March 2015) |
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<tr>
<td><strong>Start date</strong>: 1 November 2013</td>
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<tr>
<td><strong>John Linney</strong>: GP Governing Body Member</td>
<td><strong>Linney Associates Limited</strong>: Director</td>
<td><strong>Communitas (previously Croydon PBC Limited)</strong>: Clinical sessions for Croydon Intermediate Dermatology Service Shareholder</td>
<td>None</td>
<td>None</td>
<td><strong>Care UK Croydon</strong>: As part of lead role in Mental Health Older Adults service redesign attending meetings and having discussions with members of Care UK Croydon. <em>(Commenced February 2015)</em></td>
</tr>
<tr>
<td><strong>Start date</strong>: 1 November 2013</td>
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<tr>
<td>Details</td>
<td>Roles and Responsibilities held within member practices</td>
<td>Directorship/Ownership</td>
<td>Shareholding</td>
<td>Position of Authority in an organisation in the field of health and social care</td>
<td>Other</td>
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</table>
| Roger Eastwood: Lay Member  
Start Date: September 2014 | Eastbourne Homes Limited: Director  
South East Independent Living Limited: Director  
Eastwood Consultants Limited: Director | None | South East Independent Living Limited (provides support services to over 65 year olds in East Sussex for Eastbourne, Lewes and Wealden districts): Director | None |
| David Hughes: Lay Member  
Start date: January 2012  
End date: December 2012 | | | Animal Health and Veterinary Laboratories Agency - a UK wide agency which works on behalf of Defra, the Scottish Government and the Welsh Assembly Government: Non Executive Director | |
| Jonathan Norman: Secondary Care Consultant  
Start date: December 2012 | None | None | None | Heart of Kent Hospice Maidstone: Volunteer  
Hospice in Tunbridge Wells: Volunteer  
Maidstone and Tunbridge Wells NHS Trust: Chair of Medical Staff Committee |
| Helen Pernelet: Lay Member  
Start Date: January 2013 | None | None | National Society for Epilepsy (Charity providing epilepsy diagnostic services and residential care): Trustee (5 years) and Chair | None |
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<tr>
<th>Details</th>
<th>Roles and Responsibilities held within member practices</th>
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<th>Shareholding</th>
<th>Position of Authority in an organisation in the field of health and social care</th>
<th>Other</th>
</tr>
</thead>
</table>
| Fouzia Harrington: Director of Governance and Quality  
Start Date: April 2012  
Took sabbatical from 16 May 2014 until January 2015  
End Date: 31 January 2015 | None | None | None | Crystal Palace Foundation Community  
Spouse is a Development Officer | None |
| Sean Morgan: Interim Director of Governance and Quality  
Start Date: February 2015 | None | None | None | South East Commissioning Support Unit  
Substantive Employer | None |
| Amy Page: Chief Nurse  
Start Date: December 2012 | None | Amy Page Consultancy Services (Company used to deliver healthcare improvement and leadership coaching). Managing Director  
Supporting delivery of a Medical Productivity Model at Croydon University Hospital with implementation to follow | None | Jubilee Health Centre, Sutton CCG: Programme Manager (Ceased August 2014)  
Chelsea and Westminster Foundation Trust: Programme Manager (Ceased January 2015) | Leadership Insight: Associate Consultancy  
Mobius Partners Limited: Consultant |
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<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Start Date</th>
<th>End Date</th>
<th>Other Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michelle Rahman</td>
<td>Interim Director of Governance and Quality</td>
<td>19 May 2014</td>
<td>31 January 2015</td>
<td></td>
</tr>
<tr>
<td>Mike Sexton</td>
<td>Chief Finance Officer</td>
<td>June 2012</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Paula Swann</td>
<td>Chief Officer</td>
<td>May 2012</td>
<td>None</td>
<td>South London and Maudsley Mental Health Trust (SLaM): CCG Commissioner Council of Governors Representative</td>
</tr>
<tr>
<td>Stephen Warren</td>
<td>Director of Commissioning</td>
<td>September 2012</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Details</td>
<td>Roles and Responsibilities held within member practices</td>
<td>Directorship/Ownership</td>
<td>Shareholding</td>
<td>Position of Authority in an organisation in the field of health and social care</td>
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</tbody>
</table>
| **Paul Greenhalgh:** Executive Director People, Croydon Council  
Start Date: January 2015 | None | Octavo (Croydon Schools Mutual) Director | None | Journal of Emotional and Behavioural Difficulties Member of Editorial Board | None |
| **Hannah Miller:** Executive Director Adult Services, Health and Housing, Croydon Council  
Start Date: April 2012  
End Date: December 2014 | None | None | None | None | None |
| **Mike Robinson:** Director of Public Health  
Start Date: October 2012 | None | None | None | Association of Directors of Public Health: Honorary Treasurer | NHS Richmond and Twickenham CCG: Sessional GP |
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<tr>
<th>Details</th>
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<th>Shareholding</th>
<th>Position of Authority in an organisation in the field of health and social care</th>
<th>Other</th>
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<tbody>
<tr>
<td><strong>Olayinka Ajayi-Obe:</strong> GP Clinical Leader, Mayday Network</td>
<td>Eversley Medical Practice: Partner</td>
<td>Health Safeguarding Limited: Director</td>
<td>Communitas (previously Croydon PBC Limited): Eversley Medical Centre is a shareholder</td>
<td>Croydon Health Services: Wife is the Clinical Director</td>
<td>London School of General Practice: Education Supervisor for GP trainees out of hours</td>
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<tr>
<td><strong>Start Date:</strong> 1 November 2013</td>
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<td><strong>Bobby Abbot:</strong> GP Clinical Leader Woodside Shirley Network</td>
<td>Shirley Medical Practice: GP Partner</td>
<td>Abbot Medical Practice: Director</td>
<td>Croydon PBC: Shareholder</td>
<td>Croydon LMC: Member Croydon Prescribing Care Group: Member NHS England (South London): GP Appraiser Shirley Oaks Hospital: GP Sessions under GP extra service Brighton Integrated Care Service: Clinical Triager, Croydon Referral Support Service</td>
<td>Pharmaceutical Sponsored Educational Events: Chairing and talking at occasional educational meetings</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Start Date</td>
<td>End Date</td>
<td>Practice/Institution</td>
<td>Role/Commitment</td>
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<tr>
<td>Karthiga Gengatharan</td>
<td>GP Clinical Leader, East Croydon Network</td>
<td>April 2012</td>
<td>(Maternity leave from 31 July 2013 until July 2014)</td>
<td>Locum GP Guys and St Thomas NHS Trust: Husband is staff South Norwood Hill Medical Practice: Salaried GP (Ceased end 2014)</td>
<td>None GP Epsom Learning Set: Chair Croydon CCG IFR Triage Panel: Member (Commenced March 2015) Surrey CCG IFR Triage Panel Member (did not start triage work due to maternity leave) ASA (Company providing private dental sedations): Husband is staff</td>
</tr>
<tr>
<td>Kamran Khan</td>
<td>GP Clinical Leader</td>
<td>August 2012</td>
<td>30 June 2014</td>
<td>Stovell House Surgery: Partner</td>
<td>None Stovell House Surgery: Shares in Croydon PBC London School of General Practice: GP Trainer Kings College NHS Trust Practice is a teaching practice for the Trust Kings College of General Practitioners: Examiner of MRCGP</td>
</tr>
<tr>
<td>Name</td>
<td>Position/Role</td>
<td>Organization/Details</td>
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<tr>
<td>Agatha Nortley-Meshe</td>
<td>GP Clinical Leader, New Addington/Selsdon Network</td>
<td>Parchmore Medical Centre and Haling park Medical Centre: Salaried GP</td>
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<td></td>
<td></td>
<td>DAPS Global (Doctors Advancing Patient Safety - Assisting/supporting junior clinicians in quality improvement. Developing quality improvement / patient safety products / services / events): Co-Director/Board Member</td>
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<td>ADAP (African Development Association for Progress): Non Executive Board Member</td>
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<td>BUPA Medical: Working for Blackberry Clinic</td>
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<td>DAPS Global: May receive grants/funding for research. Promoting campaign as part of NHS Change Day (Youtube video/website)</td>
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<td>Long Term Conditions Workstream: Co Chair</td>
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<td>SWL Children and Young People’s Network</td>
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<td>NHS England Pan London Urgent and Emergency Care Clinical Leadership Group: Member</td>
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<tr>
<td>Brian Okumu</td>
<td>GP Clinical Leader, New Addington Selsdon Network</td>
<td>Locum GP</td>
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<td></td>
<td></td>
<td>KBO Consultancy Limited (Company used to facilitate locum work): Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BUPA Medical: Working for Blackberry Clinic</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>DAPS Global: May receive grants/funding for research. Promoting campaign as part of NHS Change Day (Youtube video/website)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Long Term Conditions Workstream: Co Chair</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>SWL Children and Young People’s Network</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>NHS England Pan London Urgent and Emergency Care Clinical Leadership Group: Member</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Position and Details</td>
<td></td>
<td></td>
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<tr>
<td>-------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rajeev Sagar</td>
<td>GP Clinical Leader, Thornton Heath Network, Start Date: April 2012, Woodside Group Practice: Partner, VSH Limited, Substance Misuse: Practice is the host site for the GPSI Substance Misuse Clinics, Brighton Integrated Care Service: Champion for Croydon Referral Support Services (Ceased 11 November 2013), St George's Medical Students: Educational Supervisor (Ceased March 2014), Virgin/London School of General Practitioners: Out of Hours Trainer (Ceased 1 May 2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farhan Sami</td>
<td>GP Clinical Leader, Purley Network, The Moorings Practice: Partner, Croydon PBC: Shareholder, Local Medical Committee: Member, NHS England (South London): GP Appraiser, Shirley Oaks Hospital: Private work as part of GP extra</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Data entered below will be used throughout the workbook:

Entity name: Croydon CCG
This year: 2014-15
This year ended: 31 March 2015
This year commencing: 1 April 2014

These account templates are a proforma for a set of NHS England Group Entity Accounts, this is not a mandatory layout for local accounts.

Please review and adjust to local reporting requirements
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<td>Statement of Financial Position as at 31st March 2015</td>
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INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF NHS CROYDON CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Croydon Clinical Commissioning Group for the year ended 31 March 2015 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the National Health Service in England.

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

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers; and
- the note on pay multiples.

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

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

Respective responsibilities of the Accountable Officer and auditor

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

Scope of the audit of the financial statements

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

Opinion on regularity

Except for the CCG's breach of its revenue resource limit set out below, in our opinion, in all material respects the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

- the parts of the Remuneration Report subject to audit have been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We are required to report if we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 23 April 2014 we referred a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 in relation to the CCG's planned breach of its revenue resource limit for the year ending 31 March 2015.

The CCG breached its revenue resource limit by £32.9 million for the year ending 31 March 2015.

We report to you if:

- in our opinion the governance statement does not reflect compliance with NHS England's Guidance; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.
Conclusion on the CCG’s arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the CCG and auditor

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014.

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

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

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

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

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

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

Basis for qualified conclusion

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

• In March 2013 the CCG was authorised with two legal directions in relation to its planning and programme management. The directions remain in place at 31 March 2015;
• The CCG reported a deficit of £32.9 million in its financial statements for the year ending 31 March 2015, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012 to break even on its commissioning budget; and
• The CCG is forecasting an in year deficit of £11.9 million for the year ending 31 March 2016.

This is evidence of weaknesses in arrangements in respect of the CCG’s financial planning.
Qualified Conclusion

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

Certificate

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

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

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

May 2015
Croydon CCG - Annual Accounts 2014-15

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

<table>
<thead>
<tr>
<th>Note</th>
<th>2014-15 £000</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Income and Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits 4.1.1</td>
<td>4,288</td>
<td>3,769</td>
</tr>
<tr>
<td>Operating Expenses 5</td>
<td>435,238</td>
<td>423,185</td>
</tr>
<tr>
<td>Other operating revenue 2</td>
<td>(1,705)</td>
<td>(1,866)</td>
</tr>
<tr>
<td><strong>Total Net Expenditure for the year</strong></td>
<td><strong>437,821</strong></td>
<td><strong>425,088</strong></td>
</tr>
</tbody>
</table>

Of which:

| Administration Income and Expenditure | | |
| Employee benefits 4.1.1 | 3,079 | 2,158 |
| Operating Expenses 5 | 5,779 | 5,797 |
| Other operating revenue 2 | (709) | (607) |
| **Net administration costs before interest** | **8,149** | **7,348** |

| Programme Income and Expenditure | | |
| Employee benefits 4.1.1 | 1,209 | 1,611 |
| Operating Expenses 5 | 429,459 | 417,388 |
| Other operating revenue 2 | (996) | (1,259) |
| **Net programme expenditure before interest** | **429,672** | **417,740** |

**Total comprehensive net expenditure for the year**

<table>
<thead>
<tr>
<th></th>
<th>2014-15 £000</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total comprehensive net expenditure for the year</td>
<td><strong>437,821</strong></td>
<td><strong>425,088</strong></td>
</tr>
</tbody>
</table>

The accounts have been prepared on a going concern basis.
## Statement of Financial Position as at 31 March 2015

<table>
<thead>
<tr>
<th>Note</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

### Current assets:

- **Trade and other receivables**
  - Note 9: £3,472, £7,500
- **Cash and cash equivalents**
  - Note 10: £62, £151

**Total current assets**: £3,534, £7,651

### Total assets

- £3,534, £7,651

### Current liabilities:

- **Trade and other payables**
  - Note 12: (£41,695), (£37,980)
- **Provisions**
  - Note 13: (£112), (£500)

**Total current liabilities**: (£41,807), (£38,480)

### Total Assets less Current Liabilities

- (£38,273), (£30,829)

### Assets less Liabilities

- (£38,273), (£30,829)

### Financed by Taxpayers’ Equity

- **General fund**: (£38,273), (£30,829)

**Total taxpayers’ equity**: (£38,273), (£30,829)

---

**Paula Swann**

Chief Officer

29 May 2015

---

**Mike Sexton**

Chief Finance Officer

29 May 2015
Croydon CCG - Annual Accounts 2014-15

Statement of Changes In Taxpayers Equity for the year ended 31 March 2015

<table>
<thead>
<tr>
<th>General fund</th>
<th>£000</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Changes in taxpayers’ equity for 2014-15</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2014</td>
<td>(30,829)</td>
</tr>
<tr>
<td>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2014-15</td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(437,821)</td>
</tr>
<tr>
<td>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(468,650)</td>
</tr>
<tr>
<td>Net (cash) funding</td>
<td>430,377</td>
</tr>
<tr>
<td>Balance at 31 March 2015</td>
<td>(38,273)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes in taxpayers’ equity for 2013-14</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2013</td>
<td>0</td>
</tr>
<tr>
<td>Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition</td>
<td>16</td>
</tr>
<tr>
<td>Adjusted NHS Clinical Commissioning Group balance at 1 April 2013</td>
<td>16</td>
</tr>
<tr>
<td>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2013-14</td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(425,089)</td>
</tr>
<tr>
<td>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(425,073)</td>
</tr>
<tr>
<td>394,244</td>
<td></td>
</tr>
<tr>
<td>Balance at 31 March 2014</td>
<td>(30,829)</td>
</tr>
</tbody>
</table>
### Croydon CCG - Annual Accounts 2014-15

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

<table>
<thead>
<tr>
<th>Note</th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

#### Cash Flows from Operating Activities

- **Net operating expenditure for the financial year**: (437,821) (425,089)
- **Impairments and reversals**: 5 0 16
- **(Increase)/decrease in trade & other receivables**: 9 4,028 (7,500)
- **Increase/(decrease) in trade & other payables**: 12 3,715 37,980
- **Provisions utilised**: 13 (500) 0
- **Increase/(decrease) in provisions**: 13 112 500

**Net Cash (Outflow) from Operating Activities**: (430,466) (394,093)

#### Net Cashflow from Investing Activities

0

**Net Cash (Outflow) before Financing**: (430,466) (394,093)

#### Cash Flows from Financing Activities

- **Grant in Aid Funding Received**: 430,377 394,244

**Net Cash Inflow from Financing Activities**: 430,377 394,244

#### Net Increase in Cash & Cash Equivalents

<table>
<thead>
<tr>
<th>Note</th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

**Net Increase in Cash & Cash Equivalents**: 89 151

#### Cash & Cash Equivalents at the Beginning of the Financial Year

151 0

#### Cash & Cash Equivalents at the End of the Financial Year

62 151
Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of CCGs shall meet the accounting requirements of the CCG Annual Reporting Guidance, which shall be agreed with the Department of Health. Consequently, the following financial statements have been prepared in accordance with the CCG Annual Reporting Guidance: 2014/15 issued by NHS England. The accounting policies contained in that Guidance follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCGs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the CCG Annual Reporting Guidance: 2014/15 permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of Croydon Clinical Commissioning Group (the ‘CCG’) for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG 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 or function in the future is anticipated, as evidenced by inclusion of financial provision for that service or function in published documents.

The following is clear evidence that the CCG meets the requirements above:

- Croydon CCG was established on 1 April 2013 as a separate statutory body and has an agreed constitution to govern its activities.
- Croydon CCG has been allocated funds from NHSE for 2014/15 and 2015/16.
- Croydon CCG has been allocated a Maximum Cash Drawdown for 2015/16 in line with its expenditure plans.
- Croydon CCG has also been notified of indicative allocations (December 2013) from 2016/17 to 2018/19 (6 years in total)
- Detailed financial plans have been submitted to the Governing Body and NHSE for 2015/16. Further iterations of the 2015/16 Financial Plans are being developed and submitted to Governing Body and NHSE. The draft Financial Improvement Plan has been submitted to the Governing Body for 2016/17 – 2018/19.

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

It should be noted that a report to the Secretary of State for Health under Section 19 of the Audit Commission Act 1998 has been issued for the breach of financial duties, i.e. failure to contain expenditure within the Revenue Resource Limit.

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 Pooled Budgets

Where the CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the CCG 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 CCG is in a “jointly controlled operation”, the CCG recognises:
- The assets the CCG controls;
- The liabilities the CCG incurs;
- The expenses the CCG incurs; and,
- The CCG’s share of the income from the pooled budget activities.

If the CCG is involved in a “jointly controlled assets” arrangement, in addition to the above, the CCG recognises:
- The CCG’s share of the jointly controlled assets (classified according to the nature of the assets);
- The CCG’s share of any liabilities incurred jointly; and,
- The CCG’s share of the expenses jointly incurred.

The CCG has not entered into any Pooled Budget arrangements in 2014/15. For 2015/16, the CCG has entered into a S75 agreement with the London Borough of Croydon on the Better Care Fund (BCF). The CCG will host the BCF under a pooled budget ‘jointly controlled operation’ arrangement.
Notes to the financial statements

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.5.1 Critical Judgements in Applying Accounting Policies

Apart from those involving estimations (see below), there are no critical judgements that management has made in the process of applying the CCG’s accounting policies that have a significant effect on the amounts recognised in the financial statements:

1.5.2 Key Sources of Estimation Uncertainty

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

- Estimate of acute contract over-performance with non-local providers has been based on forecast expenditure levels reflecting a seasonality adjusted extrapolation from Month 11 provider contact reports (£5.9m). This includes an estimate of performance against clinical quality metrics e.g. CQUIN, 30-day readmission rates, first to follow up ratios.
- Estimates of the final two months prescribing expenditure have been conservatively based on historical expenditure patterns (£7.8m).
- Estimates of continuing care expenditure in the final two months have been based on client registers (£2.3m).
- An estimate of redundancy liabilities has been made based on the latest information available (£0.1m)
- Estimate on contract disputes for individual placements (£0.4m)

1.6 Revenue

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

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

Where expenditure has been incurred by the CCG on behalf of a third party, the recharge is netted off expenditure and not disclosed as income.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

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

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the CCG 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 CCG commits itself to the retirement, regardless of the method of payment.

Employees may be members of the Local Government Superannuation Scheme (LGSS), which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the CCG’s accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure. There are no employees who are members of the LGSS.
Notes to the financial statements

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

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

1.9 Property, Plant & Equipment
1.9.1 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 CCG;
• 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.

1.9.2 Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the CCG’s services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
• Land and non-specialised buildings – market value for existing use; and,
• Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. 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. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 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.
Notes to the financial statements

1.10 Depreciation, Amortisation & Impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuations of property, plant and 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 CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG 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 CCG 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.

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

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 CCG’s surplus/deficit.

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

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

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

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

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

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the CCG has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in note 1.4 to these financial statements. The CCG’s arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 1.4 to these financial statements.

1.14 Clinical Negligence Costs
The NHS Litigation Authority operates a risk pooling scheme under which the CCG 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 CCG.

1.15 Non-clinical Risk Pooling
The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.16 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 CCG, 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 CCG. 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.

1.17 Financial Assets
Financial assets are recognised when the CCG 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:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

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

1.18.1 Financial Assets at Fair Value Through Profit and Loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the CCG’s surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.18.2 Held to Maturity Assets
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Notes to the financial statements

1.18.3 Available For Sale Financial Assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.18.4 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 CCG 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.

1.19 Financial Liabilities

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

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.19.1 Financial Guarantee Contract Liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.19.2 Financial Liabilities at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the CCG’s surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.19.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.20 Value Added Tax

Most of the activities of the CCG 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.
Notes to the financial statements

1.21 Foreign Currencies
The CCG’s functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the CCG’s surplus/deficit in the period in which they arise.

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

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

1.23 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted
The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2014/15, all of which are subject to consultation:
• IFRS 9: Financial Instruments
• IFRS 13: Fair Value Measurement
• IFRS 14: Regulatory Deferral Accounts
• FRS 15: Revenue for Contract with Customers

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

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>210</td>
<td>210</td>
<td>0</td>
<td>410</td>
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<tr>
<td>Non-patient care services to other bodies</td>
<td>1,391</td>
<td>379</td>
<td>1,012</td>
<td>1,456</td>
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<tr>
<td>Other revenue</td>
<td>104</td>
<td>120</td>
<td>(16)</td>
<td>0</td>
</tr>
<tr>
<td>Total other operating revenue</td>
<td>1,705</td>
<td>709</td>
<td>996</td>
<td>1,866</td>
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</tbody>
</table>

Administration revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Non-patient care services to other bodies includes recharges to South East CSU for space usage at the CCG, a recharge to Croydon Council for contribution towards transformation costs on the Outcomes Based Commissioning programme and recharges to Croydon Council for services to the voluntary sector under joint funding arrangements.

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

3 Revenue

Revenue is totally from the supply of services. The CCG receives no revenue from the sale of goods.
### 4. Employee benefits and staff numbers

#### 4.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th></th>
<th></th>
<th>2013-14</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
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</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>3,823</td>
<td>2,215</td>
<td>1,608</td>
<td>2,775</td>
<td>1,647</td>
<td>1,128</td>
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<tr>
<td>Social security costs</td>
<td>209</td>
<td>209</td>
<td>0</td>
<td>146</td>
<td>146</td>
<td>0</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>256</td>
<td>256</td>
<td>0</td>
<td>158</td>
<td>158</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>4,288</td>
<td>2,680</td>
<td>1,608</td>
<td>3,079</td>
<td>1,951</td>
<td>1,209</td>
</tr>
<tr>
<td>Less recoveries in respect of employee benefits (note 4.1.2)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td>4,288</td>
<td>2,680</td>
<td>1,608</td>
<td>3,079</td>
<td>1,951</td>
<td>1,209</td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>4,288</td>
<td>2,680</td>
<td>1,608</td>
<td>3,079</td>
<td>1,951</td>
<td>1,209</td>
</tr>
</tbody>
</table>

#### 4.1.2 Recoveries in respect of employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th></th>
<th></th>
<th>2013-14</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Employee Benefits - Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total recoveries in respect of employee benefits</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Total Admin Programme

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th></th>
<th></th>
<th>2013-14</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Total recoveries in respect of employee benefits</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The figures represent the financial information for the year 2014-15 and 2013-14, detailing the costs and benefits associated with the employees' salary, social security costs, and employer contributions to the NHS Pension scheme. The table also includes the recoveries in respect of employee benefits and the net employee benefits excluding any capitalised costs.
4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanently employed</td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>34</td>
<td>34</td>
</tr>
</tbody>
</table>

4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td>Total Days Lost</td>
<td>70</td>
<td>46</td>
</tr>
<tr>
<td>Total Staff</td>
<td>28</td>
<td>20</td>
</tr>
<tr>
<td>Average working Days Lost</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Number of persons retired early on ill health grounds

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Total additional Pensions liabilities accrued in the year

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td>Compulsory redundancies</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other agreed departures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

These tables report the number and value of exit packages agreed in the financial year.

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda for Change Redundancy Scheme.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

These redundancies were as a result of the restructuring of the CCG with took effect in February 2015.
4.5 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 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:

4.5.1 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 2004 to that date. Details of this valuation can be found on the pension scheme website. The previous valuation took place as at 31 March 2004. The conclusion from the 2012 valuation was that the Scheme had accumulated a notional deficit of £10.3 billion against the notional assets as at 31

In order to defray the costs of benefits, employers pay contributions at 14% of Pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of Pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their Pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time

The 2012 actuarial valuation determined the contribution rates from 1 April 2015, setting employer contribution rate at 14.3% of Pensionable pay.

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2012 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2012 with summary global member and accounting data.

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

4.5.3 Scheme Provisions

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

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

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

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year;

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

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

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross employee benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>3,829</td>
<td>2,620</td>
<td>1,209</td>
<td>3,277</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>459</td>
<td>459</td>
<td>0</td>
<td>492</td>
</tr>
<tr>
<td>Total gross employee benefits</td>
<td>4,288</td>
<td>3,079</td>
<td>1,209</td>
<td>3,769</td>
</tr>
<tr>
<td>Other costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>11,391</td>
<td>4,602</td>
<td>6,789</td>
<td>11,608</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>91,899</td>
<td>0</td>
<td>91,899</td>
<td>74,654</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>230,046</td>
<td>0</td>
<td>230,046</td>
<td>238,161</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>17</td>
<td>0</td>
<td>17</td>
<td>344</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>54,693</td>
<td>0</td>
<td>54,693</td>
<td>50,588</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>320</td>
<td>(20)</td>
<td>340</td>
<td>97</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>1,456</td>
<td>56</td>
<td>1,400</td>
<td>1,399</td>
</tr>
<tr>
<td>Establishment</td>
<td>123</td>
<td>102</td>
<td>21</td>
<td>282</td>
</tr>
<tr>
<td>Transport</td>
<td>76</td>
<td>1</td>
<td>75</td>
<td>88</td>
</tr>
<tr>
<td>Premises</td>
<td>517</td>
<td>480</td>
<td>37</td>
<td>1,530</td>
</tr>
<tr>
<td>Impairments and reversals of receivables</td>
<td>(300)</td>
<td>0</td>
<td>(300)</td>
<td>300</td>
</tr>
<tr>
<td>Impairments and reversals of property, plant and equipment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Audit fees</td>
<td>114</td>
<td>114</td>
<td>0</td>
<td>116</td>
</tr>
<tr>
<td>Other non statutory audit expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Internal audit services</td>
<td>25</td>
<td>25</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>- Other services</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>41,326</td>
<td>0</td>
<td>41,326</td>
<td>41,708</td>
</tr>
<tr>
<td>General Practice Medical Services (GPMS) / Alternative Provider Medical Services (APMS)</td>
<td>2,428</td>
<td>0</td>
<td>2,428</td>
<td>1,351</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>160</td>
<td>160</td>
<td>0</td>
<td>47</td>
</tr>
<tr>
<td>Education and training</td>
<td>238</td>
<td>198</td>
<td>40</td>
<td>374</td>
</tr>
<tr>
<td>Provisions</td>
<td>112</td>
<td>60</td>
<td>52</td>
<td>500</td>
</tr>
<tr>
<td>CHC Risk Pool Contributions</td>
<td>596</td>
<td>0</td>
<td>596</td>
<td>0</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total other costs</td>
<td>435,238</td>
<td>5,779</td>
<td>429,459</td>
<td>423,185</td>
</tr>
<tr>
<td>Total operating expenses</td>
<td>439,526</td>
<td>8,858</td>
<td>430,668</td>
<td>426,954</td>
</tr>
</tbody>
</table>

Prior Year comparators have been restated for the following areas due to changes in how certain areas of expenditure has been mapped in the financial statements:

- Services from other CCGs and NHS England
- Services from other NHS bodies
- Purchase of healthcare from non-NHS bodies
- Prescribing costs
- General Practice Medical Services (GPMS) / Alternative Provider Medical Services (APMS)

Expenditure has increased in ‘Services from foundation trusts’ primarily as a result of the following reasons:

- Shift in the ophthalmology contract from an Croydon Health Services NHS Trust to Moorfields NHS Foundation Trust
- Acquisition of services by Kings College NHS Foundation from South London Healthcare NHS Trust which was dissolved in 2013/14.
- NHs Trusts which have received Foundation Trust Status: Royal Free, Kingston, St Georges (From 01/02/2015)

Expenditure has increased in ‘GPMS/APMS’ services primarily as a result of additional funding to support older people in line with NHS planning guidance.
6.1 Better Payment Practice Code

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-NHS Payables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>11,385</td>
<td>60,004</td>
<td>9,081</td>
<td>47,919</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>10,392</td>
<td>53,591</td>
<td>8,212</td>
<td>40,970</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>91.3%</td>
<td>89.3%</td>
<td>90.4%</td>
<td>85.5%</td>
</tr>
<tr>
<td>NHS Payables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>3,402</td>
<td>331,958</td>
<td>2,463</td>
<td>316,067</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>2,702</td>
<td>330,000</td>
<td>2,143</td>
<td>313,727</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>79.4%</td>
<td>99.4%</td>
<td>87.0%</td>
<td>99.3%</td>
</tr>
</tbody>
</table>

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

The CCG has taken action with the aim of improving performance against this target.

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

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amounts included in finance costs from claims made under this legislation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Compensation paid to cover debt recovery costs under this legislation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

7 Income Generation Activities

The CCG charges rent for office accommodation costs to South London Commissioning Support Unit for staff that are based locally with the CCG.
8. Operating Leases

8.1 As lessee

The CCG occupies property owned and managed by NHS Property Services Ltd. For 2014-15, an occupancy rent based on annual property cost allocations was agreed. This is reflected in Note 8.1.1.

8.1.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Land</td>
<td>0</td>
<td>432</td>
</tr>
<tr>
<td>Buildings</td>
<td>432</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>432</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>432</strong></td>
<td><strong>1,448</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,448</strong></td>
<td></td>
</tr>
</tbody>
</table>

8.1.2 Future minimum lease payments

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Payable:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No later than one year</td>
<td>0</td>
<td>244</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>0</td>
<td>610</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>0</strong></td>
<td><strong>854</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>854</strong></td>
<td><strong>1,035</strong></td>
</tr>
</tbody>
</table>
9 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>NHS receivables: Revenue</td>
<td>508</td>
<td>0</td>
<td>551</td>
<td>0</td>
</tr>
<tr>
<td>NHS prepayments and accrued income</td>
<td>2,539</td>
<td>0</td>
<td>3,903</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS receivables: Revenue</td>
<td>196</td>
<td>0</td>
<td>1,938</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS prepayments and accrued income</td>
<td>218</td>
<td>0</td>
<td>1,361</td>
<td>0</td>
</tr>
<tr>
<td>Provision for the impairment of receivables</td>
<td>0</td>
<td>0</td>
<td>(300)</td>
<td>0</td>
</tr>
<tr>
<td>VAT</td>
<td>14</td>
<td>0</td>
<td>47</td>
<td>0</td>
</tr>
<tr>
<td>Other receivables</td>
<td>(3)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Trade &amp; other receivables</td>
<td>3,472</td>
<td>0</td>
<td>7,500</td>
<td>0</td>
</tr>
</tbody>
</table>

The great majority of trade is with NHS organisations and the London Borough of Croydon. As NHS organisations and the London Borough of Croydon are funded by Government no credit scoring of them is considered necessary.

Concentration of credit risk is limited due to the fact that the customer base is large and composed of unrelated/government bodies. Due to this, the Governing Body believes that there is no future credit risk provision required in excess of the normal provision for doubtful receivables.

9.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>By up to three months</td>
<td>688</td>
<td>2,119</td>
</tr>
<tr>
<td>By three to six months</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>By more than six months</td>
<td>2</td>
<td>370</td>
</tr>
<tr>
<td>Total</td>
<td>697</td>
<td>2,489</td>
</tr>
</tbody>
</table>

£181,919 of the amount above has subsequently been recovered post the statement of financial position date.

The CCG did not hold any collateral against receivables outstanding at 31 March 2015.

9.2 Provision for impairment of receivables

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Balance at 1 April 2014</td>
<td>(300)</td>
<td>0</td>
</tr>
<tr>
<td>Amounts recovered during the year</td>
<td>300</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>(300)</td>
</tr>
</tbody>
</table>

The prior year impairment related to receivables for recharges of costs that did not relate to CCG functions. These amounts were subsequently recovered during the 2014/15 financial year.

The CCG has reviewed the level of credit risk overall and no provision is required for doubtful receivables.
### Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Balance at 1 April 2014</td>
<td>151</td>
<td>0</td>
</tr>
<tr>
<td>Net change in year</td>
<td>(89)</td>
<td>151</td>
</tr>
<tr>
<td>Balance at 31 March 2015</td>
<td>62</td>
<td>151</td>
</tr>
</tbody>
</table>

Made up of:

- **Cash with the Government Banking Service**
  - 62
  - 151

- **Cash and cash equivalents as in statement of financial position**
  - 62
  - 151

**Balance at 31 March 2015**
- 62
- 151

No patients’ money is held by the CCG.
11 Analysis of impairments and reversals

11.1 Analysis of impairments and reversals: property, plant and equipment

<table>
<thead>
<tr>
<th>Impairments and reversals charged to the statement of comprehensive net expenditure</th>
<th>2014-15 £000</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over-specification of assets</td>
<td>0</td>
<td>(16)</td>
</tr>
<tr>
<td>Total charged to departmental expenditure limit</td>
<td>0</td>
<td>(16)</td>
</tr>
</tbody>
</table>

Furniture and Fittings at Leon House with a value of £16k were transferred from Croydon PCT. On vacating the premises in June 2013, these items were written off in 2013/14.
### 12 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 2014-15 £000</th>
<th>Non-current 2014-15 £000</th>
<th>Current 2013-14 £000</th>
<th>Non-current 2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td>8,581</td>
<td>0</td>
<td>7,384</td>
<td>0</td>
</tr>
<tr>
<td>NHS accruals and deferred income</td>
<td>6,756</td>
<td>0</td>
<td>8,320</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS payables: revenue</td>
<td>4,855</td>
<td>0</td>
<td>4,140</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS accruals and deferred income</td>
<td>21,134</td>
<td>0</td>
<td>17,912</td>
<td>0</td>
</tr>
<tr>
<td>Social security costs</td>
<td>38</td>
<td>0</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>Tax</td>
<td>41</td>
<td>0</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Other payables</td>
<td>290</td>
<td>0</td>
<td>165</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Trade &amp; Other Payables</strong></td>
<td><strong>41,695</strong></td>
<td><strong>0</strong></td>
<td><strong>37,980</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Total current and non-current</strong></td>
<td><strong>41,695</strong></td>
<td><strong>0</strong></td>
<td><strong>37,980</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

There are no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £44k (2013/14, £56k) of outstanding pension contributions at 31 March 2015. These contributions were paid over to the NHS Pensions Agency in April 2015.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Redundancy</td>
<td>112</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>500</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>112</strong></td>
<td><strong>0</strong></td>
<td><strong>500</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Total current and non-current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Pensions Relating to Former Directors £000s</th>
<th>Pensions Relating to Other Staff £000s</th>
<th>Restructuring £000s</th>
<th>Redundancy £000s</th>
<th>Other £000s</th>
<th><strong>Total £000s</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2014</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>500</td>
<td>500</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>112</td>
<td>0</td>
<td>112</td>
</tr>
<tr>
<td>Utilised during the year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(500)</td>
<td>(500)</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2015</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>112</strong></td>
<td><strong>0</strong></td>
<td><strong>112</strong></td>
</tr>
</tbody>
</table>

**Expected timing of cash flows:**

<table>
<thead>
<tr>
<th></th>
<th>Within one year</th>
<th><strong>Balance at 31 March 2015</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Expected timing of cash flows:</strong></td>
<td><strong>Within one year</strong></td>
<td><strong>Balance at 31 March 2015</strong></td>
</tr>
</tbody>
</table>

£Nil is included in the provisions of the NHS Litigation Authority as at 31 March 2015 in respect of clinical negligence liabilities of the CCG.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2015 is £4,265k.
14 Contingencies

The CCG does not have any Contingent Liabilities or Contingent Assets.
15 Commitments

The CCG does not have any Capital Commitments.

16 Financial instruments

16.1 Financial risk management

16.1.1 Currency risk

16.1.2 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.

16.1.3 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.

16.1.4 Liquidity risk

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

17.2 Financial assets

<table>
<thead>
<tr>
<th>Loans and Receivables</th>
<th>Available for Sale</th>
<th>Total 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>508</td>
<td>0</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>196</td>
<td>0</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>62</td>
<td>0</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>(3)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2015</strong></td>
<td>763</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Loans and Receivables</th>
<th>Available for Sale</th>
<th>Total 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>551</td>
<td>0</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>1,938</td>
<td>0</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>151</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td>2,640</td>
<td>0</td>
</tr>
</tbody>
</table>

17.3 Financial liabilities

<table>
<thead>
<tr>
<th>Financial Liabilities</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014-15</td>
</tr>
<tr>
<td></td>
<td>£000</td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>15,337</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>26,280</td>
</tr>
<tr>
<td><strong>Total at 31 March 2015</strong></td>
<td>41,617</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payables:</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013-14</td>
</tr>
<tr>
<td></td>
<td>£000</td>
</tr>
<tr>
<td>· NHS</td>
<td>15,704</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>22,052</td>
</tr>
<tr>
<td><strong>Total at 31 March 2015</strong></td>
<td>37,756</td>
</tr>
</tbody>
</table>
18 Operating segments

The CCG has only one segment: commissioning of healthcare services.
19 Pooled budgets

The CCG was not party to any pooled budget arrangements during 2014-15. For 2015/16, the CCG has entered into a S75 agreement with the London Borough of Croydon on the Better Care Fund (BCF). The CCG will host the BCF under a pooled budget ‘jointly controlled operation’ arrangement.

### 20 Intra-government and other balances

<table>
<thead>
<tr>
<th></th>
<th>Current Receivables</th>
<th>Non-current Receivables</th>
<th>Current Payables</th>
<th>Non-current Payables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balances with:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Central Government bodies</td>
<td>14</td>
<td>0</td>
<td>274</td>
<td>0</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>167</td>
<td>0</td>
<td>954</td>
<td>0</td>
</tr>
<tr>
<td>Balances with NHS bodies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS bodies outside the Departmental Group</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS Trusts and Foundation Trusts</td>
<td>3,047</td>
<td>0</td>
<td>15,337</td>
<td>0</td>
</tr>
<tr>
<td>Total of balances with NHS bodies:</td>
<td>3,047</td>
<td>0</td>
<td>15,337</td>
<td>0</td>
</tr>
<tr>
<td>Public corporations and trading funds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bodies external to Government</td>
<td>244</td>
<td>0</td>
<td>25,130</td>
<td>0</td>
</tr>
<tr>
<td>Total balances at 31 March 2015</td>
<td>3,472</td>
<td>0</td>
<td>41,695</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Current Receivables</th>
<th>Non-current Receivables</th>
<th>Current Payables</th>
<th>Non-current Payables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013-14 (£000)</td>
<td>2013-14 (£000)</td>
<td>2013-14 (£000)</td>
<td>2013-14 (£000)</td>
</tr>
<tr>
<td>Balances with:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Central Government bodies</td>
<td>47</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>1,938</td>
<td>0</td>
<td>156</td>
<td>0</td>
</tr>
<tr>
<td>Balances with NHS bodies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS bodies outside the Departmental Group</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS Trusts and Foundation Trusts</td>
<td>4,454</td>
<td>0</td>
<td>15,704</td>
<td>0</td>
</tr>
<tr>
<td>Total of balances with NHS bodies:</td>
<td>4,454</td>
<td>0</td>
<td>15,704</td>
<td>0</td>
</tr>
<tr>
<td>Public corporations and trading funds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bodies external to Government</td>
<td>1,061</td>
<td>0</td>
<td>22,080</td>
<td>0</td>
</tr>
<tr>
<td>Total balances at 31 March 2014</td>
<td>7,500</td>
<td>0</td>
<td>37,880</td>
<td>0</td>
</tr>
</tbody>
</table>
## 21 Related party transactions

Details of transactions with parties related to individual Governing Body members are outlined below. These represent payments for services provided by the related party to the CCG.

<table>
<thead>
<tr>
<th>Related Party</th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queenhill Medical Practice - Dr Anthony Brzezicki*</td>
<td>31</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Parchmore Partnership - Dr Agnelo Fernandes*</td>
<td>26</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Haling Park Medical Practice - Dr Agnelo Fernandes*</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Eversley Medical Centre - Dr John Chan*</td>
<td>38</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ke斯顿 House &amp; Purley Medical Practice - Dr Atif Hasan*</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>National Society for Epilepsy - Helen Pernelet**</td>
<td>176</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Shirley Medical Practice - Dr Bobby Abbott**</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Stovell House Surgery - Dr Kamran Khan*</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Woodside Group Practice - Dr Rajeev Sagar*</td>
<td>12</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The Moorings Practice - Dr Farnham Sami*</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>283</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Represents payments to GP Practices for Primary Care Services to support out of hospital care (Local Enhanced Services, Anticoagulation Clinics, medical care for intermediate care beds). These payments are made to the majority of all Croydon GP practices.

** Represents payments to the National Society of Epilepsy for patient care. Helen Pernelet is the Chair of the Board of Governors of the Society, however, she has no controlling interest, enhanced voting rights, executive functions or executive responsibilities.

In addition to the specific payments above, the following payment was also made:

<table>
<thead>
<tr>
<th>Related Party</th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communitas (formerly known as Croydon PBC Ltd) of which the following GPs were shareholders: Dr A Brzezicki</td>
<td>629</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dr John Chan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr John Linney</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Bobby Abbott</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Kamran Khan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Farnham Sami</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Department of Health is regarded as a related party. During the year Croydon CCG has had a significant number of material transactions for the provision of healthcare with entities for which the Department is regarded as the parent Department. Including:

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

<table>
<thead>
<tr>
<th>Related Party</th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon Health Services NHS Trust</td>
<td>177,225</td>
<td>54</td>
<td>2,745</td>
<td>2,107</td>
</tr>
<tr>
<td>South London and Maudsley NHS Foundation Trust</td>
<td>41,111</td>
<td>-</td>
<td>2,672</td>
<td>-</td>
</tr>
</tbody>
</table>

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Croydon Council.
Croydon CCG - Annual Accounts 2014-15

22 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the clinical commissioning group.

23 Losses and special payments

23.1 Losses

Croydon CCG has not had any losses in 2014-15.

23.2 Special payments

<table>
<thead>
<tr>
<th>Compensation payments</th>
<th>Total Number of Cases 2014-15</th>
<th>Total Value of Cases 2014-15 £'000</th>
<th>Total Number of Cases 2013-14</th>
<th>Total Value of Cases 2013-14 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation payments</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
24 Financial performance targets

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

### Financial performance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income (in year)</td>
<td>424,816</td>
<td>439,526</td>
<td>(14,710)</td>
<td>408,726</td>
<td>426,955</td>
<td>(18,229)</td>
</tr>
<tr>
<td>Expenditure not to exceed income (cumulative)</td>
<td>406,587</td>
<td>439,526</td>
<td>(32,939)</td>
<td>408,726</td>
<td>426,955</td>
<td>(18,229)</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>404,882</td>
<td>437,921</td>
<td>(32,939)</td>
<td>406,860</td>
<td>425,089</td>
<td>(18,229)</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>9,115</td>
<td>8,149</td>
<td>966</td>
<td>9,110</td>
<td>7,349</td>
<td>1,761</td>
</tr>
</tbody>
</table>

The excess of expenditure above the revenue resource limit has occurred in the following context:

- NHS England agreed a cumulative control total, or financial target, of £35.2m deficit for 2014/15 financial year. The CCG is reporting an improvement on that planned position of £32.9m cumulative deficit. The in year target was a £17.0m deficit against which the CCG is reporting an improvement on that position of £14.7m.

- The CCG successfully delivered in 2014/15 £11.0m (2013/14, £14m) efficiency savings following a clinically-led service redesign approach that targets quality, innovation, productivity and prevention as the key levers for improving financial performance.

- NHS England has confirmed that based on the 2014/15 allocations, the CCG is underfunded by 8.5% (£38.0m) when based on the relative need of the population. The 2015/16 allocation has moved the CCG closer to target (6.87% below target) with further commitment to move to 5% below target in 2016/17.

- The CCG Directions 2013 were issued by the Secretary of State for Health and contain the following two restrictions: (i) NHS England will oversee and supervise the development of the CCG’s clear and credible integrated plan, to include, but not limited to, the CCG’s financial modelling and implementation plans, and (ii) NHS England will oversee and supervise the development of the CCG’s project management capacity and governance structures for the purpose of delivering QIPP savings and efficiency plans.

It should be noted that a report to the Secretary of State for Health under Section 19 of the Audit Commission Act 1998 was issued by the external auditors on 23 April 2014 for the breach of financial duties.