ANNUAL REPORT AND ACCOUNTS
2015/16
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SECTION 1: PERFORMANCE REPORT
Overview

Welcome

Welcome to NHS Croydon Clinical Commissioning Group’s Annual Report for 2015/16. This has been our third year in operation and in that time we have made great progress, working with our partners and providers, towards our vision of longer healthier lives for everyone in Croydon.

This report looks back at our key achievements this year as well as looking forward to the challenges we must continue to address in the years ahead.

The health needs of our unique population in Croydon continue to evolve. The population is growing and becoming more diverse. People are living longer, and an increasing number of younger people are moving into the borough. We need to make sure we commission the highest possible quality services to best meet our population’s changing health needs within our available resources.

We are developing and delivering ambitious plans to improve the efficiency, effectiveness and sustainability of health services we commission. Together with Croydon Council we are making great strides in our Outcomes Based Commissioning (OBC) programme of work, transforming the way services for patients over 65 years old will be provided in Croydon by putting the things that matter most to them and their families at the heart of service provision.

Over the last two years we have invested £8.8 million in improving access to mental health services, including launching a new 24 hour Mental Health Crisis Line for the public, patients and carers this year.

Acting with our main providers, access and waiting times to hospital and community services have improved so that people are seen and treated more quickly.

We have also further strengthened clinical leadership across the organisation by encouraging more GPs to take leadership roles within the CCG and regional health and care programmes. Continuing to enhance our clinical leadership over the coming years remains one of our top priorities, as the clinical perspective from our GPs and other clinicians is crucial to the transformative changes we wish to continue to implement in Croydon, and to making sure the services we commission are of the highest standard.

We are pleased to have exceeded our financial targets for 2015/16 delivering an additional £1.1 million against our plan. This is a positive step in addressing the significant financial shortfall that we inherited when we were established in 2013, and is a significant achievement given the challenging financial environment facing all NHS organisations in the country. Our journey to achieve financial balance continues to be central to our challenges.
We are proud of our achievements this year and since our inception in 2013. I would like to thank all of our dedicated staff and local partners in health and social care who have worked with us during the year. We could not have achieved so much without your commitment and support.

Most importantly, throughout all our work, we remain focused on the health and wellbeing outcomes we want for the people of Croydon.

Dr Anthony Erzezicki
Chairman
24 May 2016

Paula Swann
Accountable Officer
24 May 2016
Who we are and what we do

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.

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

We are a clinically-led membership organisation bringing together all 57 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.

GP practices in Croydon
Health and wellbeing of our population

We serve a population of over 398,000. Croydon’s population is growing by about one percent per year.

Nationally, the population is ageing as life expectancy increases and the baby boomer generation approaches older age. Compared to other areas, however, 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.

Key health facts for Croydon at a glance

- 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.

- Circulatory diseases, cancers and respiratory diseases remain the cause of the majority of excess deaths which contribute to the gap in life expectancy.

- Deprivation in the borough is lower than average, however there is significant variation between wards. In Fieldway, nearly half of children live in poverty, whereas in some wards in the south of the borough, only 1 in 10 children live in poverty.

- Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have also fallen.

- An estimated 17.0% of adults smoke.

- There were 254.4 deaths per 100,000 attributable to smoking in 2012-14, which equated to 1,173 deaths

- One in four children aged four to five years are overweight or obese, and one in three children aged ten to eleven years are overweight or obese.

- An estimated 62% of adults are overweight or obese.

- There were 4,912 admissions for alcohol related conditions in 2014/15

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

- Croydon is in the 25% worst performing areas for new cases of tuberculosis and significantly worse than the England average.
How we spend your money

In 2015/16, we had a budget of £464.3 million to spend on health services for Croydon. This was £437.8 million in 2014/15. The pie chart below shows how this was spent on different elements of healthcare.

Who we commission services from

The services we buy include hospital, community, mental health services and some primary care services.

Our main local providers of healthcare include:

- Croydon Health Services NHS Trust
- St George’s University Hospitals NHS Foundation Trust
- Kings College Hospital
- The Royal Marsden NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- Care UK
- Virgin Care.
Risks and challenges for our organisation

Health Challenges

Health and social care face a number of challenges. 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 need in Croydon. Over half of Croydon’s population is from Black, Asian and minority ethnic groups, and the proportion is increasing over time.

Croydon has an estimated 2,000 net immigrants from outside the UK each year (an inflow of around 4,000 offset by an outflow of around 2,000). This is partly as a result of the presence of the Home Office within Croydon, which attracts new migrants upon their entry into the UK adding a strain to the whole local health economy as many of these new immigrants will not be registered with a local GP, and therefore may be more likely to attend hospital in the first instance. Over time, Croydon is becoming more similar to Inner London as a result of net migration of people from Inner London into Croydon, and from Croydon to South Eastern England.

In recent years outer London has become more deprived and inner London more affluent when compared with England as a whole. Between 2004 and 2010, levels of deprivation increased in Croydon more than in any other borough in the south of London. In 2010, Croydon was the 19th most deprived borough in London. If Croydon continues to grow more deprived at the same rate as recent years, by 2020 it will be the 12th most deprived borough in London.

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 against the context of a significant financial challenge as a result of an imbalance between our resources and our population needs.

By analysing our local population’s developing needs we anticipate a number of health and social care challenges for service needs. We have therefore developed these priority outcomes in order to deliver the best possible health services for the people of Croydon are:

- Reducing potential years of life lost through preventable 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

Finance and efficiency

When Croydon CCG was established in April 2013, we inherited from our predecessor organisation, Croydon Primary Care Trust, a significant recurrent financial short-fall between the resources we had allocated to us and our population’s health needs.
This amounts to a £33.9 million recurrent deficit.

The CCG has successfully delivered our Quality, Innovation, Productivity and Prevention (QIPP) programmes over the past three years:

- £14 million for 2013/14
- £11 million for 2014/15
- And £10.5 million for 2015/16

This was over and above the QIPP achieved in the final two years of the PCT of £38.2 million.

The CCG reports an end of year position of £10.8 million (£43.7 million cumulative) deficit which is an improvement on the original financial plan of £11.9 million (£44.8 million cumulative) deficit for 2015/16 submitted to NHS England. Within this position, activity levels were significantly above contractual plans for acute hospital services. In particular, emergency admissions and outpatient attendances at Croydon Health Services and Adult Continuing Health Care.

There remains a £53.8 million gap in funding over the next five years for the CCG. However the CCG has identified a potential further £17 million savings over that five year period. This should be considered in the context of the pressures facing our local providers and the Council, who also face significant financial challenges.

**Managing risk**

The CCG assesses our key risks and uncertainties throughout the year using the Board Assurance Framework. The Board Assurance Framework sets out the principal risks to delivering our strategic objectives and how these risks are managed.

There is an established method to identify, monitor, control and mitigate risks throughout the organisation as part of and within the CCG’s Risk Management Strategy and Assurance Framework.

The Board Assurance Framework is presented to the Integrated Governance and Audit Committee at every meeting and quarterly to the Governing Body, so members can review the risks and mitigations and receive assurances that the risks are being managed. Further details on risk are included in the governance statement.

**Explanation of going concern basis**

The CCG’s financial statements have been prepared on a “going concern basis” despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act for the breach of financial duties. 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 NHS England for 2016/17 and 2017/18.

• 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 (January 2016) from 2016/17 to 2020/21 (5 years in total.)

• The CCG has submitted detailed financial plans to the Governing Body and to NHS England for 2016/17, with further iterations to follow.

• The CCG has submitted a draft Financial Improvement Plan to NHS England for the period from 2016/17 – 2020/21.
Our achievements this year

Key areas of focus during 2015/16
At the beginning of the year we set our selves key areas of focus for 2015/16, to deliver our ambitious and transformative strategy. These were:

- Prevention, self-care, shared decision making
- Improving access to mental health services
- Older people - Outcomes based commissioning
- Urgent and emergency care system resilience
- Transforming primary care

Our Objectives for 2015/16 are:

- To develop as a mature membership organisation
- To commission integrated, safe, high quality service in the right place at the right time
- To develop collaborative relationships to ensure an integrated approach
- To achieve financial balance

Improving quality and safety
We undertook a number of initiatives to improve the quality of services focussing on patient groups within our population with specific health needs. Here are some examples of our work:

- Female Genital Mutilation

Preventing female genital mutilation (FGM) and supporting victims is a national priority. In Croydon, there are estimated to be 3,480 females who have been affected by FGM at some point in their lives, which is equivalent to 1 in 104 females. Women who have undergone FGM are more likely to have complications during childbirth and damage to their reproductive system, as well other serious short and long term physical and psychological problems.

Croydon CCG has worked with partners to implement the FGM project which has received recognition from NHS England as an example of good practice. The Home Office, Department of Health, Metropolitan Police FGM Unit ‘Project Azure’ and the Prime Minister’s Delivery/Implementation Unit have all sought guidance and learning from the project.

Highlights of our work this year include launching a multi-agency risk assessment tool to identify and guide appropriate referrals and an FGM conference attended by over 100 professionals from health, the local authority and voluntary sector.
• Improving care for patients with epilepsy

We have launched a new nurse-led intermediary service, delivering a person-centred support service directly to people with epilepsy, to improve their health outcomes. By February 2016, all people with epilepsy seen in the community epilepsy nurse clinic should have a care plan in place and have discussed their safety, and 60% of women of child bearing age discussed pregnancy. 100% of patients using the service said they were either ‘extremely likely’ or ‘likely’ to recommend the service.

• Improving follow-up care for prostate cancer patients

Croydon CCG worked in partnership with Prostate Cancer UK and the NHS England Transforming Cancer Services Team to pilot an enhanced primary care-led prostate cancer follow-up service.

The aim of the pilot was to develop and test a holistic follow-up service that caters to the physical and emotional well-being of patients, and to move the focus from hospital to primary care. The services delivers test results closer to home, and ensures that with the right information, patients are fully supported toward self-management.

For more information on the Croydon model for enhanced primary care led prostate cancer follow-up service please visit https://www.myhealth.london.nhs.uk/healthy-london/cancer/resources

Working in partnership to transform the way we deliver care

Croydon health and social care have a good record of working in partnership to improve health and well-being and to transform local health and care services.

Together for health

Together for health is a new programme which aims to improve patients’ outcomes and experience by empowering them to protect and promote their own health and that of their families, so that they improve their health and wellbeing and rely less on healthcare provision. It also promotes shared decision-making with healthcare professionals, so that patients feel more in control of their treatment and care.

During 2015/16:

• Public information campaigns like self-care week in November 2015 and the Ask Three Questions campaign, which encourages patient-focused shared decision making.

• Speciality-specific prevention, self-care and shared decision making approaches developed for musculoskeletal care, respiratory care and urgent care.

• We recruited a Darzi Fellow to lead engagement and education among the clinical community in Croydon.
For 2016/17 we want to implement our plans at greater pace, our focus includes:

- Implementing training programme across Croydon practices to support clinician behaviours and delivery of shared decision consultations
- Enshrining the practical principles of PSSSD in acute and community through monitored KPIs.
- Working in partnership with Public Health weight management services to develop CCG tier 3 Weight Management capabilities incorporating PSSSD interventions.

**Transforming adult community services**

Our Transformation Board leads our work to develop and implement some of our transformational plans such as Transforming Adult Community Services. During the year we:

- Expanded the Rapid Response service, providing support to people at home (including care/nursing homes) within two hours to reduce the likelihood of admission to hospital
- Implemented a joint Consultant Geriatrician, GPs and nursing ward rounds to support improved care in nursing homes
- Implemented a GP Roving Service pilot to provide greater access to rapid medical care within the community
- Increased intermediate care beds and step up facilities to reduce pressure on hospital services and ensure patients are cared for in a more appropriate setting.

**Transforming mental health**

Over the last two years the CCG has invested £8.8 million in mental health services, so that we now provide more mental health services for our local population.

- **Improving access to psychological therapies (IAPT)**

  During 2015/16 we expanded and developed the Croydon IAPT Psychological Therapies and Wellbeing Service, based on service user and stakeholder feedback, to ensure we have a service that achieves national standards and works for the Croydon community.

  Achievements include:

  - increasing capacity: In 2015/16 4583 people entered the service compared with 2594 in 2014/15. This is an increase of 77%.
  - more treatment options including online therapy, workshops and groups
• expanding mental health support for people with long term physical health conditions for example chronic pain, chronic fatigue, diabetes, HIV, and renal disease

Other improvements to mental health services made during 2015/16 include:

• developing post diagnosis support services for patients with dementia, in partnership with the Alzheimer’s Society

• Development of a 24 hour Mental Health Crisis Line open to the public, carers, and professionals which was launched on 18 December 2015. The total number of calls received between 18 December 2015 – 31 March 2016 was 1544

• developing an Early Detection in Psychosis service to identify and work with young people aged 18-35 years at risk of developing psychosis

• improving the pathway for patients with Attention Deficit Hyperactivity Disorder and Autistic Spectrum Disorder, which will be fully implemented from April 2016

• Commissioning more capacity within Liaison Psychiatry services for people presenting at A&E in times of crisis. The additional Night Psychiatry Liaison Nurse doubled the capacity to see, assess and discharge patients between 9pm and 8:15am each night and on average had the capacity to see 12% to 25% of the total number of patients each day of the month in the Emergency Department.

Child and adolescent mental health services (CAMHS)

The CCG and NHS England have invested an additional £1.1m in CAMHS in Croydon, providing more mental health services for children and young people

During 15/16 we have:

• Successfully recruited more specialist CAMHS staff to ensure improved access

• Vastly reduced CAMHS average waiting time for routine appointments over the last year, from an average of 104 weeks to 24 weeks. It continues to see children and young people in crisis within 48 hours

• Expanded our Crisis Care capacity to ensure that young people in A&E are assessed and followed up in a timely way

• Expanded the capacity of open access counselling services to see more young people in flexible, weekend and evening appointments

• Commissioned an online counselling platform from Off the Record, in response to the consultation with young people

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Our strategy going forward

During 2015/16 we refreshed our long term organisational strategy to ensure that it reflects national priorities such as the NHS Five Year Forward View as well as our own local priorities.

Following a wide engagement process we reconfirmed our vision and developed organisational values. We have also revised our objectives for 2016/17 and we will finalise the outcomes during the early part of 2016/17.

Outcomes Based Commissioning

The national Five Year Forward View sets out the need for local health communities to consider radical new care delivery. Croydon CCG and Croydon Council have been working towards an exciting and innovative approach that incentivises providers based on their achievement of a set of outcomes. Outcomes Based Commissioning aims to significantly improve health and wellbeing outcomes for the over 65s, as well as driving efficiency and promoting the integration of health and social care services. We will commission a 10-year contract for managing and delivering services for over 65s that are high quality, cost effective, integrated and focused on the achievement of outcomes. The new contract will begin in October 2016.

The outcomes we are commissioning for are:

- staying healthy, active and independent for as long as possible
- getting access to the best quality care so people can live how they choose
- having support from professionals with specialist knowledge to understand how health and social care affects individuals
- getting more care and support tailored to individuals’ needs
- being supported to manage long term conditions
Transforming Urgent Care

NHS England has made a commitment to developing a coherent urgent care service 24 hours a day, seven days a week in every area of England. In Croydon we will aim to deliver better integration through:

- Improved communications within and between service providers
- Improved coordination of services
- Reduced duplication of services and activities

Over the last year we have made significant progress in improving urgent care services and reducing attendances there is further to go. We now want to redesign the system to create lasting conditions for success, improve self-care and move services and appropriate activity out of hospital whilst improving access and experience through an outcome based model of care. The vision is to ensure the right care is delivered at the right place, first time.

A detailed System Resilience plan has been in place during 2015/16 with the following highlights:

- Commissioned the 'Edgecome Unit' at the local acute provider to provide rapid access to specialist hospital treatment
- Consultant geriatricians in A&E to support early review of the frail and elderly
- Recruitment of an additional consultant
- Therapy and OT assessments now in place over the weekend to support safe discharge

The focus for 2016/17 will be to:

- Continue implementation of the System Resilience plan with a priority focus on effective and timely discharge in order to alleviate urgent care pressures and ensure the best possible care for patients
- The Croydon integrated urgent care model will be procured during 16/17 with an implementation date of 01/04/17.

Cancer

Croydon CCG is continuing to develop cancer services in line with the London and National priorities. The CCG’s local strategy reflects the national strategic requirements to improve the percentage of one year survival rates across all cancers combined to 75% by 2020 and to move to a definitive diagnosis or all clear being given to the patient by day 28 of their pathway.

We have been working with Croydon Health Services on issues relating to delivery of pathways, which helped us improve performance against the national targets, particularly in relation to the 62 day standard where the local provider has exceeded the standard set for October to December 2016.

During 2015/16 we have:
• Introduced a programme of practice visits by the newly-appointed Macmillan GP and Cancer Research UK Health Professional Engagement Facilitator to engage primary care in promoting best practice and sharing of tools and information to reduce variation throughout primary care and promote early detection and diagnosis of cancer.
• Developed an Acute Oncology Service at CHS with benefits to patients with timely intervention and diagnostic testing
• Developed the Croydon Cancer Development and Implementation Group
• Piloted the Enhanced Prostate Follow-Up in Primary Care.

**Diabetes Prevention**

The National Diabetes Prevention Programme (NDPP) was set out in the Five Year Forward View as a key mechanism for reducing the prevalence of diabetes in the country and tackling the obesity crisis.

During 2015/16 we have:

• Begun a revised Local Incentive Scheme with more practices having signed up to than in the previous year
• Delivered a Diabetes Protected Learning Time session for our GPs and successfully run training and education sessions for primary care clinicians
• As part of a South London bid we will be in the first wave of the National Diabetes Prevention Programme with NHS England funding to implement our prevention strategy in 2016/17

**Developing our organisation, its leadership and innovation**

Leadership development is crucial to being able to deliver transformational change in financially challenged times. We have begun a significant organisational development programme to further develop our Governing Body, clinicians and managers.

The CCG has five strategic organisational development priorities:

• Recognition by the community as having its interests at heart
• An engaged and lively membership that believes it is part of the CCG and shapes its agenda
• A strong and shared leadership with longer term succession
• A commissioning organisation that builds on the experience and skills of staff, making the CCG a desirable place to work
• A strong and durable partnership with Croydon Council in forging a new shared commissioning agenda for outcomes.
Our organisational development plan focus for 2016/17

- Delivery of a leadership development programme for all staff across the CCG
- Design and delivery of a development programme to support joint working of clinical leads and commissioning managers to deliver on transformation
- Roll out of a new online appraisal approach
- Targeted development sessions for the senior leadership team and Governing Body to develop relationships and promote a collaborative approach to lead the organisation

For more information you can read the CCG’s Operating Plan 2016/17 at www.croydonccg.nhs.uk
Improving quality and performance

The CCG is required to commission health services that are safe, that maintain or improve quality and that offer information to inform patients’ choice on how, when and where they receive their health care services. We have a range of performance measures by which we judge whether we have delivered what we set out to do, as set out below.

We have a legal duty to work with our providers to ensure that continuous improvement is made against the national NHS Constitution standards. We have established weekly calls with providers to be assured and monitor progress. In addition, monthly System Resilience Group Meetings are held where the CCG monitors performance and reviews demand and capacity plans. The CCG Chief Officer leads fortnightly internal performance meetings.

We have effective quality assurance processes. The CCG holds Clinical Quality Review Committees (CQRG) with all its key providers, chaired by a clinician, where they monitor and seek assurance about the quality of services provided. The CCG’s Quality Committee receives assurance from these on behalf of the Governing Body.

CCG Assurance Framework

NHS England has a statutory duty to conduct performance assessments of each CCG. During the last financial year, this was carried out through the CCG Assurance Framework 2015/16, used to determine whether CCGs are meeting their statutory duties (the things they must do) and appropriately exercising their key statutory powers (the things they have the freedom to do).

These duties and powers link to the five components of the National NHS assurance framework, including:

- Well-led organisation
- Delegated functions
- Finance
- Performance
- Planning

In 2015/16 NHS England changed the assurance process from the previous year, replacing quarterly assurance meetings with a more continuous monitoring process. The CCG met with NHS England formally on two occasions, for a Quarter 1 Assurance Meeting and a Month 6 Stocktake.

Assessments were intended to be made for each component based upon a range of available evidence. The possible levels of assurance rating for each component and overall are as follows:

- Assured as outstanding
- Assured as good
- Limited assurance, requires improvement
- Not assured
The CCG’s overall, headline assessment for the financial year will be available later this year at www.croydonccg.nhs.uk

Performance against NHS Constitution standards and national performance indicators in 2015-16

Performance indicators help us to know where our local services are performing well and where they are not. This information is used to identify and spread good practice ideas, as well as to inform us where to focus our attention to improve the care our patients receive in partnership with our service providers.

We cannot judge performance on one single measure and therefore we look at a range of information using national and local performance data that helps us to compare the performance of similar health service providers.

Areas of good performance

- **Referral to Treatment Times (RTT)**

  Following the admitted and non-admitted RTT standards being abolished in June, Croydon CCG has continued to achieve the Incomplete RTT standard throughout 2015/16. The average performance for the year was 93.6% a marginal improvement on the annual performance of 2014/15, with 93.3%. This means that more of Croydon patients on an incomplete pathway had waited less than 18 weeks for treatment, against a National standard of 92%.

  CHS has also delivered the incomplete RTT standard for 2015/16 and expect to maintain this performance in 2016/17.

- **Diagnostic Test Waiting Times**

  The CCG’s performance against this target is largely determined by performance at CHS. The CCG has achieved this standard all year in 2015/16. This means that, for the year, 99.5% of Croydon patients referred for key diagnostic tests were able to access services in less than 6 weeks. This is an improvement on 2014/15 when the CCG achieved 94.3%. The national standard is 99.0%

Areas of improving performance

- **Cancer waiting time standards**

  Overall the CCG was compliance against most cancer standards for 2015/16: two week waits, 31 day and 62 day pathways. The only cancer waiting time standard not met as an average for the year was the 62 day standard for GP referrals to first treatment, with a performance of 82.2% against an 85.0% threshold.

  CHS has made considerable progress in 2015/16 by increasing the size of its cancer services and improving processes to reduce the time it takes for patients to be treated. See the table below for individual Cancer Waiting Time performance.
• **Dementia Diagnosis Rate**

From April 2015, this national metric looks at the number of people, over 65 years of age, with a dementia diagnosis. This is to help improve the detection and care provided to those people that have been diagnosed. Croydon CCG had been delivered 66.5% performance against the 66.7% national standard. The CCG has prioritised meeting the national standard in 2016/17.

• **Transforming Care for People with Learning Disabilities**

NHS England charges CCGs with ensuring that all people with Learning Disabilities (LD) in inpatient wards have personalised care plans and appropriate patients within inpatient settings are transitioned towards community based care.

All people receiving inpatient care for LD, commissioned by the CCG, have personalised care plans and new patients receive a Care and Treatment Review (CTR) within 6 weeks of being identified.

A number of patients have been discharged or have plans in place for discharge as of end of March. The CCG is carrying out a local review of LD case management provision, existing care settings and local provision of community resources for this cohort. The CCG is also engaging with the Strategic Transformation Programme (STP) for LD being led by Merton Clinical Commissioning Group in preparation for monitoring in 2016/17 across a wider geographical area of South London.

**Priorities for improvement**

• **A&E 4 hour wait standard**

Delivery of the A&E 4 hour wait target, 95%, was not achieved by Croydon CCG in 2015/16, with a projected performance for the year of 91.9% compared with 93.2% in 2014/15. This takes into account A&E waits for all of the CCG’s hospital providers.

Locally, the CCG agreed a non-compliant trajectory for A&E with CHS to allow recovery of poor performance at the end of the previous year and in recognition that the A&E department were moving to temporary accommodation within the hospital whilst the new Emergency Department was built. This building work is planned to conclude in April 2017.

CHS achieved 92.32% for 2015/16 compared with 93.78% in 2014/15.

Nationally, performance has been below the 95% standard as an average for 2015/16.

• **Healthcare Acquired Infections**

The CCG was assigned 4 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 59 cases of Clostridium Difficile as of February. This is slightly higher than in the previous year. Each case has been investigated fully and lessons are now being actioned. CHS continues to rigorously apply control measures with good outcomes.

- **Improving access to psychological therapies (IAPT)**

  Having achieved the local target last year with 6.9%, the CCG fell short of the national target of 15% in 2014/15. In 2015/16 the recovery trajectory set by the CCG was ambitious, increasing in each of the third and final quarters of the year, to a planned 3.75% in Q4, equating to a rate sufficient to deliver 15% annually, and compliant with the national quarterly target.

  Further work promoting IAPT to GPs, community groups and the public is necessary to improve utilisation of the service,
## Performance Summary for NHS Constitution and other National Standards

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E waits</td>
<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>94.5%</td>
<td>95.3%</td>
<td>93.7%</td>
<td>92.3%</td>
<td>93.81%</td>
<td>95%</td>
</tr>
<tr>
<td>Cat A Ambulance Calls</td>
<td>Category A calls resulting in an emergency response arriving within 8 minutes - Red 1</td>
<td>77.8%</td>
<td>77.4%</td>
<td>67.2%</td>
<td>68.1%</td>
<td>TBC</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Category A calls resulting in an emergency response arriving within 8 minutes - Red 2</td>
<td>76.3%</td>
<td>75.3%</td>
<td>59.7%</td>
<td>63.7%</td>
<td>TBC</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Category A calls resulting in an ambulance arriving at the scene within 19 minutes</td>
<td>98.2%</td>
<td>97.9%</td>
<td>92.0%</td>
<td>93.4%</td>
<td>TBC</td>
<td>95%</td>
</tr>
<tr>
<td>Referral To Treatment waiting times for non-urgent consultant-led treatment</td>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>90.7%</td>
<td>91.5%</td>
<td>89.4%</td>
<td>81.0%</td>
<td>-</td>
<td>N/A¹</td>
</tr>
<tr>
<td></td>
<td>Non-admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>97.2%</td>
<td>96.4%</td>
<td>95.4%</td>
<td>93.4%</td>
<td>-</td>
<td>N/A²</td>
</tr>
<tr>
<td></td>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral</td>
<td>90.7%</td>
<td>93.3%</td>
<td>94.2%</td>
<td>93.6%</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Diagnostic test waiting times</td>
<td>Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral</td>
<td>99.1%</td>
<td>96.8%</td>
<td>94.3%</td>
<td>99.5%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Mixed Sex Accommodation</td>
<td>Minimise breaches</td>
<td>-</td>
<td>32</td>
<td>4</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

¹ National standards discontinued in 2015/16  
² National standards discontinued in 2015/16
<table>
<thead>
<tr>
<th>Cancer waits - two-week wait</th>
<th>Actuals</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>95.8% 95.8% 95.6% 95.2%</td>
<td>93% 93%</td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td>96.2% 95.9% 97.8% 95.2%</td>
<td>93.2% 93%</td>
</tr>
<tr>
<td>Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers</td>
<td>98.2% 98.7% 98.0% 98.0%</td>
<td>96.7% 96%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer waits - 31 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer waits - 62 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment for cancer</td>
</tr>
<tr>
<td>Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
</tr>
<tr>
<td>Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Infections</td>
</tr>
<tr>
<td>Care Programme Approach (CPA)</td>
</tr>
<tr>
<td>Dementia*</td>
</tr>
<tr>
<td>IAPT</td>
</tr>
<tr>
<td>IAPT Waiting Times</td>
</tr>
<tr>
<td>IAPT Waiting Times</td>
</tr>
<tr>
<td>IAPT Waiting Times</td>
</tr>
<tr>
<td>Direct Commissioning Primary Care</td>
</tr>
<tr>
<td>Direct Commissioning Primary Care</td>
</tr>
<tr>
<td>Direct Commissioning Primary Care</td>
</tr>
</tbody>
</table>

* Dementia Diagnosis Rate calculated on patients over >65 years from April 2015
† Annual 2015/16 forecast position based upon year to date, February data
‡ Annual 2015/16 forecast position based upon Q3 year to date and provisional Q4 data
**Activity Measures**

The following activity measures are used for CCG and National planning purposes and represent activity occurring at acute hospitals, generated by Croydon registered patients.

Below is a comparison across 2014/15 and 2015/16 for key activity measures.

**Months 1-11 Activity Variances**

<table>
<thead>
<tr>
<th>Attendance/inpatient admissions (not number of individual patients)</th>
<th>2014/15</th>
<th>2015/16</th>
<th>% variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>First outpatient attendance</td>
<td>97,211</td>
<td>110,638</td>
<td>14%</td>
</tr>
<tr>
<td>Follow-up outpatient attendance</td>
<td>292,689</td>
<td>303,459</td>
<td>4%</td>
</tr>
<tr>
<td>Electives and Day cases</td>
<td>34,994</td>
<td>34,191</td>
<td>-2%</td>
</tr>
<tr>
<td>Non-Elective</td>
<td>41,784</td>
<td>42,143</td>
<td>1%</td>
</tr>
<tr>
<td>A&amp;E attendances</td>
<td>123,247</td>
<td>124,313</td>
<td>1%</td>
</tr>
</tbody>
</table>

**First outpatient attendances**

First outpatient activity presents the largest variance seen in 2015/16 compared to 2014/15. Despite growth being in the plans, increased activity was seen at all other Trusts with the greatest impact occurring at Croydon Health Services. Outpatient over-performance is mainly driven by attendances in the following areas: cardiology; gynaecology and paediatrics.

**Follow-up outpatient attendances**

In 2015/16, Croydon CCG introduced a number of out of hospital services which aimed to shift activity out of hospital to a more appropriate setting allowing for improved patient pathways with the correct resource allocation.

**Electives and day cases**

Electives including day cases have seen decreases across all Trusts over the year (2015/16). The main areas contributing to the reduction was in eye procedures which was the result of the service transferring to Moorfields Eye Hospital. This shifted the activity from day case to an outpatient procedure setting.

**Non-electives**

Non-electives have seen a 1% increase compared to last year. Increases in non-electives spells have been seen in paediatric services and gynaecology.
A&E Attendances
There has been a slight increase in A&E attendances in 2015/16 compared to 2014/15, however this has been fairly flat compared to the increases across London. Croydon offers a number of alternatives to A&E for patients including the Urgent Care Centre, Minor Injuries unit at the Purley and Parkway sites as well as the GP led walk-in health centre; these locations are easily accessible to patients and provide excellent alternatives to A&E where appropriate.

Better Care Fund (BCF) Performance Summary
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.

Croydon CCG and Croydon Council have continued to fund the provision of health and social services in 2015/16 that support reductions in:

- non-elective admissions
- permanent admissions of older people (65 and over) to residential and nursing care homes
- proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement/rehabilitation services
- delayed transfers of care (delayed days) from hospital per 100,000 population

The table below sets out the performance against the BCF metrics for the reporting period up to 30 December 2015 (month 10).

In summary, Croydon’s BCF performance is on an upward trajectory towards its ambitious performance targets, but performance is not yet meeting the required targets in all areas. A range of mitigating actions is in hand to bring performance to the required level.
## Better Care Fund Performance Summary

<table>
<thead>
<tr>
<th>REF</th>
<th>Indicator</th>
<th>2015/16 YTD Target</th>
<th>2015/16 (to date)</th>
<th>RAG rating and trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCF1</td>
<td>Total non-elective admissions in to hospital (general &amp; acute), all-age, per 100,000 population</td>
<td>36,914</td>
<td>38,067</td>
<td>R</td>
</tr>
<tr>
<td>BCF2</td>
<td>Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population</td>
<td>317.0 (end Jan 16)</td>
<td>302.6 (end Jan 16)</td>
<td>G</td>
</tr>
<tr>
<td>BCF3</td>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</td>
<td>88%</td>
<td>88.1% (Jan-Oct 15)</td>
<td>G</td>
</tr>
<tr>
<td>BCF4</td>
<td>Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)</td>
<td>145.7 (Dec 15)</td>
<td>214.6 (Dec 15)</td>
<td>R</td>
</tr>
<tr>
<td>BCF5</td>
<td>Local Performance Metric: % of discharges over the weekend for Croydon Healthcare Service.</td>
<td>20%</td>
<td>18% M9 YTD</td>
<td>R</td>
</tr>
<tr>
<td>BCF6</td>
<td>Patient/Service User Experience Metric Social Care related quality of life (ASCOF 1A)</td>
<td>19</td>
<td>18.4 (Mar 15)</td>
<td>R</td>
</tr>
</tbody>
</table>

To read more about the Better Care Fund go to [www.croydon.gov.uk](http://www.croydon.gov.uk)
Safety Thermometer
The NHS Safety Thermometer is the measurement tool for a programme of work to support patient safety improvement.

The NHS Safety Thermometer records the presence or absence of four harms:

- pressure ulcers
- falls
- urinary tract infections (UTIs) in patients with a catheter
- new venous thromboembolisms (VTEs)

These four harms were selected as the focus by the Department of Health’s QIPP Safe Care programme because they are common, and because there is a clinical consensus that they are largely preventable through appropriate patient care.

The table overleaf shows how Croydon Health Services NHS Trust (CHS) has performed in each of the 4 harms. The table also provides a benchmark in the final column which shows how CHS is performing nationally. The figures in brackets are percentages.

<table>
<thead>
<tr>
<th>Croydon Health Services RJ6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Safety Thermometer Category 2015/16</strong></td>
</tr>
<tr>
<td>Patient Sample Size</td>
</tr>
<tr>
<td>Total Falls (%)</td>
</tr>
<tr>
<td>Falls with Harm (%)</td>
</tr>
<tr>
<td>Pressure Ulcer Prevalence (%)</td>
</tr>
<tr>
<td>New Pressure Ulcers (%)</td>
</tr>
<tr>
<td>UTIs (%)</td>
</tr>
<tr>
<td>UTIs in patients with catheter (%)</td>
</tr>
<tr>
<td>Patients not VTE (%)</td>
</tr>
</tbody>
</table>
The above table demonstrates that when benchmarked against other trusts in the South London area, Croydon Health Services consistently delivers a higher level of ‘harm free’ care.

**Friends and Family Test**

The NHS friends and family test allows patients and staff the opportunity to provide feedback on the care and treatment they receive, which can be used to improve services. It was introduced in 2013 and asks patients whether they would recommend hospital wards, A&E departments and maternity services to their friends and family if they needed similar care or treatment giving hospitals a better understanding of the needs of their patients and enabling improvements.

When discharged, or within the 48 hours that follow, patients are asked to answer the following question:

“How likely are you to recommend our ward/A&E department/maternity service to friends and family if they needed similar care or treatment?”

Patients are invited to respond to the question by choosing one of six options, ranging from “extremely likely” to “extremely unlikely”. The average scores for the last year for CHS are shown in the diagram below:
Croydon’s average Friends and Family Test for 2015/16

<table>
<thead>
<tr>
<th>FFT Area</th>
<th>Responses</th>
<th>Recommend/ Satisfied 2015/16%</th>
<th>Recommend/ Satisfied % 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>909</td>
<td>95</td>
<td>94%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>635</td>
<td>89</td>
<td>95%</td>
</tr>
<tr>
<td>Community</td>
<td>661</td>
<td>96</td>
<td>95%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>2194</td>
<td>95</td>
<td>92%</td>
</tr>
<tr>
<td>Staff (recommending care)</td>
<td>588</td>
<td>61</td>
<td>53%</td>
</tr>
<tr>
<td>Staff (place to work)</td>
<td>588</td>
<td>54</td>
<td>54%</td>
</tr>
</tbody>
</table>

These scores are collated each month by the CCG and are discussed at the Clinical Quality Review Group. With the exception of A&E, FFT results for Croydon have been equal to or above London averages, and demonstrate a very high level of patient satisfaction with CHS services.

With regards to staff culture, Croydon Health Services should be commended for their implementation of the “Hello My Name is” campaign. In the same vein, South London and Maudsley NHS Foundation Trust now includes a regular ‘Patient Story’ at Trust Board Meetings.

**Improving prescribing**

The CCG has worked with member practices on a number of initiatives to improve prescribing quality and reduce costs.

The medicines management team engaged with clinicians, patients and public and has consistently delivered QIPP efficiencies by:

- Developing and maintaining customised Scriptswitch messaging
- Providing a strong Practice Support Team to implement at CCG network and member practice level
- Successfully delivering multiple waste initiatives
- Implementing innovative partnership projects with Local Authority (LA) to support patients in taking their medicines, for example award winning domiciliary Medicine Use Reviews and Multi-Disciplinary Team (MDT) medication reviews in care homes and in practices.

Some examples of the quality benefits realised as part of the Prescribing QIPP project are:

- **The antibiotics initiative**
  - Overall prescribing of antibiotics in Croydon has reduced from 1.101 items/STAR PU at baseline (March 2015) to 0.978 (January 2016)
  - Prescribing of broad spectrum antibiotics has reduced from 9.128% (March 2015) to 8.617% (January 2016).
• **Reducing medicine specific risk project**  
  o 63 patients were identified by the PINCER audits and have been reviewed by practices.  
  o Systems within practices have been reviewed to reduce the risk of reoccurrence.  
  o 215 patients have been identified by the Eclipse Radar software and, currently, over 185 patients have been reviewed.

• **Inhaled Therapies**  
  o 50 health care professionals undertook Inhaler Technique Training during 2015/16 and are proficient in inhaler technique and confident in instructing patients how to correctly use their inhaler.

• **Safe and cost effective prescribing of inhaled Corticosteroids in primary care**  
  o In 2015/16 the data collected from the 2,720 adults and 339 children reviewed as part of the Prescribing Incentive Scheme (PIS) 14/15 were analysed.  
  o As a result, 74 (22%) children and 502 (18%) adults had their dose of ICS stepped down (i.e. reduced).  
  o The review highlighted that only 49% of children and 48% of adults had their asthma under control. Therefore, more needs to be done to improve the numbers of patients with their asthma controlled.

**Adult and Children Safeguarding**

Croydon CCG is responsible for assuring that the services we commission have effective safeguarding arrangements in place to protect children and adults at risk of abuse or neglect. The safeguarding team work to make sure that safeguarding arrangements across the Croydon health economy and collaborative working with partner agencies both locally and nationally are robust and fit for purpose.

Safeguarding achievements for 2015/16 include:

• Three GP safeguarding lead workshops to share learning and endorse key safeguarding messages from a multi-agency perspective.

• 90% of CCG staff including Governing Body members have completed safeguarding training.

• Piloted an Adults and Children’s Safeguarding Self-Assessment tool to make sure that GP practices has the right systems and processes to support good safeguarding practice with 23 practices actively engaged so far.

• Croydon CCG has worked with partners to implement the FGM project which has received recognition from NHS England as an example of good practice (please see “Our achievements” section for more detail).

• Following the NHSE deep dive (in November 2015) the CCG was benchmarked and identified as having good practice in three areas.
Achieving financial sustainability

The economic environment

The government’s 2015 Budget set out action to secure financial recovery over the following five years. Although the UK economy was forecast to continue to grow, further reductions in public expenditure were outlined.

Whilst the government committed to give the NHS a further £8bn by 2020, in addition to the £2bn already announced, rising demand for health services (e.g. ageing population), increase in supply through new technologies and drugs, 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 allocation process in January 2016 restated the 2015/16 distance from target to only 5.23% and further awarded the CCG a 5.86% uplift which moved its distance below target allocation to 3.71%. 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 2015/16, the CCG was funded £1,054 (2014/15 £1,030) per patient for its GP registered population of 398,122 (2014/15 394,560).

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 2014/15 (£14.7m deficit) and 2015/16 (£10.8m deficit). This has been achieved after delivering efficiency improvement in 2014/15 (£11.0m) and 2015/16 (£10.5m).

Our largest provider, Croydon Health Services, is also facing significant financial challenges during 2015/16. 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 2016/17 to in-year breakeven in 2020/21. This will require the delivery of savings and efficiency targets of £49.2m identified in our revised 5-Year Financial Plan (March 2016). Whilst underlying inflation assumptions are low in line with the 2015 Budget public sector pay expectations, growth in the demand for services continues to be high.

Based on the 2016/17 – 2020/21 planning guidance, the CCG is focussed on delivering a deficit of £12.8m for 2016/17 including delivery of a £7.0m 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 2015/16

In the context of the inherited underfunding position, Croydon has successfully delivered ahead of expectations recording a £10.8m deficit against the £11.9m deficit plan in 2015/16. The delivery of £10.5m (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>£11.9m</td>
<td>£10.8m deficit (£43.7m cumulative)</td>
<td>No</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>£465.3m</td>
<td>£465.4m</td>
<td>Yes</td>
</tr>
<tr>
<td>Cash Balance as at 31/3/16</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>£11.9m deficit (£44.8m cumulative)</td>
<td>£10.8m deficit (£43.7m cumulative)</td>
<td>Yes</td>
</tr>
<tr>
<td>Running Cost</td>
<td>Non-Statutory</td>
<td>£8.6m</td>
<td>£8.3m</td>
<td>Yes</td>
</tr>
<tr>
<td>QIPP Savings</td>
<td>Non-Statutory</td>
<td>£10.5m</td>
<td>£10.5m</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

Total costs incurred in 2015/16 is £464.3m (2014/15 £437.8m) split as detailed below. Key providers (annual contract value greater than £1.5m) account for 71% of the 2015/16 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 East Commissioning Support Unit staff that are based locally with the CCG.

Capital investment

The CCG did not directly incur capital expenditure in 2015/16.

Productivity and efficiency

The CCG successfully managed to deliver £10.5m (2.5% of the CCG’s Revenue Resource Limit) of efficiency savings in the year and looks to build on this position in 2016/17 (£7.0m). The CCG 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 2015/16 the CCG achieved this target and paid 95.5% by value and 95.9% by number of non-NHS trade invoices and 99.3% by value and 95.2% by number of NHS invoices within the required timescale.

External auditors

The CCG’s external auditors for the financial year 2015/16 were Grant Thornton LLP. Their fees amounted to £86k 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

Information on how pension liabilities are treated and relevant pension schemes are found in the Remuneration and Staff Report. The treatment of pension liabilities is detailed in note 4.5 to the Financial Statements.
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 Section Two on page 68-70.

Sickness absence data

Sickness absence data is provided in note 4 of the financial statement and within the Remuneration and Staff Report on page 82.

Paula Swann
Accountable Officer

24 May 2016
Sustainable development

Introduction
As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities.

The CCG is committed to sustainability and to reducing our carbon footprint. We achieve this by working closely with our landlord and suppliers to improve utilisation and functionality in all areas of the business and day-to-day operations. We recognise the importance of sustainability and continue to develop our environmental strategy to meet the requirements of the Climate Change Act and to reduce our carbon footprint.

The CCG occupies office space situated in Croydon Council’s new building, Bernard Weatherill House (BWH), which has a range of innovative features to help reduce carbon and save energy. It has won a BREEAM (Building Research Establishment Environmental Assessment Method) (2006) Excellent certificate. BREEAM is the world’s foremost environmental assessment method and rating system for buildings.

All building service contracts are managed by the Council, meaning that the CCG has not been in a position to implement a separate Sustainable Management Development Plan. We work closely with the Council to ensure continuous improvements in terms of waste, utility consumption, water consumption and all other areas of building management in line with their ISO14001 Environmental Management System.

Future Strategy
- We will make sure all staff are regularly reminded of the recycling facilities and that this is included in new staff inductions
- Promote to staff the buildings shower facilities to encourage healthier travel to work.
Working with our partners in South West London to improve care

Croydon CCG is working with the other five CCGs in south west London – Kingston, Merton, Richmond, Sutton and Wandsworth – to tackle challenges that cross borough boundaries. The six CCGs have established a partnership called South West London Collaborative Commissioning (SWLCC) to achieve this.

SWLCC is working with local hospitals, mental health trusts, primary and community care services, local councils and local people to meet the challenges and aspirations set out in the NHS Five Year Forward View. We want to ensure that patients have access to the same high quality care wherever they access services.

What are the challenges?

- There are 1.45 million people living in south west London. The population is ageing and up to a third of people are living with long-term conditions, meaning we need to provide more and better care out of hospital and closer to where people live.

- All patients should get the best possible care but the quality and safety of our health services varies enormously depending where and when they are treated.

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

- Patients need ‘joined up’ services that work together and across boundaries; this does not happen effectively enough now.

- The NHS Five Year Forward View commits us to moving towards a seven-day NHS, so that patients get the same quality of care at weekends and out of hours as they do during the normal working day.

- The costs of providing healthcare are rising much faster than the rate of inflation. If we do not make changes, we would not be able to pay for the services we currently provide in five years’ time.

- There is a national shortage of key specialist staff and nurses, so getting the right staff in our services is a major challenge.

- We need to reshape mental health services so that they achieve the highest possible standards and are focused primarily in the community.

- We need to ensure that primary care and other community-based services meet the highest possible standards.

- We need to do more to prevent people becoming ill and to provide better information to patients about where to get help and when.
While the clinical, financial and workforce challenges are daunting and urgent, there is compelling evidence that we can get improved services that are more affordable for the NHS if we spend our money differently.

Our Issues Paper

In June 2014, all NHS organisations in south west London produced an Issues Paper, setting out the challenges we face, some emerging ideas and some questions for local people to consider. Large-scale focus groups were held in each of the six boroughs and we wrote to over 1,000 local organisations asking for their views. Independent feedback from the events can be found on the SWLCC website. During the next few months, we will publish further information about all of the feedback received to date and our response to it.

Planning for the future

In December 2015, NHS England published new planning guidance requiring all NHS regions across the country to work together, and with local councils, on a five-year ‘sustainability and transformation plan’ for their local NHS. We have formed a ‘Strategic Planning Group’ to deliver this work, working with our South West London CCG partners, local provider trusts and local authorities. The plan will be published later this year and will build on the five year strategy published by SWLCC in 2014. Those elements of the SWL plan which have an impact on Surrey Downs residents will be managed in partnership with Surrey Downs CCG, via the newly-established South West London and Surrey Downs Healthcare Partnership. The main focus of this partnership will be how acute services are organised, improving productivity and a strategy to deliver more care outside hospital.

Final decision-making on any changes to local health services continues to rest with the local CCGs. If significant changes to local services are proposed, these would be subject to public consultation.

Croydon’s predominant footprint is within South West London, but also within South East London (for mental health) and across South West London and South East London and nationally for Learning Disabilities. Our local case for change, outcomes and priorities will inform the development of the STPs; and as the STPs develop we will be able to strengthen our local plans accordingly. Our Outcomes Based Commissioning approach will become a key priority for delivering the STP locally. The national priorities require development and delivery at a number of levels; whether that is at a STP level, a sub-regional planning group (ie across Croydon’s health and social care) or at CCG level.
Health and Wellbeing Board

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 joint 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 joint health and wellbeing strategy can be found at www.croydon.gov.uk/

In 2015/16 we shared our commissioning intentions and operating plan with the Health and Wellbeing Board, ensuring that the plans are aligned. Over the year we asked for feedback on programmes of work including child and adolescent mental health, the Urgent Care Strategy, Outcomes Based Commissioning, Transforming Adult Mental Health Care Services.
Patient and Public involvement (PPI)

Why do we engage?
NHS Croydon CCG sees the roles of patients, residents and stakeholders as much more than a legal duty. We believe that by engaging with our communities and building their knowledge and experiences into commissioning decisions we will be better placed to offer services that are responsive and accountable. We will also be better able to buy local services that reflect the needs, priorities and aspirations of the local population.

We want to build clear and visible mechanisms that support engagement throughout the entire commissioning process, from pre-planning to implementation.

To help us to do this Croydon CCG needs to review and continually monitor the ways we:

- Engage with, and listen to, patients, carers, diverse groups and other stakeholders; Ensure that patients’ experiences are taken into account when commissioning decisions are made

- Engage with and listen to staff, local providers, clinicians, voluntary sector groups, and other key partners.

Reviewing our Patient and Public Involvement vision
In October 2015 we began a review of the way we engage locally. We did this by talking to our patients, Healthwatch Croydon, our local community and voluntary sector representatives and other partners. The review will complete in April 2016.

The review builds upon our established framework for patient and public engagement and will ensure patient and community views are integral to the commissioning work of the CCG, as part of our day-to-day business and throughout the entire process.

As our organisation matures and our communities and their needs change, we recognise that we need to evolve our thinking around PPI to ensure that we can reach out to all communities across Croydon.

Through our review we are developing a series of local guiding principles, which we will take out to test and refine with patients, public and our stakeholders.

Our main achievements 2015-16
2015 – 16 was a busy year for Croydon CCG and two central commissioning programmes, Urgent Care and Outcomes Based Commissioning, made up a significant part of our work and more details about our engagement is given below. Alongside this our PPI activity covered a wide range of other areas, such as:

- Partnered with Croydon Voluntary Action to support our outreach and engagement with seldom heard groups. This gave us vital local intelligence as part of the urgent care engagement and also helped to develop stronger working relationships for the future
• Strengthening our relationship with Healthwatch Croydon by beginning to support joint working, especially around areas highlighted as a concern to Healthwatch Croydon through their patient networks. These include in particular, anticoagulation services and muscular-skeletal services.

• Supporting the local implementation of the South West London Collaborative Commissioning Grass Roots programme with Healthwatch Croydon. This programme will go into 2016-17 and will support the development of a citizen’s panel to support the engagement of seldom heard groups across the six partner CCGs.

• Engaging with patients around the following commissioning themes: termination of pregnancy services, anti-coagulation service patient information sessions, ear, nose and throat services, Dermatology services and musculo-skeletal services.

• Engaged with over 400 older people through local Community and Voluntary sector partners which led to the development of five new models of care due to be implemented by the Outcomes Based Commissioning Programme.

• Listened to and responded to, through direct feedback, over 1000 residents from across the Borough as part of the urgent care review.

• Worked with two patient and PPG working groups on the service specification for the proposed new urgent care system and developed a series of patient-led service standards

  Two Patient and Public Forum open meetings were held in May and September, during which key issues and conversations took place around urgent care services and other future commissioning plans.

• The Patient and Public Involvement Reference Group met until September 2015. The group includes representatives from Healthwatch, patient participation groups, other community groups and local stakeholders.

Our plans for the next year will focus on
• strengthening our patient and public involvement infrastructure and systems,
• strengthening our relationships with our local stakeholders
• developing partnership working across the health and social care system.

We are in the process of updating our engagement work plan and will publish this on our website later in the year.
Reducing Inequality

Croydon CCG adopted the Equality Delivery System for the NHS (EDS) in 2011. The EDS gives NHS organisations an opportunity to improve fairness in service commissioning and performance evaluation for the benefit of the whole community – patients, carers and staff. It also enhances collaboration with local stakeholders and interest groups by enabling the analysis of service commissioning, provision and performance. This leads to clearer identification of equality objectives and ensures compliance with statutory equality obligations.

The EDS enabled NHS Croydon 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.

Croydon CCG’s constitution commits the organisation to work towards meeting the public sector equality duties of the Equality Act 2010 and reduce health inequalities. As commissioners of services, Croydon CCG recognises that it must account for not only its own organisational equality performance but also that of the providers of services that it commissions.

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 Analysis. Croydon CCG has prepared commissioning plans which look carefully at population needs based on demographics, health inequalities and access to services. At the heart of these strategies is a key objective to reduce health inequalities, improve outcomes for patients ensuring services are accessible and responsive to patients.


Achievements during 2015/16 include:

- **Delivering the Integrated Mental Health Strategy**
  The CCG has been working with partners in Croydon Council, South London and Maudsley, voluntary and community sector organisations to redesign services needed to both expand and develop community based services and to reduce the boroughs dependency on bed based care. This has also included significant PPI engagement and involvement activities with the feedback received being incorporated into future planning.
Examples of services that have derived from the strategy are the Tier III Child and Adolescent Mental Health Services and the Croydon CCG OASIS (Early Detection in Psychosis) Service.

- **Safeguarding**
  Croydon CCG was successful in securing funding through the Quality Premium to take forward a project across Croydon with the aim of improving the health and wellbeing of women and girls affected by FGM.

- **Equality Delivery System2 and Implementation of Equality Objectives 2015**
  The CCG implementation of EDS2 process and Equality Objectives during 2015 has highlighted areas of good practice:
  - Commissioning Child and Adolescent Mental Health Services and the Croydon CCG OASIS (Early Detection in Psychosis) Service
  - Organisational Development and development opportunities for staff
  - Improved data collection and analysis systems to capture information across the protected groups
  - Increased embedding of Equality and Diversity into the CCG’s operations
  - Improved and sustained engagement with more communities in Croydon

- **Joint Strategies**
  The CCG has developed a range of strategies with its partners to improve quality, access to services and health and wellbeing, examples include:
  - End of Life Care Strategy 2015/16 – 2017/18
  - Emotional Wellbeing and Mental Health/Child and Adolescent Mental Health Services Local Transformation Plan – Strategic Plan
  - Children and Families’ Plan 2015-16

- **Equality Analysis (previously Equality Impact Assessments)**
  Equality Analysis forms part of Croydon CCG’s commissioning cycle and is considered during the redesign of a service or policy to ensure that the needs of our community groups are being met. Equality Analysis is integrated into the commissioning process, enabling commissioners to assess impacts and inform decision making.

Croydon CCG will continue to work closely with local partners and Croydon HealthWatch to ensure that equality and diversity requirements are embedded across its business activities in accordance with the Equality Act 2010.
Emergency Preparedness Resilience and Response

Emergency Preparedness Resilience and Response (EPRR) is defined by a series of statutory responsibilities covered by the Civil Contingencies Act (2004) which requires NHS-funded organisations to maintain a robust capability by planning for, and responding to, incidents that could impact on health or services to patients.

All organisations were required to complete a RAG rated self-assessment against the core standards, and a further 4 questions relating to Pandemic Influenza. Evidence to be provided to support the self-assessment included:

- Major Incident Plan
- Corporate Business Continuity Plan
- EPRR Policy / Strategy
- Pandemic Influenza Plan

The CCG’s overall compliance level for emergency preparedness for 2015/16 is “substantial”.

The CCG exercised its Business Continuity Plan in November and hosted a multi-agency Influenza Pandemic exercise in February. Exercises help to test the effectiveness of emergency plans, the learning from which can be incorporated in to the annual work plan for 2016/17.

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 2015/16, there were 56 complaints, of these 22 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

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 165 PALS enquiries received in 2015/16. Of the 165 PALS queries, 21 were redirected to NHS England as they related to primary care services. 35 PALS enquiries related to acute hospital, mental health and community services and 19 to other providers (for example Croydon Council, NHS 111).

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

Freedom of Information

NHS South East Commissioning Support Unit provides a complete Freedom of Information service to Croydon CCG. Following are details of the FOI requests made to NHS Croydon CCG under the Freedom of Information Act 2000 (FOIA) in the financial year 2015/16.

<table>
<thead>
<tr>
<th>Year</th>
<th>April</th>
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<th>March</th>
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<td>18</td>
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<td>27</td>
<td>19</td>
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<tr>
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The number of request received by the CCG are similar to the number of requests received by other CCGs South East Commissioning Support Unit (South East CSU) provides a Freedom of Information (FOI) service to although at the higher end.

The table above shows the number of request received by month and by quarter for the financial year 2015/16.

There has been a 6% increase in the total number of requests received for the year to date (YTD) when compared to the same point in 2014/15.

There has been a general trend towards an increase in the number of requests received across the past three financial years with a total increase of 31% from 2013/14. This increase is expected to continue in 2016/17.

Meeting FOI targets

The Freedom of Information Act states that applicants should be given a response within 20 working days. Good practice guidance suggests that at least an 85% response rate should be achieved. The table below shows the CCGs performance for this financial year.
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<th>Year</th>
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<th>Total YTD</th>
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<tr>
<td>Target</td>
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<td>19</td>
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<td>4</td>
<td>1</td>
<td>2</td>
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<td>6</td>
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<td>71%</td>
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<td>97%</td>
<td>92%</td>
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<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Total YTD</th>
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<td>Compliant</td>
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<tr>
<td>Breached</td>
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<td>14</td>
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<td>%</td>
<td>84%</td>
<td>89%</td>
<td>79%</td>
<td>96%</td>
<td>87%</td>
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</table>

Target – The total number of requests received.
Compliant – The total number of requests responded to within the statutory 20 working days.
Breached – The total number of requests not responded to within the statutory 20 working days.
% - The percentage of the total number of request received which were responded to within the statutory 20 working days.

The CCG has just met the current good practice guidance of 85% with an annual compliance rate of 87%. There has been a vast improvement in the CCGs compliance in the final two months of the financial year. Quarter 4 saw a compliance of 93%. The CCG also achieved 100% compliance in February 2016.
Corporate Governance Report

Members’ report

GP Member Practices (as at 31 March 2016)

NHS Croydon Clinical Commissioning Group (Croydon CCG) is a membership organisation made up of all 57 GP practices in the borough of Croydon. Organised in six Clinical Networks, our practices are listed below:

**Mayday Network**

<table>
<thead>
<tr>
<th>Practice Name</th>
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<tbody>
<tr>
<td>Valley Park Surgery</td>
<td>Thornton Road Surgery</td>
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<tr>
<td>North Croydon Medical Centre</td>
<td>Norbury Medical Practice</td>
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<tr>
<td>Leander Road Medical Practice</td>
<td>Fairview Medical Centre</td>
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<tr>
<td>London Road Medical Practice</td>
<td>Eversley Medical Centre</td>
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<tr>
<td>Broughton Corner Medical Centre</td>
<td>Brigstock and South Norwood Partnership</td>
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<tr>
<td>Brigstock Family Practice</td>
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**Thornton Heath Network**

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<th>Practice Name</th>
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<tbody>
<tr>
<td>South Norwood Hill Medical Practice</td>
<td>Mersham Medical Centre</td>
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<tr>
<td>Auckland Surgery</td>
<td>Thornton Heath Health Centre</td>
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<tr>
<td>Parchmore Medical Practice</td>
<td>South Norwood Medical Practice</td>
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<td>Upper Norwood Group Practice</td>
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**Woodside / Shirley Network**

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<tbody>
<tr>
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</tr>
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<td>The Enmore Practice</td>
<td>Addiscombe Surgery</td>
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<td>Hartland Way Surgery</td>
<td>Portland Medical Centre</td>
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<td>Ashburton Park Medical Centre</td>
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<td>Woodside Group Practice</td>
<td>Broom Road Medical Practice</td>
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**New Addington / Selsdon Network**

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<th>Practice Name</th>
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<tbody>
<tr>
<td>Headley Drive Surgery</td>
<td>Parkway Medical Centre (AT Medics)</td>
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<td>Fieldway Medical Centre</td>
<td>Parkway Medical Centre (Baskaran)</td>
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<tr>
<td>Queenhill Medical Practice</td>
<td>Parkway Health Centre (Salerno)</td>
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<td>Farley Road Medical Practice</td>
<td>Selsdon Park Medical Practice</td>
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**Purley Network**

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<td>The Moorings</td>
<td>Bramley Avenue Surgery</td>
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<tr>
<td>Keston Medical Practice</td>
<td>Coulsdon Medical Practice</td>
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<td>Parkside Group Practice</td>
<td>Mitchley Avenue Surgery</td>
</tr>
<tr>
<td>Woodcote Group Surgery</td>
<td></td>
</tr>
</tbody>
</table>
Each geographically based locality has a GP network lead and deputy.

<table>
<thead>
<tr>
<th>Network</th>
<th>GP network lead</th>
<th>Deputy network lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Croydon Network</td>
<td>Dr Karthiga Gengarathan</td>
<td>Dr Tom Chan</td>
</tr>
<tr>
<td>Mayday Network</td>
<td>Dr Yinka Aje-Obe</td>
<td>Dr Ameesh Patel</td>
</tr>
<tr>
<td>New Addington / Selsdon Network</td>
<td>Dr Agatha Nortley-Meshe*</td>
<td>Dr Shahab Karim</td>
</tr>
<tr>
<td>Purley Network</td>
<td>Dr Farhan Sami</td>
<td>Dr Tish Gooneratne</td>
</tr>
<tr>
<td>Thornton Heath Network</td>
<td>Dr Rajeev Sagar</td>
<td>Dr Shamaila Masood Hussain</td>
</tr>
<tr>
<td>Woodside / Shirley Network</td>
<td>Dr Bobby Abbott</td>
<td>Dr Amit Abbott</td>
</tr>
</tbody>
</table>

(Note:  
*Dr Agatha Nortley Meshse stepped down on 30 September 2015  
**Dr Mike Simmonds took on the role from 1 December 2015)

**Clinical Leadership Group**

The Clinical Leadership Group (CLG) is an elected body, which provides clinical and corporate support to the Governing Body. The group leads 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.

The members of the Clinical Leadership Group are as follows:

- Dr Anthony Brzezicki, Chair and Clinical Lead for Long Term Conditions and Planned Care
- Dr Agnelo Fernandes, Assistant Clinical Chair and Clinical Lead for Urgent Care
- Dr Atif Hasan, GP Governing Body Member and Medical Director
- Dr John Linney, Governing Body Member and Clinical Lead for Mental Health
- Dr Bobby Abbott, Clinical Network Leader for Woodside/Shirley Network
- Dr Yinka Ajayi-Obe, Clinical Network Leader for Mayday Network
- Dr Karthiga Gengatharan, Clinical Network Leader for East Croydon Network
- Dr Mike Simmonds, Clinical Network Leader for New Addington/Selsdon Network
- Dr Rajeev Sagar, Clinical Network Leader for Thornton Heath Network
- Dr Farhan Sami, Clinical Network Leader for Purley Network
Our Governing Body
The membership of the Governing Body for 2015/16 is as follows:

Executive Members
- Paula Swann (Chief Officer)
- Mike Sexton (Chief Financial Officer)
- Stephen Warren (Director of Commissioning)
- Sean Morgan (Interim Director Quality and Governance from 2/2/2015 to 1/8/2015)
- Elaine Clancy (Director Quality and Governance from 1/6/2015)

Non-Executive Members
- Dr Anthony Brzezicki (Chair)
- Dr Agnelo Fernandes (Assistant Clinical Chair)
- Dr John Chan (GP Governing Body Member and Medical Director to 31/12/2015)
- Dr John Linney (GP Governing Body Member)
- Dr Atif Hasan (GP Governing Body Member) (Medical Director from 1/3/16)
- Amy Page (Lay Member and Registered Nurse*)
- Dr Jonathan Norman (Secondary Care Consultant)
- Helen Pernelet (Vice Chair and Lay Member, Governance and PPI)
- Roger Eastwood (Lay Member – Finance)

In attendance (no voting rights)
- Paul Greenhalgh (Executive Director Adult Services, Health and Housing Croydon Council)
- Dr Mike Robinson (Director of Public Health, Croydon Council to 30/11/2015)
- Ellen Schwartz (Interim Director of Public Health – from 1/12/2015 – 21/2/1016)
- Steve Morton (Interim Director of Public Health – from 1/12/2015 – 21/2/2016)
- Rachel Flowers, Director of Public Health (from 23/2/2016)
- Charlie Ladyman (CEO, Healthwatch Croydon)

(* Please note Amy Page was Chief Nurse until August 2015).

Croydon CCG is managed in an open and accessible way, which enables local people to question what the CCG does and why. We meet regularly in public and publish board papers on our website. For further information visit: www.croydonccg.nhs.uk/about us

Statement on disclosure to auditors
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.
Our Integrated Governance and Audit Committee
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.

The membership of the Integrated Governance and Audit Committee for 2015/16 is as follows:

- Helen Pernelet (Chair / GB Vice Chair and Lay Member, Governance and PPI)
- Roger Eastwood (Lay Member – Finance)
- Dr John Linney (GP Governing Body Member)
- Dr John Chan (GP Governing Body Member and Medical Director to 31/12/2015)
- Dr Atif Hasan (GP Governing Body Member and Medical Director from 1/3/2016)
- Amy Page – (Lay Member, Registered Nurse)

Governing body register of interests
Our register of interests is available on our website.

Information governance – information breaches
We have processes for the reporting and investigation of information breaches. This year, we have had zero information breaches reported to the Information Commissioner’s Office.
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 Croydon 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.
I also confirm that:

- as far as I am aware, there is no relevant audit information of which the entity’s auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself or herself aware of any relevant audit information and to establish that the entity’s auditors are aware of that information.

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

[Signature]

Paula Swann
Accountable Officer
24 May 2016
Croydon Clinical Commissioning Group
Annual Governance Statement (AGS)

Introduction and context
NHS Croydon Clinical Commissioning Group (Croydon CCG) is a membership organisation made up of 57 GP practices in the London Borough of Croydon.

On 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006, we became legally responsible for commissioning healthcare services for the residents of Croydon.

During the last three years we have successfully submitted evidence to NHS England (NHSE) 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.

Purpose and role of the CCG
We manage local healthcare budgets in excess of £465 million and commission a range of healthcare services, including hospital, community and mental health services.

We serve over 398,000 people across the very diverse borough of Croydon. The Clinical Commissioning Group (CCG) 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. The CCG continues to explore 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.

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 work collaboratively with the public health and Local Authorities Adults and Children’s 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. 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 have responsibility 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 personally responsible, in accordance with the responsibilities assigned to me in Managing
Public Money. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter. I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

**Compliance with the UK Corporate Governance Code**

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code and the Corporate Governance in Central Government Departments: Code of Good Practice 2011 (HM Treasury and Cabinet Office) that we consider to be relevant to the CCG.

**The Clinical Commissioning Group Governance framework**

The National Health Service Act 2006 (as amended), at paragraph 14L (2) (b) states: The main function of the Governing Body (GB) 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 57 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 (CoM) is a forum of one representative appointed by each of the 57 Member Practices. The CoM 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.

**Achievements**

In 2015-16, the CoM met on four separate occasions and:

- Approved the Annual Accounts and Annual Report.
- Agreed the Strategic Plan
- Reviewed the 2015/16 Operating Plan
- Received reports on Enhanced Clinical Engagement and PPI Engagement Activities
- Noted changes to the Constitution in relation to a merger of GP practices and change in practice name and agreed submission to NHSE.
The CoM discussed the recommendation to continue to co-commission primary care, shadowing delegated commissioning for 2016/17 with a view to taking full delegated responsibility from April 2017. The Council of Members deferred making a decision until early 2016.

Assurance:
The CoM confirms that it has fulfilled its obligations in line with its agreed Terms of Reference.

The Governing Body
The GB arrangements comply with The National Health Service Act 2006 (as amended). The membership of the Governing Body is set out in the constitution, along with the responsibilities of the clinical leaders and member practices. 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. Details of membership and attendance are set out in Appendix 1. All meetings have declarations of interests as an agenda item, where made, and recorded where relevant.

Governing Body members:
- Tony Brzezicki - CCG Chair
- Agnelo Fernandes – Assistant Clinical Chair
- John Linney - GP Governing Body Member
- Atif Syed Hasan - GP Governing Body Member
- John Chan - GP Governing Body Member (to 31 December)
- Amy Page – Registered Nurse Governing Body Member
- Jon Norman – Secondary Care Consultant Governing Body Member
- Helen Pernelet - Lay Member/ Vice Chair
- Roger Eastwood - Lay Member
- Paula Swann- Chief Officer
- Mike Sexton – Chief Financial Officer
- Stephen Warren – Director of Commissioning
- Elaine Clancy – Director of Quality & Governance

Achievements:
In 2015-16, the GB met on nine separate occasions and agreed:
- The strategic direction and assumptions in the emotional wellbeing mental health/child adolescent mental health services (CAMHS) Local Transformation Plan – Strategy;
- The Croydon Urgent Care Re-Procurement Strategy; formative scenarios through involvement and engagement with stakeholders, patients and the public and preferred option.
- The Health and Wellbeing Strategy;
- The End of Life Care Strategy for Croydon;
- 2016/17 draft commissioning intentions, and Operating Plan;
- The refreshed Vision, objectives, aims and values of the CCG.
Highlights of its work include:

- Approval of partnership arrangements under Section 75 of the NHS Act 2006 with Croydon Council in relation to the Better Care Fund to enable pooled funds to be established and to govern the delivery of the Croydon Better Care Fund 2015/16
- Deliberations on delegated Primary Medical Services Commissioning
- Agreeing and approving the extension of the Improving Access to Psychological Therapy element of the Mental Health contract with SLaM
- Approving the Information Management & Technology Strategy (IMT)
- Agreeing the 2015/16 Financial Plan and Financial Improvement Plan
- Agreeing the financial control environment self-assessment; rated as overall – excellent,
- And regularly receiving and reviewing reports on Outcomes-Based Commissioning, Quality, Innovation, Productivity and Prevention (QIPP), Finance, Quality, Integrated Performance and Safeguarding and Risk, amongst others.
- Reviewing and recommending changes to the CCG’s constitution

The GB also approved governance arrangements to deliver next phase of the programme to deliver the South West London 5 year Strategy and Terms of Reference for the programme Board and Clinical Board and agreed the planning process and timetable for 2016/17 London transformation plan and governance arrangements.

Assurance:
Croydon CCG is committed to transparency, and holds public GB meetings regularly. GB papers and the minutes of those meetings are published on the NHS Croydon CCG website.4

GB Roles and responsibilities
The role of the Governing Body is to ensure that the CCG exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of its 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. All GB members are required to record annually any interests relevant to their role on the GB. The register of interests, updated quarterly, is a public document which is open to public scrutiny and published on the CCG’s website.5

GB Performance
With the completion of each Annual Governance Statement 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 improvements in the organisation’s effectiveness in areas such as Leadership, Effectiveness and relationships with our

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4 http://www.croydonccg.nhs.uk/about-us/Governing%20body/Pages/Governing-body-papers.aspx
Membership and considers that we have been more challenging of each other in progressing our business, this year, compared to previous years.

This year, we have taken a reflective view of our progress over the past three years and set ourselves a high bar for achievement. Whilst we recognise that there are still areas for improvement, there is also much to celebrate. The CCG has been extremely effective in engaging with our main provider trusts and we have seen improvements in the recorded quality of care. We have also continued with our significant investment in relationships supporting new ways of engaging with patients, public and other stakeholders, particularly in developing Outcomes Based Commissioning (OBC) and Urgent Care proposals.

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 we are sufficiently informed and supported in the discharge of our duties; and that appropriate relationships are maintained with internal and external stakeholders and partner organisations. It was noted, however, that there was scope for further refining the pre-decision and deliberation stage of our decision making, especially clinical, so as to support timely and context driven input to our discussions. Overall the Governing Body has had adequate time to discharge its responsibilities and was supported through access to relevant information, of an appropriate quality; however, in general, information could be presented in a more concise and timely fashion.

We believe we are effective in making decisions based on quality and evidence-based practice and regularly engage in challenge of executive proposals; thus ensuring that the decision making process is open and transparent. However, we concluded that there remains scope for Governing Body members to more constructively challenge and appraise each other and to engage even more fully with the wider membership. Accordingly, we have agreed that our Membership Engagement Plan and Organisational Development Strategy will be refreshed and re-promoted for 2016/2017.

**GB Committees:**
The GB is supported by a number of committees which support its assurance and oversight of the organisation.

**INTEGRATED GOVERNANCE AND AUDIT COMMITTEE (IGAC)**
The Committee provides assurance to the GB on how the CCG manages its risks. It ensures that the system of internal control, governance and risk management is effective.

**IGAC Members:**
- Helen Pernelet - Lay Member/GB Vice Chair (chair)
- Roger Eastwood - Lay Member
- John Linney - GP Governing Body Member
- Amy Page – Chief Nurse
- John Chan - GP Governing Body Member (to 31 December)
Achievements:
In 2015-16, the Committee met on seven separate occasions. Highlights of its work, as outlined in its annual report, include:

- Ratification of the Internal Audit Strategy and approval of the annual programme of work to be undertaken by Internal Audit and Counter Fraud services and in year monitoring of delivery against the plan including reviewing internal audit reports and receiving assurance on follow up actions.
- Agreed standard Letter of Representation.
- Agreed actions regarding the confirmation of Compliance with Standards of Business Conduct.
- Agreed actions regarding the Financial Control Environment Self-Assessment.
- The review and recommendation of the draft Annual Report to the Council of Members and Governing Body.
- Review of tender waivers and special payments.
- Adoption of Accounting Policies.
- Received reports on Conflicts of Interests.
- The Committee regularly receives and reviews reports from the Local Counter Fraud Specialist, Quality Committee and minutes of the Finance Committee and regularly reviews and challenges strategic risks via the board assurance framework and risk reports.

Assurance:
The Committee confirms that it has fulfilled its obligations in line with its review of its work as reported to the Governing Body. The Terms of Reference themselves have been reviewed and found to adequately represent the functions and duties of the Committee and have been renewed for the year 2016/2017.

FINANCE
The Committee provides assurance by reporting to the IGAC, ensuring a robust financial strategy is in place and overseeing the organisation-wide system of financial management. It ensures the viability, effectiveness and financial probity of the CCG.

Finance Committee Members:
- Roger Eastwood - Lay Member/ (Chair)
- Atif Syed Hasan - GP Governing Body Member
- Jon Norman - Secondary Care Consultant Governing Body Member
- Jon Linney – GP Governing Body Member
- Tony Brzezicki - CCG Chair (Optional attendance)

Achievements:
In 2015-16, the Committee met on nine separate occasions. Highlights of its work, as outlined in its annual report, include:

- Reviewing the Financial Self-Assessment where most areas had benchmarked as good/excellent.
- Receiving national benchmarking of CCG responses.
- Providing oversight to CCG activities related to population trajectories and links to funding.
• Reviewing planning data regarding historical growth in demand, historical population trends, and forecast trends for the Croydon population
• Review of the final, December 2015, target allocations announced by NHSE, as well as the NHSE pace of change policy
• Reviewing and recommended the 2015/16 Financial Plan
• Monitoring and challenging the development of the 2015/16 QIPP initiatives and reviewing the summary forecast for each scheme.
• Review of the Outcomes-Based Commissioning 10-year Financial Model, which included assumptions regarding the CCG’s Financial Plan, and the Outcomes-Based Commissioning Memorandum of Information
• Review of the financial modelling for the Urgent Care Procurement business case
• Reviewing the SWL CCG’s risk share agreement and agreeing the amendments to the 2015/16 agreement and Terms of Reference for the Finance Review Group (FRG).
• Reviewing and recommending the 5-Year Financial Improvement Plan (July 2015)

The Committee regularly receives and reviews reports and plans on Finance, QIPP progress, integrated contract and performance and monitors and reviews the financial position of key Providers.

Assurance:
The Committee confirms that it has fulfilled its obligations in line with its review of its work as reported to the Governing Body. The Terms of Reference themselves have been reviewed and found to adequately represent the functions and duties of the Committee and have been renewed for the year 2016/2017.

REMUNERATION
The Committee provides assurance by assisting the CCG Governing Body in meeting their responsibility to ensure appropriate remuneration, allowances and terms of service for the CCG officers and senior staff, having proper regard to the organisation’s circumstances and performance and to the provisions of any national arrangements where appropriate.

Attendees:
Roger Eastwood - Chair
Tony Brzezicki – (CCG Chair)Jon Norman - Secondary Care Consultant
Helen Pernelet - Lay Member/ Vice Chair

Achievements:
In 2015-16, the Committee met once and:
• Approved the CCG Car Parking Policy
• Reviewed the Local Pay Award Framework for non-Agenda for Change roles
• Considered the Agenda for Change (AfC) Pay Agreement Framework and recommended that the Executive Management Team implement a retention programme for CCG staff enabling non-financial reward and recognition for all staff.
Assurance:
The Committee confirms that it has fulfilled its obligations in line with its agreed Terms of Reference.

QUALITY
The Quality Committee provides oversight reporting to IGAC on the application of quality in commissioning activity. The Committee reviews and discusses the identification and management of quality, patient safety; safeguarding and performance risk (where relevant to quality). It provides assurance 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.

Quality Committee Members:
Amy Page – Registered Nurse Governing Body Member
Helen Pernelet - Lay Member/ Vice Chair
Jon Norman - Secondary Care Consultant
Atif Hasan - Clinical Leader
John Chan - GP Governing Body Medical Director

Achievements:
In 2015-16, the Committee met on six separate occasions. Highlights of its work, as outlined in its annual report, include:

- Agreeing the Terms of Reference reflecting its assurance role
- Review of the Equality and Diversity Report
- Regularly receiving and reviewing Quality and Safeguarding Reports to be assured of the quality of services
- Regularly reviewed the CCG’s strategic, operational quality and safety risks, agreed the level of risk, and identified any risks that should be included on the Risk Register.
- Receiving and reviewing the Quality Accounts for Croydon Health Services (CHS) and South London and Maudsley (SLaM)
- Receiving CQC Reports for CHS, SLaM and London Ambulance Service (LAS) to understand implications for the CCG and its patients and to understand the work that the CCG needed to undertake with providers moving forward.
- Receiving and reviewing reports on the quality of care provision in nursing homes and residential settings.
- Regularly receiving Patient Advice and Liaison Service (PALS)/Complaints Reports, Medicines Management and Integrated Performance Reports

Assurance:
The Committee confirms that it has fulfilled its obligations in line with its review of its work, reported to the Governing Body. The Terms of Reference themselves have been reviewed and found to adequately represent the functions and duties of the Committee and have been renewed for the year 2016/2017.
The Clinical Commissioning Group Risk Management Framework

Through all its corporate plans and the way it operates, the CCG aims to continuously improve the quality of commissioned services. However, it is acknowledged that delivering these improvements and embracing the creation of positive advantages, benefits and opportunities will inevitably involve taking risks. We cannot expect to create a risk free environment, but rather one in which risk is considered as an integral part of everything we do and is appropriately identified and controlled. We are committed to ensuring a high-level of probity and accountability and have put in place a robust governance structure to enable effective tracking of internal controls and provide reasonable assurance of effective and efficient operations, financial stewardship, and compliance with laws and policies. The CCG’s Risk Management Strategy and Assurance Framework, developed in line with key Department of Health publications and best practice guidelines, is a key enabler.

During 2016/17 the GB plans to re-evaluate the level of risk that it regards as acceptable.

Internal control mechanisms (risk)
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. 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 principal objectives. All directors discuss risk on a monthly basis with the Risk Manager.

The CCG ensures that risk management is embedded within all areas of its operation by facilitating a culture of openness and transparency. Risk discussions are built into committee agendas and relevant risks are outlined on report cover sheets. All teams are encouraged to include risk discussions during team meetings and to ensure that relevant risks are captured and fed into the risk registers where relevant.

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.

The CCG’s 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.

Throughout the year our arrangements have been reviewed by our Internal Auditors to provide us with an opinion on the overall adequacy and effectiveness of our systems of internal control. Our processes for managing and reporting risk have been assessed as providing us with reasonable assurance. On their recommendation, we have streamlined and simplified our Assurance Framework to ensure that the Governing Body receives a comprehensive view of the strategic risks
facing the CCG and how we are managing them. Since this point we have continued to develop and enhance our approach.

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.

While the risk management function is led by the Director of Quality and Governance, 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, risks are assigned to individual owners and the executive directors are accountable for managing operational risks associated with their areas of responsibility.

Risk Reporting
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
- There is 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

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 inform priorities for resources and supporting the case for capital bids.

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 relevant 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, governance or clinical risks, are added to the Corporate Risk Register along with control measures and actions to be taken.

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 Governing Body receives and reviews the Assurance Framework quarterly.

The **Integrated Governance and Audit Committee (IGAC)** reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control and compliance across all organisational activities, both clinical and non-clinical, which support the achievement of the CCG’s objectives. IGAC receives the Assurance Framework and high-level risks at each meeting and the full Corporate Risk Register, quarterly.

In 2016/2017 the Committee will undertake ‘deep dives’ into pertinent issues to assure itself of the robustness of CCG processes, policies and procedures.

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 (QIPP) performance risks.

The **Quality Committee** has responsibility for maintaining an oversight of the management of clinical risk within Croydon commissioned services and to appraise the Integrated Governance and Audit Committee of any significant or clinical risks associated with performing statutory and non-statutory functions. The Committee reviews and discusses the identification and management of quality, patient safety and safeguarding risks. The process for internal reporting is supplemented by the CCGs arrangements for receiving GP Amber Alerts, a quality early warning system, which assists and supports risk management in the commissioning process.

In addition, the Committee provides assurance to the Governing Body that procedures in place to manage clinical incidents within commissioned services effectively are robust and that learning from serious incidents, mistakes and “near misses” is captured and disseminated to ensure improved patient safety. The Quality and Safety Risk Register is presented and reviewed at each committee meeting.

**2015/16 Significant Risks to Strategic Objectives:**
In considering the key risks to our strategic objectives, particular attention was given to those relating to finance. This has been re-evaluated throughout the year, using the risk management processes described in detail above.
The key financial risk we face is that we will not be in a position to plan for a break even position in 16/17. To mitigate this risk, we have invested heavily in QIPP schemes and service redesign to achieve savings and deliver value for money such as our commissioning activity in Outcome-Based Commissioning (OBC), Transforming Adult Community Services (TACS) and similar schemes. Our financial position is monitored closely and our 5 Year Financial Improvement Plan is reviewed regularly. We engage proactively with NHS England to ensure that we are compliant with the terms of our licence and implement agreed actions promptly. Our current financial trajectory indicates that the risk is being reduced and we continue to explore innovative commissioning strategies to close the financial gap.

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. In 2015/2016, our target was to deliver £10.5m in savings, under achievement of this target would have a significant impact on our objective to achieve financial balance. However, there is also 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 strong, transparent and good working relationship with Croydon Health Services (CHS), our main acute and community provider. We have set up a monthly Executive joint QIPP group to explore and develop opportunities across both the CCG and CHS which addresses pressure points, demand and capacity and capability issues whilst strengthening the clinical relationships across primary, community and acute care. In addition, all our QIPP initiatives have steering groups that oversee the delivery of the initiatives. The steering group membership is made up of clinicians, managers and patients across the CCG and CHS which facilitates strong ownership of the initiatives across both partners. To maximise delivery of our goals, we have also strengthened the commissioning and service redesign teams, clinical leadership (network deputies) and primary care variation team.

We realise that in order to deliver our operating plan and achieve our objectives, we must work with partners and providers. However the risk inherent in this approach is that we must rely on the effectiveness of third-party capacity, capability and processes. To mitigate this risk, we maintain oversight of quality and safety and regularly review and update partnership governance arrangements. Quality of service provision is monitored via our governance processes described in detail above. We have effective quality assurance processes and hold regular contract Monitoring and Clinical Quality Review meetings with our providers to ensure continued focus on value for money and improving quality. We also work with our providers to ensure that continuous improvement is made against the NHS Constitution measures. Where issues have been highlighted, we rigorously employ contract levers to ensure compliance.

Public involvement and consultation
Croydon CCG adopted the Equality Delivery System for the NHS (EDS) in 2011. During 2015/16, we completed a significant amount of work for the EDS2 process, including; identifying three services areas to be reviewed, carrying out a staff survey,
developing robust organisational development plans and delivering equality and diversity training.

The EDS enabled Croydon CCG to meet the aims of the Equality Act 2010, 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

Croydon CCG published its Public Sector Equality Duty report including Equality Objectives on 31 January 2016. Please click here to view the report: Croydon CCG Public Sector Equality Duty Report (PDF)  

When making decisions about the services to be commissioned, we ensure that equality and diversity intelligence informs our decisions, by routinely using the Joint Strategic Needs Assessment (JSNA) and by carrying out Equality Analyses (EA). EA training, guidance and support is available to all 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, which will help us prioritise, review and evaluate the effectiveness of our engagement activities. 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.

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. In 2015/2016, we held quarterly Public and Patient Involvement (PPI) Forum and engagement events on specific topics during the course of the commissioning cycle. Views from such engagements influenced and shaped our 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. Developing an effective framework will help us embed patient and public involvement in all stages of the commissioning cycle.

The CCG manages the risk of being compliant with the Equality Act 2010 by:

- Ensuring that Equality Analyses are part of the decision making process, for example an EA pro-forma is part of the Commissioning Workbook.
- Ensuring that patients and the public have an opportunity to take part in the decision making process, with a sustained engagement plan with an increasing number of communities in Croydon

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• Ensuring that staff are offered Equality and Diversity training and Dignity and Respect at Work training.
• Carrying out the Equality Delivery System2 to test the CCG equality performance in a range of service areas.
• Ensuring that our providers are compliant with equality responsibilities under the Equality Act 2010, the Equality Delivery System2 and the Workforce Race Equality Standard that are all clauses in the NHS Standard Contract.

The Clinical Commissioning Group Internal Control Framework
A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

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

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 3 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.

We have in place a reliable governance framework with robust plans and processes to enable effective delivery of our 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 we cover.
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.

Ensuring effective risk management, financial management and compliance with statutory duties is high on the list of our 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. 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 (IGAC). The Committee also ensures that, in non-financial and non-clinical areas that fall within the remit of its terms of reference, appropriate standards are set and compliance with them is monitored. 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.

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). The IGSG’s membership has been expanded this year to include a representative from each main business area of the CCG. These arrangements continue to ensure appropriate management of all information risks within the CCG. In addition, there is an issues log which captures issues which may have effect on information risk, positively or adversely. The IGSG also maintains a register of contract reviews and privacy impact assessments for areas where personal confidential data (PCD) might be affected. These processes ensure that all risks associated with the use of PCD are managed appropriately.

We place high importance on ensuring there are robust information governance (IG) systems and processes in place to help protect personal and corporate information. The CCG submitted the Information Governance Toolkit at Level 2 or above in all requirements with a satisfactory score of 90%, an improvement of 10% on last year’s score. The Internal Audit report has been received by the Senior Information Risk Owner. The report concluded that Croydon CCG’s procedures for managing information risk, including monitoring and reporting, were robust. There were 4 low priority actions, and all have been completed prior to submission of the Information Governance Toolkit.

We are ensuring all staff undertake appropriate IG training and have developed staff awareness materials including a new staff IG quick reference guide for 2016. We have undertaken a staff survey to increase staff awareness of their information governance roles and responsibilities. Additionally, IG is included in the regular Staff Briefings in order to assist with engagement and understanding of new risks and issues.

We have established processes in place for incident reporting and investigation of Serious Incidents Requiring Investigation (SIRI). No SIRIs have been reported requiring onward reporting to HSCIC or the Information Commissioner during 2015/16.

Review of economy, efficiency and 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 that the CCG is funded 4% (£18m) less than its needs-based fair-share of national resources; the CCG was established with Directions in respect of Financial Planning and QIPP.
Programme Management, and that the CCG has set and delivered reducing deficit financial plans across 2013/14, 2014/15 and 2015/16.

To determine the opportunities for the improved use of resources, we have annually, independently benchmarked our expenditure levels against other similar CCGs and had this independently reviewed by PricewaterhouseCoopers (PwC). The latest benchmarking report was finalised in March 2015. This report has been supplemented with the national RightCare reports that benchmark CCGs on outcomes and expenditure across 23 disease groups. It should be noted that the benchmarked opportunity for net financial savings (£8m) is less than the level of underfunding, meaning we would need to deliver better than benchmark to deliver our statutory duties.

Within a peer group of 11 CCGs with similar demographic profiles, Croydon 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, we are a significant outlier for emergency admissions, which we are addressing. The CCG is also an outlier for follow-up outpatient appointments and consultant-to-consultant outpatient referrals. The variations in utilisation are being addressed through our Quality Innovation, Productivity, Prevention programme (QIPP).

We are following the national approach to improving the use of resources which focuses on four domains Quality, Innovation, Productivity and Prevention (QIPP). We developed and delivered a £10.5m (2.0% of allocation) QIPP savings programme for 2015/16, 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. Since establishment, the CCG has delivered £35.5m (8%) cumulative efficiency improvement.

We have 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. This new framework builds on the existing redesign programmes which redirect resources away high cost reactive hospital care to proactive community and primary care – for both physical and mental health.

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

The CCG has a Scheme of Delegation that sets out delegated areas of responsibility and authority and clearly defined limits that properly reflect roles and responsibilities. It is underpinned by a comprehensive system of internal control, including budgetary control measures and ensures that there are sufficient safeguards and management mechanisms in place to maintain high standards in terms of effective, efficient and economic operation of the group. The Scheme captures the decision-making roles of the CCG Accountable Officer, Executives, Governing Body and Committees, and is linked to the terms of reference of each committee.
The Integrated Audit and Governance Committee maintains an oversight of delegated functions and responsibilities to ensure that resources are used efficiently and economically and that there are effective processes in place to guard against fraudulent usage.

The CCG, in accordance with its Constitution reviews its Scheme of Delegation annually. Amendments are approved by the Integrated Governance and Audit Committee. Any changes to the overarching Scheme of Delegation must be approved by the Council of Members. The CCG remains accountable for all of its functions, including those that it has delegated.

Review of the effectiveness of Governance, Risk Management & Internal Control
As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

Capacity to Handle Risk
Our mechanisms for internal control ensure that the CCG's business activities are efficient, 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, scrutinise internal control and risk management. The Chief Officer and Chief Financial Officer are jointly responsible for implementing the internal control and risk management frameworks, supported by the CCG senior management team, finance managers and heads of services.

The Senior Information Risk Owner (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; and as Caldicott Guardian, patient confidentiality & information sharing issues

During this year, a concerted effort has been made to raise the level of risk awareness within the CCG. A number of risk training and awareness sessions have been conducted on both an individual and team level. Risk management guidance has also been developed and distributed. Our Risk Management Policy and Strategy has been reviewed and revised and is applied throughout 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, Covalent, 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.

**Review of Effectiveness**

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the 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, policies and processes to enable effective delivery of its strategic priorities and over time 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.
Head of Internal Audit Opinion

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

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

"Based on the work undertaken in 2015/16 there is a generally sound system of internal control, designed to meet the CCG’s objectives, and that controls are generally being applied consistently. We have provided either a substantial or reasonable assurance in all areas reviewed from the CCG Internal Audit Plan for the year to date. The Board Assurance Framework was reviewed and we consider it to be operating effectively within the CCG."

All of the recommendations raised by internal audit have been accepted by management, actions have been agreed to address these and considerable focus has been placed on the implementation of the actions in a timely manner.

Data Quality

The GB and Council of Members (CoM) regularly receive reports that cover financial, governance, compliance, performance and quality matters for the CCG. The data contained in the reports is subject to significant scrutiny and review, both by management and by various GB committees. The quality of information received to direct decision making is also assured through the service level specification arrangements with the South East Commissioning Support Unit (SECSU) and the use of contractual arrangements with the commissioned providers. The GB and CoM are confident that the information they are presented with has been through appropriate review and scrutiny, and that it continues to develop with organisational needs.

Business critical models

Croydon CCG recognises the importance of quality assurance across the full range of its analytical work. Mechanisms are in place to ensure that wider government recommendations are adopted into our analysis work. The output of business-critical models is validated by NHS England through their assurance process of the CCG. No business critical models have been identified that require information about quality assurance processes for those models to be provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health.

The key business critical models on which the Governing Body relies, are in-year financial forecasts, medium-term financial planning and financial evaluation and forecasting of quality led savings schemes. These models are the responsibility of the Chief Finance Officer and operated by the Financial Management & Planning team and the Programme Management Office (PMO).
The supplier of our information and computer technology (ICT) and Business Intelligence (BI) and Finance support functions is SECSU. Business critical models in use within ICT and Finance are subject to a number of quality assurance processes which link into the overall framework and management commitment to quality. There is transparency and management oversight over models and data sources used to make business critical and strategic decisions, with scrutiny within the IGAC and Information Governance Steering Group through which we receive assurance.

Through an arrangement with NHS England, Deloitte LLP provides Independent Service Auditor Reporting opinions for the applicable services provided to Croydon CCG by SECSU. The Independent Service Auditor’s Report for 2015/16 on internal controls (Type II), Finance and Payroll covered the following business process areas:

- Payroll
- Financial Ledger
- Accounts Payable
- Accounts Receivable
- Financial Reporting
- Treasury and Cash Management

The Service Auditor Report was prepared by Deloitte LLP in accordance with the International Standards on Assurance Engagements 3000 and 3402 (“ISAE 3000 and 3402”) and the Institute of Chartered Accountants in England and Wales Technical Release AAF 01/06 (“AAF 01/06”). The report assisted the CCG in evaluating those elements of our control environment outsourced to SECSU. The report set out the control objectives developed by the CSU as the criteria against which the control procedures were evaluated, alongside the control procedures and the tests performed in concluding whether the controls operated as described.

Business critical models in use within BI include processes which support the identification and maintenance of a list of all business critical models and a schedule for periodic review. Qualified and experienced analysts exercise professional scepticism over the outputs from key models and organisational use of data. These processes are subject to review by internal audit, who review management information data and process owners, and external audit whose work covers the quality assurance processes of financial models. Where an error might have a significant reputational, financial or patient care impact, we have agreed with SECSU, an approach that audits the quality assurance strategy of models.

I can confirm an appropriate framework and environment is in place to provide quality assurance of business critical models, and that all business critical models have been identified. In line with the Macpherson report the CCG believes no business critical models have been identified that require information about quality assurance processes for those models to be provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health.
Data Security

The CCG purchases information technology and security services as a managed service from SECSU. There is an appropriate contract in place, commensurate with the requirements of the Data Protection Act 1998.

Additionally, the CCG receives assurances via the CSU’s annual submission of the Information Governance Toolkit. There is a mechanism for serious incidents to be reported to the CCG where they might affect the business of the CCG, and the CSU has appropriate internal mechanisms in place to ensure their Senior Information Risk Owner is informed of serious incidents and that new mitigations are applied where necessary. The CSU provides expertise to the CCG via its ICT service provision as well as through its Information Governance service. South East CSU has submitted a satisfactory Information Governance Toolkit score of 100%.

The section on Information Governance earlier in the document outlines the internal framework applies to mitigating information risk and managing staff behaviour to further support data security requirements.

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 all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decisions 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 we have identified no significant issues of internal control.

Paula Swann
Accountable Officer

24 May 2016
Remuneration and staff 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>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>
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</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>
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<tr>
<td>Sarah Patmore</td>
<td>Principle Associate HR and OD</td>
</tr>
</tbody>
</table>

Sarah Patmore, Principle Associate HR and OD, 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 CSU 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 who is 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>Elaine Clancy*</td>
<td>Director of Quality &amp; Governance</td>
<td>1 June 2015</td>
<td></td>
<td>3 Months</td>
</tr>
</tbody>
</table>

*From 1 February until 7 July 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:
<table>
<thead>
<tr>
<th>Member</th>
<th>Role</th>
<th>Contract Date</th>
<th>Date member left organisation or changed role</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governing Body Members</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<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>31 December 2015</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>29 February 2016</td>
</tr>
<tr>
<td>Dr.Atif Hasan</td>
<td>GP Governing Body Member and Medical Director</td>
<td>1 March 2016</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>31 July 2015</td>
</tr>
<tr>
<td>Amanda Page</td>
<td>Registered Nurse, Lay Member</td>
<td>1 August 2015</td>
<td></td>
</tr>
<tr>
<td>Roger Eastwood</td>
<td>Lay Member, Finance</td>
<td>September 2014</td>
<td></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>
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<tr>
<td><strong>Clinical leaders</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Bobby Abbott</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>31 October 2015</td>
</tr>
<tr>
<td>Dr Mike Simmonds</td>
<td>Clinical Network Leader</td>
<td>1 February 2016</td>
<td></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>
</tbody>
</table>
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 (bands of £5,000) £000</th>
<th>(d) Long term performance pay and bonuses (bands of £5,000) £000</th>
<th>(e)¹ All pension-related benefits (bands of £2,500) £000</th>
<th>(f)² 2015/16 TOTAL (a to e) (bands of £5,000) £000</th>
<th>(g) 2014/15 TOTAL (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>32.5-35.0</td>
<td>155-160</td>
<td>175-180</td>
</tr>
<tr>
<td>Mike Sexton, Chief Financial Officer</td>
<td>105-110</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>42.5-45.0</td>
<td>150-155</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>37.5-40.0</td>
<td>130-135</td>
<td>140-145</td>
</tr>
<tr>
<td>Elaine Clancy, Director of Quality and Governance</td>
<td>70-75</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>42.5-45.0</td>
<td>115-120</td>
<td>-</td>
</tr>
<tr>
<td>Sean Morgan, Interim Director of Quality &amp; Governance³</td>
<td>40-45</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>40-45</td>
<td>20-25</td>
</tr>
</tbody>
</table>

¹ All pension related benefits means the annual increase in cumulative pension entitlement, and does not include the amounts paid to senior managers in the year.

² The total included within column f is skewed as this includes the annual increase in cumulative pension entitlement, and not the total payments made to senior managers during the financial year.

³ The Interim Director of Quality & Governance post was filled by Sean Morgan who was 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) £000</th>
<th>(d) Long term performance pay and bonuses (bands of £5,000) £000</th>
<th>(e) All pension-related benefits (bands of £2,500) £000</th>
<th>(f) 2015/16 TOTAL (a to e) (bands of £5,000) £000</th>
<th>(g) 2014/15 TOTAL (bands of £5,000) £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fouzia Harrington, Director of Quality and Governance (pro rata)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>70-75</td>
<td></td>
</tr>
<tr>
<td>Michelle Rahman, Interim Director of Quality and Governance (pro rata)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</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>
<td></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>
<td></td>
</tr>
<tr>
<td>Dr John Chan, GP Governing Body Member and Medical Director</td>
<td>25-30</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25-30</td>
<td></td>
</tr>
<tr>
<td>Dr John Linney, GP Governing Body Member</td>
<td>30-35</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>30-35</td>
<td></td>
</tr>
<tr>
<td>Dr Atif Hasan, GP Governing Body Member and Medical Director*</td>
<td>30-35</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>30-35</td>
<td></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>
<td></td>
</tr>
<tr>
<td>Mrs Amanda Page, Chief Nurse and Registered Nurse, Lay Member</td>
<td>15-20</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15-20</td>
<td></td>
</tr>
<tr>
<td>David Hughes, Lay Member,</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

- £2,500 bands

Note: The table above shows the remuneration details of various individuals in an organization. Each row represents an individual's name and title along with their respective salary and related benefits for the financial years 2015/16 and 2014/15.
<table>
<thead>
<tr>
<th>Name and title</th>
<th>(a) Salary (bands of £5,000) £000</th>
<th>(b) Expense payments (taxable) to nearest £100 £</th>
<th>(c) Performance pay and bonuses (bands of £5,000) £000</th>
<th>(d) Long term performance pay and bonuses (bands of £5,000) £000</th>
<th>(e) All pension-related benefits (bands of £2,500) £000</th>
<th>(f) 2015/16 TOTAL (a to e) (bands of £5,000) £000</th>
<th>(g) 2014/15 TOTAL (bands of £5,000) £000</th>
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</thead>
<tbody>
<tr>
<td>Finance (pro rata)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roger Eastwood, Lay Member, Finance</td>
<td>10-15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10-15</td>
<td>5-10</td>
</tr>
<tr>
<td>Helen Pernelet, Vice Chair and Lay Member, Governance and Patient and Public Involvement PPI</td>
<td>10-15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10-15</td>
<td>10-15</td>
</tr>
<tr>
<td>CLINICAL LEADERS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Bobby Abbot*, Clinical Network Leader</td>
<td>20-25</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20-25</td>
<td>20-25</td>
</tr>
<tr>
<td>Dr Yinka Ajayi-Obe, Clinical Network Leader</td>
<td>20-25</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20-25</td>
<td>20-25</td>
</tr>
<tr>
<td>Dr Karthiga Gengatharan*, Clinical Network Leader</td>
<td>25-30</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25-30</td>
<td>15-20</td>
</tr>
<tr>
<td>Dr Agatha Nortley Meshe*, Clinical Network Leader</td>
<td>15-20</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15-20</td>
<td>45-50</td>
</tr>
<tr>
<td>Dr Mike Simmonds, Clinical Network Leader</td>
<td>5-10</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5-10</td>
<td>-</td>
</tr>
<tr>
<td>Dr Brian Okumu*, Clinical Network Leader</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5-10</td>
</tr>
<tr>
<td>Name and title</td>
<td>(a) Salary (bands of £5,000)</td>
<td>(b) Expense payments (taxable) to nearest £100 £</td>
<td>(c) Performance pay and bonuses (bands of £5,000) £000</td>
<td>(d) Long term performance pay and bonuses (bands of £5,000) £000</td>
<td>(e) All pension-related benefits (bands of £2,500) £000</td>
<td>(f) 2015/16 TOTAL (a to e) (£000)</td>
<td>(g) 2014/15 TOTAL (bands of £5,000) £000</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</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>
<td>25-30</td>
</tr>
<tr>
<td>Dr Farhan Sami*, Clinical Network Leader</td>
<td>25-30</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25-30</td>
<td>20-25</td>
</tr>
</tbody>
</table>

*Dr Atif Hasan was appointed as a Medical Director from 1st March 2016 and amounts disclosed above represent payment to him for both GP Governing Body Member and Medical Director posts.

*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. 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 2015/16 (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>1,056</td>
<td>-</td>
<td>1,056</td>
</tr>
<tr>
<td>Mike Sexton</td>
<td>Chief Finance Officer</td>
<td>727</td>
<td>-</td>
<td>727</td>
</tr>
<tr>
<td>Stephen Warren</td>
<td>Director of Commissioning</td>
<td>85</td>
<td>-</td>
<td>85</td>
</tr>
<tr>
<td>Dr Anthony Brzezicki</td>
<td>Chair</td>
<td>309</td>
<td>-</td>
<td>309</td>
</tr>
<tr>
<td>Amanda Page</td>
<td>Chief Nurse</td>
<td>207</td>
<td>-</td>
<td>207</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 pension age</th>
<th>(b) Real increase in pension lump sum at pension age</th>
<th>(c) Total accrued pension at pension age at 31 March 2016</th>
<th>(d) Lump sum at pension age related to accrued pension at 31 March 2016</th>
<th>(e) Cash Equivalent Transfer Value at 1 April 2015</th>
<th>(f) Real increase in Cash Equivalent Transfer Value</th>
<th>(g) Cash Equivalent Transfer Value at 31 March 2016</th>
<th>(h) Employer's contribution to stakeholder pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Swann, Chief Officer</td>
<td>0-2.5</td>
<td>-</td>
<td>45-50</td>
<td>135-140</td>
<td>770</td>
<td>22</td>
<td>801</td>
<td>18</td>
</tr>
<tr>
<td>Mike Sexton, Chief Financial Officer</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>25-30</td>
<td>70-75</td>
<td>384</td>
<td>23</td>
<td>412</td>
<td>15</td>
</tr>
<tr>
<td>Stephen Warren, Director of Commissioning</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>40-45</td>
<td>120-125</td>
<td>749</td>
<td>38</td>
<td>796</td>
<td>14</td>
</tr>
<tr>
<td>Elaine Clancy, Director of Quality and Governance</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>20-25</td>
<td>70-75</td>
<td>327</td>
<td>33</td>
<td>371</td>
<td>11</td>
</tr>
<tr>
<td>Amanda Page, Chief Nurse</td>
<td>-</td>
<td>-</td>
<td>35-40</td>
<td>105-110</td>
<td>673</td>
<td>1</td>
<td>685</td>
<td>2</td>
</tr>
</tbody>
</table>

The CETV factors used in the Senior Managers' Pension Benefits calculation are effective as at 15 March 2016 rather than 31 March 2016. These factors represent the latest available following the Government’s announcement that the discount rate for unfunded pension schemes would reduce, as new CETV factors post 15 March 2016 are not yet available.
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 2015/16 was £123k (2014/15, £123k). This was 2.3 times (2014/15, 2.6 times) the median remuneration of the workforce, which was £53k (2014/15, £47k).

In 2015/16, no employee received remuneration in excess of the highest paid member of the Governing Body or the highest paid director. Annual remuneration ranged from £23k to £123k (2014/15 £19k-£123k).

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.

Off-payroll Engagements

There were no off-payroll engagements as of 31 March 2016. There were 21 (2014/15: 21) individuals that have been deemed “Governing Body members, and/or, senior officials with significant financial responsibility”, during the financial year. These were all on-payroll engagements.
Our staff

Communicating and Engaging

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

- A SWL Staff Partnership Forum where managers and staff from the six SWL CCGs meet to discuss and consult on issues.
- There are regular team briefings with the staff and Executive Management Team.
- The CCG participated in the national NHS Staff Survey in 2015. This has provided the CCG with the opportunity to build up a picture of staff experience and to compare their scores with other CCGs. An action plan will be agreed based on the results from the survey.
- The CCG have worked with the South East Commissioning Support Unit on an important piece of Organisational Development (OD) work during 2015. The work was designed to address concerns raised via the Staff Survey, at staff forums, at the Governing Body meeting and by members and focused on the following 4 key areas. Action plans relating to each area have been developed and are being implemented.
  1. Vision and values, behaviour and culture
  2. Leadership and people development
  3. Communications, staff engagement and clinical engagement
  4. Recruitment, retention, performance and reward

Training and Development

There is a requirement for staff to undertake Statutory & Mandatory training, which they can complete either via e-learning from Skills for Health or through in-house sessions. Training compliance is reported back to the CCG on a regular basis.

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 global emails 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 2016)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of persons of each sex who were on the Governing Body (excluding senior managers)</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>The number of other senior managers of each sex who were a grade Very Senior Manager</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The number of other senior managers of each sex who were a Band 9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The number of persons of each sex who were employees of the CCG</td>
<td>22</td>
<td>49</td>
</tr>
</tbody>
</table>

The above table reports the number and composition of staff as at 31 March 2016. This differs from the 21 Governing Body members and/or senior officials stated on page 91 and within the Senior Managers’ Salaries and Allowances table as these report on staff holding the role of Governing Body member and/or senior official during the financial year.

The number and composition of staff as at 31 March 2016 will also vary from the whole time equivalent number of employees reported, which reports the average number of employees during the year, and includes both permanently employed and other staff.
Staff numbers (Audited)

The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year.

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th></th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Number</td>
<td>Permanently employed Number</td>
<td>Other Number</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
<td>49</td>
<td>16</td>
</tr>
</tbody>
</table>

Sickness Absence (Audited)

The CCG Sickness Absence percentage 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.

Sickness absence data

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total days lost</td>
<td>195</td>
<td>70</td>
</tr>
<tr>
<td>Total staff Years</td>
<td>49</td>
<td>28</td>
</tr>
<tr>
<td>Average Working days lost</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Number of persons retiring on ill health grounds</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Paula Swann
Accountable Officer

24 May 2016
SECTION 3: ANNUAL ACCOUNTS
Data entered below will be used throughout the workbook:

Entity name: NHS Croydon CCG
This year 2015-16
This year ended 31-March-2016
This year commencing: 01-April-2015
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<th>Page Number</th>
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<td>Statement of Changes in Taxpayers' Equity for the year ended 31st March 2016</td>
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<table>
<thead>
<tr>
<th>Notes to the Accounts</th>
<th>Page Number</th>
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<td>Accounting policies</td>
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</tr>
<tr>
<td>Revenue</td>
<td>109</td>
</tr>
<tr>
<td>Employee benefits and staff numbers</td>
<td>110-112</td>
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<tr>
<td>Operating expenses</td>
<td>113</td>
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<td>Operating leases</td>
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<tr>
<td>Trade and other receivables</td>
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<tr>
<td>Cash and cash equivalents</td>
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</tr>
<tr>
<td>Trade and other payables</td>
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<tr>
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<tr>
<td>Contingencies</td>
<td>119</td>
</tr>
<tr>
<td>Commitments</td>
<td>119</td>
</tr>
<tr>
<td>Financial instruments</td>
<td>119-120</td>
</tr>
<tr>
<td>Operating segments</td>
<td>121</td>
</tr>
<tr>
<td>Pooled budgets</td>
<td>121</td>
</tr>
<tr>
<td>Related party transactions</td>
<td>122</td>
</tr>
<tr>
<td>Events after the end of the reporting period</td>
<td>123</td>
</tr>
<tr>
<td>Losses and special payments</td>
<td>123</td>
</tr>
<tr>
<td>Financial performance targets</td>
<td>123</td>
</tr>
</tbody>
</table>
INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS CROYDON CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Croydon Clinical Commissioning Group for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014 (the “Act”). 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 International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the Department of Health Group Manual for Accounts 2015/16 (the 2015/16 MFA) and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

This report is made solely to the members of the Governing Body of NHS Croydon Clinical Commissioning Group (CCG), as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer’s Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Act (the “Code of Audit Practice”).

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG’s resources. We are required under Section 21 (1)(c) of the Act to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report our opinion as required by Section 21(4)(b) of the Act.

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

Scope of the audit of the financial statements

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, issued by the Comptroller and Auditor General in November 2015, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016, and to report by exception where we are not satisfied.

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

Opinion on financial statements

In our opinion the financial statements:
• give a true and fair view of the financial position of NHS Croydon Clinical Commissioning Group as at 31 March 2016 and of its expenditure and income for the year then ended; and
• have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MIA and the Accounts Direction.

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 recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Opinion on other matters

In our opinion:

• the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MIA and the Accounts Direction; and
• the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Act because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 17 May 2016 we referred a matter to the Secretary of State under section 30 of the Act in relation to the CCG's breach of its Revenue Resource Limit for the year ending 31 March 2016. The CCG breached its Revenue Resource Limit for the year ending 31 March 2016 by £43.7m.

We are also required to report to you if:

• in our opinion the governance statement does not comply with the guidance issued by the NHS Commissioning Board; or
• we issue a report in the public interest under section 24 of the Act; or
• we make a written recommendation to the CCG under section 24 of the Act; or
• we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of its resources for the year ended 31 March 2016.

We have nothing to report in these respects.

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 Act and the Code of Audit Practice.

Sarah L. Ironmonger
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Fleming Way
Manor Royal
Crawley
RH10 9GT

24 May 2016
NHS Croydon CCG - Annual Accounts 2015-16

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

<table>
<thead>
<tr>
<th>Note</th>
<th>2015-16 £000</th>
<th>2014-15 £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>5,866</td>
<td>4,288</td>
</tr>
<tr>
<td>Operating Expenses 5</td>
<td>460,844</td>
<td>435,238</td>
</tr>
<tr>
<td>Other operating revenue 2</td>
<td>(2,383)</td>
<td>(1,705)</td>
</tr>
<tr>
<td><strong>Net operating expenditure before interest</strong></td>
<td>464,327</td>
<td>437,821</td>
</tr>
<tr>
<td><strong>Total Net Expenditure for the year</strong></td>
<td>464,327</td>
<td>437,821</td>
</tr>
</tbody>
</table>

Of which:

**Administration Income and Expenditure**

<table>
<thead>
<tr>
<th>Note</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee benefits 4.1.1</td>
<td>2,971</td>
<td>3,079</td>
</tr>
<tr>
<td>Operating Expenses 5</td>
<td>5,613</td>
<td>5,779</td>
</tr>
<tr>
<td>Other operating revenue 2</td>
<td>(322)</td>
<td>(709)</td>
</tr>
<tr>
<td><strong>Net administration costs before interest</strong></td>
<td>8,262</td>
<td>8,149</td>
</tr>
</tbody>
</table>

**Programme Income and Expenditure**

<table>
<thead>
<tr>
<th>Note</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee benefits 4.1.1</td>
<td>2,895</td>
<td>1,209</td>
</tr>
<tr>
<td>Operating Expenses 5</td>
<td>455,231</td>
<td>429,459</td>
</tr>
<tr>
<td>Other operating revenue 2</td>
<td>(2,061)</td>
<td>(996)</td>
</tr>
<tr>
<td><strong>Net programme expenditure before interest</strong></td>
<td>456,065</td>
<td>429,672</td>
</tr>
</tbody>
</table>

**Total comprehensive net expenditure for the year**

<table>
<thead>
<tr>
<th>Note</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>464,327</td>
<td>437,821</td>
</tr>
</tbody>
</table>
NHS Croydon CCG – Annual Accounts 2015-16

Statement of Financial Position as at 31-March-2016

<table>
<thead>
<tr>
<th>Note</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>3,237</td>
<td>3,472</td>
</tr>
<tr>
<td>10</td>
<td>62</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td><strong>3,299</strong></td>
<td><strong>3,534</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>(40,791)</td>
<td>(41,695)</td>
</tr>
<tr>
<td>12</td>
<td>0</td>
<td>(112)</td>
</tr>
<tr>
<td></td>
<td><strong>(40,791)</strong></td>
<td><strong>(41,807)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(37,492)</td>
<td>(38,273)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(37,492)</td>
<td>(38,273)</td>
</tr>
</tbody>
</table>

The financial statements were approved by the Governing Body on 24 May 2016 and signed on its behalf by:

Paula Swann  
Accountable Officer

24 May 2016

Mike Sexton  
Chief Finance Officer

24 May 2016
## Statement of Changes In Taxpayers Equity for the year ended 31-March-2016

<table>
<thead>
<tr>
<th>General fund</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes in taxpayers’ equity for 2015-16</strong></td>
<td></td>
</tr>
<tr>
<td>Balance at 1 April 2015</td>
<td>(38,273)</td>
</tr>
<tr>
<td><strong>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2015-16</strong></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(464,327)</td>
</tr>
<tr>
<td><strong>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</strong></td>
<td>(464,327)</td>
</tr>
<tr>
<td>Net funding</td>
<td>465,108</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2016</strong></td>
<td>(37,492)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General fund</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes in taxpayers’ equity for 2014-15</strong></td>
<td></td>
</tr>
<tr>
<td>Balance at 1 April 2014</td>
<td>(30,829)</td>
</tr>
<tr>
<td><strong>Changes in NHS Commissioning Board taxpayers’ equity for 2014-15</strong></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(437,821)</td>
</tr>
<tr>
<td><strong>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</strong></td>
<td>(437,821)</td>
</tr>
<tr>
<td>Net funding</td>
<td>430,377</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2015</strong></td>
<td>(38,273)</td>
</tr>
</tbody>
</table>
## Statement of Cash Flows for the year ended 31-March-2016

### Cash Flows from Operating Activities

<table>
<thead>
<tr>
<th>Note</th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(464,327)</td>
<td>(437,821)</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>9</td>
<td>235</td>
</tr>
<tr>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>11</td>
<td>(904)</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>12</td>
<td>(17)</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>12</td>
<td>(95)</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Operating Activities</strong></td>
<td><strong>(465,108)</strong></td>
<td><strong>(430,466)</strong></td>
</tr>
</tbody>
</table>

### Net Cash Inflow (Outflow) from Investing Activities

<table>
<thead>
<tr>
<th></th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Cash Inflow (Outflow) before Financing</strong></td>
<td><strong>(465,108)</strong></td>
<td><strong>(430,466)</strong></td>
</tr>
</tbody>
</table>

### Cash Flows from Financing Activities

<table>
<thead>
<tr>
<th></th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant in Aid Funding Received</td>
<td>465,108</td>
<td>430,377</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Financing Activities</strong></td>
<td><strong>465,108</strong></td>
<td><strong>430,377</strong></td>
</tr>
</tbody>
</table>

### Net Increase (Decrease) in Cash & Cash Equivalents

<table>
<thead>
<tr>
<th></th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Increase (Decrease) in Cash &amp; Cash Equivalents</strong></td>
<td><strong>0</strong></td>
<td><strong>(89)</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</strong></td>
<td>62</td>
<td>151</td>
</tr>
</tbody>
</table>

### Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year

<table>
<thead>
<tr>
<th></th>
<th>2015-16 £000</th>
<th>2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash &amp; Cash Equivalents (including bank overdrafts) at the End of the Financial Year</strong></td>
<td>62</td>
<td>62</td>
</tr>
</tbody>
</table>
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 Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2015/16 issued by NHS England. The accounting policies contained in Manual for Accounts 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 Manual for Accounts 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 despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act for the breach of financial duties. 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 2016/17 and 2017/18.
- 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 actual and indicative allocations (January 2016) from 2016/17 to 2020/21 (5 years in total).
- Detailed financial plans have been submitted to the Governing Body and NHSE for 2016/17. Further iterations of the 2016/17 Financial Plans are being developed and submitted to Governing Body and NHSE. A draft Financial Improvement Plan has been submitted to NHS England for the period from 2016/17 – 2020/21.

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 30 of the Local Audit and Accountability Act 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

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 hosts the BCF under a pooled budget ‘jointly controlled operation’ arrangement.

Where the CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the CCG 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.

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 contract reports (£1.3m).
- Estimates of the final two months prescribing expenditure have been conservatively based on historical expenditure patterns (£6.8m).
- Estimates of continuing care expenditure in the final two months have been based on client registers (£1.9m) and expenditure trends.

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
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

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

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.

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.

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 valuation 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 clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical lifetime of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

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

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

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

Contingent rentals are recognised as an expense in the period in which they are incurred. Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

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

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

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 1.55%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.00%
- Timing of cash flows (over 10 years): Minus 0.80%
- All employee early departures: 1.37%

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

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

1.14 Clinical Negligence Costs

The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.15 Non-clinical Risk Pooling

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

1.16 Continuing healthcare risk pooling

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

1.17 Contingencies

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

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

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

1.18 Financial Assets

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

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 clinical commissioning group’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.

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.
Notes to the financial statements

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

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

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

1.19 Financial Liabilities

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

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

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

1.21 Foreign Currencies

The clinical commissioning group’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 clinical commissioning group’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 normality of payments. They are divided into different categories, which govern the way that individual cases are handled.

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

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>2015-16 Total £000</th>
<th>2015-16 Admin £000</th>
<th>2015-16 Programme £000</th>
<th>2014-15 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education, training and research</td>
<td>229</td>
<td>127</td>
<td>102</td>
<td>210</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>2,001</td>
<td>195</td>
<td>1,806</td>
<td>1,391</td>
</tr>
<tr>
<td>Other revenue</td>
<td>153</td>
<td>0</td>
<td>153</td>
<td>104</td>
</tr>
<tr>
<td><strong>Total other operating revenue</strong></td>
<td><strong>2,383</strong></td>
<td><strong>322</strong></td>
<td><strong>2,061</strong></td>
<td><strong>1,705</strong></td>
</tr>
</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 the London Borough of Croydon for contribution towards transformation costs on the Outcomes Based Commissioning programme and recharges to the London Borough of Croydon 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>2015-16</th>
<th>Total</th>
<th>Admin</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
<td>Other</td>
<td>Total</td>
<td>Permanent</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>5,139</td>
<td>3,239</td>
<td>1,900</td>
<td>2,598</td>
</tr>
<tr>
<td>Social security costs</td>
<td>312</td>
<td>312</td>
<td>0</td>
<td>171</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>415</td>
<td>415</td>
<td>0</td>
<td>202</td>
</tr>
<tr>
<td>Gross employee benefits expenditure</td>
<td>5,866</td>
<td>3,966</td>
<td>1,900</td>
<td>2,971</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>
</tr>
<tr>
<td>Total - Net admin employee benefits including capitalised costs</td>
<td>5,866</td>
<td>3,966</td>
<td>1,900</td>
<td>2,971</td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net employee benefits excluding capitalised costs</td>
<td>5,866</td>
<td>3,966</td>
<td>1,900</td>
<td>2,971</td>
</tr>
</tbody>
</table>

#### 4.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>Total</th>
<th>Admin</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
<td>Other</td>
<td>Total</td>
<td>Permanent</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Employee Benefits</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>
</tr>
<tr>
<td>Social security costs</td>
<td>209</td>
<td>209</td>
<td>0</td>
<td>146</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>256</td>
<td>256</td>
<td>0</td>
<td>158</td>
</tr>
<tr>
<td>Gross employee benefits expenditure</td>
<td>4,288</td>
<td>2,680</td>
<td>1,608</td>
<td>3,079</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>
</tr>
<tr>
<td>Total - Net admin employee benefits including capitalised costs</td>
<td>4,288</td>
<td>2,680</td>
<td>1,608</td>
<td>3,079</td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net employee benefits excluding capitalised costs</td>
<td>4,288</td>
<td>2,680</td>
<td>1,608</td>
<td>3,079</td>
</tr>
</tbody>
</table>

#### 4.1.2 Recoveries in respect of employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>Total</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Employee Benefits - Revenue</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>
</tr>
</tbody>
</table>

In February 2015 staff employed by South East Commissioning Support Unit transferred to the CCG’s Prescribing and Clinical Engagement Teams to manage services directly. This has lead to an increase in both Programme employee benefits and number of people employed.
4.2 Average number of people employed

<table>
<thead>
<tr>
<th>Total Number</th>
<th>Permanently employed Number</th>
<th>Other Number</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>49</td>
<td>16</td>
<td>40</td>
</tr>
</tbody>
</table>

4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>195</td>
<td>70</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>49</td>
<td>28</td>
</tr>
<tr>
<td>Average working Days Lost</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

The total days lost balance of 195 days includes one instance of long term sickness accounting for 102 days sickness absence which ended in September 2015, and one ongoing instance of sickness absence accounting for 24 days. As a result of these periods the total days lost recorded in 2015/16 has increased in comparison with 2014/15.

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons retired early on ill health grounds</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total additional Pensions liabilities accrued in the year</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

There have been no exit packages or redundancies agreed during 2015/16.

In 2014/15 there was one compulsory redundancy for £26,180 recorded in the banding £25,001 to £50,000 which was paid in accordance with the provisions of the Agenda for Change Redundancy Scheme.
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 2008 to that date. Details can be found on the pension scheme website at www.nhsbsa.nhs.uk/pensions.

For 2015-16, employers’ contributions of £415,028 were payable to the NHS Pensions Scheme (2014-15: £256,813) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme’s actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.4.1.
## 5. Operating expenses

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>5,317</td>
<td>2,422</td>
<td>2,895</td>
<td>3,829</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>549</td>
<td>549</td>
<td>0</td>
<td>459</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>5,866</td>
<td>2,971</td>
<td>2,895</td>
<td>4,288</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>9,669</td>
<td>4,754</td>
<td>4,915</td>
<td>11,391</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>113,459</td>
<td>10</td>
<td>113,459</td>
<td>91,899</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>224,048</td>
<td>0</td>
<td>224,048</td>
<td>230,046</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies*</td>
<td>63,906</td>
<td>0</td>
<td>63,906</td>
<td>53,833</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>240</td>
<td>0</td>
<td>240</td>
<td>320</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>1,456</td>
</tr>
<tr>
<td>Establishment</td>
<td>440</td>
<td>124</td>
<td>316</td>
<td>123</td>
</tr>
<tr>
<td>Transport</td>
<td>34</td>
<td>1</td>
<td>33</td>
<td>76</td>
</tr>
<tr>
<td>Premises</td>
<td>632</td>
<td>274</td>
<td>358</td>
<td>517</td>
</tr>
<tr>
<td>Impairments and reversals of receivables</td>
<td>178</td>
<td>0</td>
<td>178</td>
<td>(300)</td>
</tr>
<tr>
<td>Audit fees</td>
<td>86</td>
<td>86</td>
<td>0</td>
<td>114</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>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Other services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>42,492</td>
<td>0</td>
<td>42,492</td>
<td>41,326</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS*</td>
<td>3,598</td>
<td>0</td>
<td>3,598</td>
<td>3,288</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>248</td>
<td>184</td>
<td>64</td>
<td>185</td>
</tr>
<tr>
<td>Education and training</td>
<td>220</td>
<td>176</td>
<td>44</td>
<td>238</td>
</tr>
<tr>
<td>Provisions</td>
<td>763</td>
<td>0</td>
<td>(95)</td>
<td>112</td>
</tr>
<tr>
<td>CHC Risk Pool contributions</td>
<td>1,673</td>
<td>0</td>
<td>1,673</td>
<td>596</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>466,844</td>
<td>5,613</td>
<td>455,231</td>
<td>435,238</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>466,710</td>
<td>8,584</td>
<td>458,126</td>
<td>439,526</td>
</tr>
</tbody>
</table>

*Prior year comparatives have been restated for the following areas due to changes in the presentation of expenditure for these items in the financial statements.

Purchase of healthcare from non-NHS bodies (860)

GPMS/APMS and PCTMS 860
6.1 Better Payment Practice Code

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£000</td>
<td>Number</td>
<td>£000</td>
</tr>
<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>14,238</td>
<td>74,993</td>
<td>11,385</td>
<td>60,004</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>13,657</td>
<td>71,616</td>
<td>10,392</td>
<td>53,591</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>95.9%</td>
<td>95.5%</td>
<td>91.3%</td>
<td>89.3%</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>3,223</td>
<td>369,145</td>
<td>3,402</td>
<td>331,958</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>3,068</td>
<td>366,583</td>
<td>2,702</td>
<td>330,000</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>95.2%</td>
<td>99.3%</td>
<td>79.4%</td>
<td>99.4%</td>
</tr>
</tbody>
</table>

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

There have been no claims made under the Late Payment of Commercial Debts (Interest) Act 1998 in 2015/16 (2014/15: nil).

7 Income Generation Activities

The CCG charges rent for office accommodation costs (£195k) to South East 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 2015/16, 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>Payments recognised as an expense</th>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Land £000</td>
<td>Buildings £000</td>
</tr>
<tr>
<td>Minimum lease payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>528</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>528</td>
</tr>
</tbody>
</table>

### 8.1.2 Future minimum lease payments

<table>
<thead>
<tr>
<th>Payable:</th>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Land £000</td>
<td>Buildings £000</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>366</td>
</tr>
<tr>
<td>After five years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>610</td>
</tr>
</tbody>
</table>
9. Trade and other receivables

<table>
<thead>
<tr>
<th>Current</th>
<th>Non-current</th>
<th>Current</th>
<th>Non-current</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

NHS receivables: Revenue 449 0 508 0
NHS prepayments 2,044 0 2,539 0
Non-NHS receivables: Revenue 584 0 196 0
Non-NHS prepayments 272 0 218 0
Provision for the impairment of receivables (178) 0 0 0
VAT 66 0 14 0
Other receivables 0 0 (3) 0
Total Trade & other receivables 3,237 0 3,472 0
Total current and non current 3,237 3,472

9.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

By up to three months 822 688
By three to six months 22 7
By more than six months 393 2
Total 1,237 697

£164k 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 2016.

9.2 Provision for impairment of receivables

<table>
<thead>
<tr>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Balance at 01-April-2015 0 (300)

Amounts written off during the year 0 0
Amounts recovered during the year 0 300
(Increase) decrease in receivables impaired (178) 0
Transfer (to) from other public sector body 0 0
Balance at 31-March-2016 (178) 0

The impairment relates to two invoices raised to the London Borough of Croydon: the 2014/15 falls reaeblement funding of £216k and a recharge for bed usage in Amberley Lodge of £140k. A 50% impairment has been made against both invoices.
10 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Balance at 01-April-2015</td>
<td>62</td>
<td>151</td>
</tr>
<tr>
<td>Net change in year</td>
<td>0</td>
<td>(89)</td>
</tr>
<tr>
<td>Balance at 31-March-2016</td>
<td>62</td>
<td>62</td>
</tr>
</tbody>
</table>

Made up of:
- Cash with the Government Banking Service: 62
- Cash with Commercial banks: 0
- Cash in hand: 0
- Current investments: 0
- Cash and cash equivalents as in statement of financial position: 62
- Bank overdraft: Government Banking Service: 0
- Bank overdraft: Commercial banks: 0
- Total bank overdrafts: 0

Balance at 31-March-2016: 62

No patients' money is held by the CCG.

11 Trade and other payables

<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 payables: revenue</td>
<td>6,951</td>
<td>0</td>
<td>8,581</td>
<td>0</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>8,221</td>
<td>0</td>
<td>6,756</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS payables: revenue</td>
<td>7,937</td>
<td>0</td>
<td>4,855</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS accruals</td>
<td>17,208</td>
<td>0</td>
<td>21,134</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS deferred income</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social security costs</td>
<td>48</td>
<td>0</td>
<td>38</td>
<td>0</td>
</tr>
<tr>
<td>Tax</td>
<td>52</td>
<td>0</td>
<td>41</td>
<td>0</td>
</tr>
<tr>
<td>Other payables</td>
<td>372</td>
<td>0</td>
<td>290</td>
<td>0</td>
</tr>
<tr>
<td>Total Trade &amp; Other Payables</td>
<td>40,791</td>
<td>0</td>
<td>41,695</td>
<td>0</td>
</tr>
</tbody>
</table>

Total current and non-current: 40,791

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

Other payables include £130k (2014/15, £195k) of outstanding pension contributions at 31 March 2016. The 2014/15 balance has been restated from following an update on the amount reported as outstanding pension contributions. Previously reported as £44k.
12 Provisions

<table>
<thead>
<tr>
<th>Current 2015-16 £000</th>
<th>Non-current 2015-16 £000</th>
<th>Current 2014-15 £000</th>
<th>Non-current 2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pensions relating to former directors</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pensions relating to other staff</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Restructuring</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Redundancy</td>
<td>0</td>
<td>0</td>
<td>112</td>
</tr>
<tr>
<td>Agenda for change</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Equal pay</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Legal claims</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Continuing care</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>112</strong></td>
</tr>
</tbody>
</table>

**Total current and non-current**

<table>
<thead>
<tr>
<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>Agenda for Change £000s</th>
<th>Equal Pay £000s</th>
<th>Legal Claims £000s</th>
<th>Continuing Care £000s</th>
<th>Other £000s</th>
<th>Total £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 01-April-2015</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>112</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Arising during the year</td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Utilised during the year</td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>(17)</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Reversed unused</td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>(95)</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Unwinding of discount</td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Change in discount rate</td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Transfer (b) from other public sector body</td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Balance at 31-March-2016</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

**Expected timing of cash flows:**

- **Within one year**
  - **0**
  - **0**
  - **0**
  - **0**
- **Between one and five years**
  - **0**
  - **0**
  - **0**
  - **0**
- **After five years**
  - **0**
  - **0**
  - **0**
  - **0**

<table>
<thead>
<tr>
<th>Balance at 31-March-2016</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

£Nil is included in the provisions of the NHS Litigation Authority as at 31 March 2016 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 2016 is £3,890k.
13 Contingencies
The CCG does not have any Contingent Liabilities or Contingent Assets.

14 Commitments
14.1 Capital commitments
The CCG does not have any Capital Commitments.

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

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

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

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

15.1.2 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.

15.1.3 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.

15.1.4 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.
15 Financial instruments cont’d

15.2 Financial assets

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>Loans and Receivables</th>
<th>Available for Sale</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Receivables:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>449</td>
<td>0</td>
<td>449</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>584</td>
<td>0</td>
<td>584</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>0</td>
<td>62</td>
<td>0</td>
<td>62</td>
</tr>
<tr>
<td><strong>Total at 31-March-2016</strong></td>
<td>0</td>
<td>1,095</td>
<td>0</td>
<td>1,095</td>
</tr>
</tbody>
</table>

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

15.3 Financial liabilities

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Payables:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>15,172</td>
<td>15,172</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>25,517</td>
<td>25,517</td>
</tr>
<tr>
<td><strong>Total at 31-March-2016</strong></td>
<td>0</td>
<td>40,689</td>
<td>40,689</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Payables:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>15,337</td>
<td>15,337</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>26,279</td>
<td>26,279</td>
</tr>
<tr>
<td><strong>Total at 31-March-2015</strong></td>
<td>0</td>
<td>41,616</td>
<td>41,616</td>
</tr>
</tbody>
</table>
16 Operating segments

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

17 Pooled budgets

For 2015/16, the CCG has entered into a S75 agreement with the London Borough of Croydon (LBC) on the Better Care Fund (BCF). The CCG hosts the BCF under a pooled budget 'jointly controlled operation' arrangement.

The financial contributions of the CCG and the London Borough of Croydon are set out in Schedule 1 Part 1 of the S75 agreement. Subject to the requirements of National Guidance and the Better Care Fund Plan, the agreed return of any underspend is in the following proportions: CCG 70%; Council 30%.

The share of the income and expenditure handled by the pooled budget in the financial year were:

<table>
<thead>
<tr>
<th></th>
<th>2015/16 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
</tr>
<tr>
<td><strong>Contribution of Funds</strong></td>
<td></td>
</tr>
<tr>
<td>Croydon CCG</td>
<td>21,498</td>
</tr>
<tr>
<td>London Borough of Croydon</td>
<td>2,642</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>24,140</td>
</tr>
<tr>
<td><strong>Application of Funds</strong></td>
<td></td>
</tr>
<tr>
<td>Health Initiatives (Croydon CCG)</td>
<td>(12,600)</td>
</tr>
<tr>
<td>Social Care Initiatives (London Borough of Croydon)</td>
<td>(10,635)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(23,235)</td>
</tr>
<tr>
<td><strong>Surplus Funds</strong></td>
<td>905</td>
</tr>
<tr>
<td>Distribution of Surplus Funds:</td>
<td></td>
</tr>
<tr>
<td>Croydon CCG (70%)</td>
<td>(633)</td>
</tr>
<tr>
<td>London Borough of Croydon (30%)</td>
<td>(272)</td>
</tr>
<tr>
<td><strong>Balance carried forward</strong></td>
<td>-</td>
</tr>
</tbody>
</table>
Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2015/16 Payments to Related Party £000</th>
<th>2015/16 Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
<th>2014/15 Payments to Related Party £000</th>
<th>2014/15 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&lt;sup&gt;1&lt;/sup&gt;</td>
<td>98</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>197</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Eversley Medical Centre - Dr John Chan&lt;sup&gt;1&lt;/sup&gt;</td>
<td>122</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>97</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Parchmore Partnership - Dr Agnelo Fernandes&lt;sup&gt;1&lt;/sup&gt;</td>
<td>216</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>181</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Haling Park Medical Practice - Dr Agnelo Fernandes&lt;sup&gt;1&lt;/sup&gt;</td>
<td>62</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>34</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>South Norwood Medical Practice - Dr Agnelo Fernandes&lt;sup&gt;1&lt;/sup&gt;</td>
<td>69</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>79</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Boots PLC - Dr Agnelo Fernandes&lt;sup&gt;1&lt;/sup&gt;</td>
<td>74</td>
<td>-</td>
<td>54</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bromley Healthcare - Dr Agnelo Fernandes&lt;sup&gt;1&lt;/sup&gt;</td>
<td>1,056</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>978</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Keeston House - Dr Atif Hasan&lt;sup&gt;1&lt;/sup&gt;</td>
<td>177</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>105</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>National Society for Epilepsy - Helen Pernelet&lt;sup&gt;3&lt;/sup&gt;</td>
<td>177</td>
<td>-</td>
<td>14</td>
<td>-</td>
<td>176</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>2,053</td>
<td>0</td>
<td>68</td>
<td>0</td>
<td>1,947</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

<sup>1</sup>Dr Anthony Brzezicki retired from Queenhill Medical Practice on 31 August 2015. Transactions disclosed are those up to this period.

<sup>2</sup>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).

<sup>3</sup>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.

<sup>4</sup>Parchmore Partnership premises are used for the delivery of services managed by Boots PLC and Bromley Healthcare.

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.

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 London Borough of Croydon.
19 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.

20 Losses and special payments

20.1 Losses

The CCG has not had any losses in 2015/16 (2014/15: nil).

20.2 Special payments

The CCG made two special payments total value of £20k in 2015/16 (2014/15: nil).

21 Financial performance targets

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

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Performance</td>
<td>Variance</td>
<td>Target</td>
<td>Performance</td>
<td>Variance</td>
</tr>
<tr>
<td>Expenditure not to exceed income (in year)</td>
<td>455,932</td>
<td>466,710</td>
<td>(10,778)</td>
<td>424,816</td>
<td>439,526</td>
<td>(14,710)</td>
</tr>
<tr>
<td>Expenditure not to exceed income (cumulative)</td>
<td>422,993</td>
<td>466,710</td>
<td>(43,717)</td>
<td>406,587</td>
<td>439,526</td>
<td>(32,939)</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>420,610</td>
<td>464,327</td>
<td>(43,717)</td>
<td>404,882</td>
<td>437,821</td>
<td>(32,939)</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>8,623</td>
<td>8,262</td>
<td>361</td>
<td>9,115</td>
<td>8,149</td>
<td>966</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 £44.8m deficit for 2015/16 financial year. The CCG is reporting an improvement on that planned position of £43.7m cumulative deficit. The in year target was an £11.9m deficit against which the CCG is reporting an improvement on that position of £10.8m.

- The CCG successfully delivered in 2015/16 £10.5m (2014/15, £11m) 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 was underfunded by 8.5% (£38.0m) when based on the relative need of the population. The 2015/16 allocation moved the CCG closer to target (6.87% below target) with a further movement to 3.71% 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 30 of the Local Audit and Accountability Act has been issued for the breach of financial duties, i.e. failure to contain expenditure within the Revenue Resource Limit.