NHS Sheffield CCG Annual Report for 2016/17

Governing Body meeting

D

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Purpose of Paper

CCGs have a statutory requirement to produce and publish an Annual Report each year in line with detailed national guidance regarding content.

The draft Annual Report was presented to Governing Body on 4 May 2017 and the final designed version is now presented for approval. As there have only been minor changes to the content, and given the size of the document, the report has not been printed but made available online on the CCG's website. **A link will be forwarded prior to the meeting, once the design proof has been completed.**

Key Issues

The annual report has been reviewed by NHS England (NHSE) and the CCG's external auditors and a number of minor amends have been made following their feedback.

Feedback from Governing Body members has also been incorporated, including the inclusion of some additional text to highlight challenges faced during 2016-17.

In accordance with the Health and Social Care Act 2012, the CCG has consulted with the Sheffield Health and Wellbeing Board (HWB) on the content of this report.

Is your report for Approval / Consideration / Noting

For approval

Recommendations / Action Required by Governing Body

T
he Governing Body is asked to approve the Annual Report.

Which of the CCG's objectives does this paper support?

- To improve patient experience and access to care
- To ensure there is a sustainable, affordable healthcare system in Sheffield.

It supports management of the following principal risks:

- 1.1 Insufficient communication and engagement with patients and the public on CCG priorities and service developments, leading to loss of confidence in CCG decisions.
- 3.1 CCG is unable to undertake the actions, and deliver the outcomes from them, that

are set out in the HWB's plan for reducing health inequalities, eg due to financial constraints.

- 4.1 Financial Plan with insufficient ability to flex to meet in-year demands and at same to meet the NHSE business rules for 2016/17
- 4.2 Risk management and other governance arrangements put in place by CCG and Sheffield City Council (SCC) SCC to manage the Better Care Fund (BCF) prove inadequate to deliver our integrated commissioning programme and meet our joint efficiency challenges
- 4.3 Inability to deliver the Quality, Innovation, Productivity, Prevention (QIPP) (efficiency) savings plan of £19.5m due to lack of internal capacity and lack of engagement by our key partners

Are there any Resource Implications (including Financial, Staffing etc)?

No

Have you carried out an Equality Impact Assessment and is it attached?

Not relevant

Have you involved patients, carers and the public in the preparation of the report?

The report includes a number of patient stories and a section on how the CCG works with patients and the public. It also takes account of feedback on the previous year's report, which showed people valued a more reader-friendly style.

NHS Sheffield CCG

Annual Report

Performance Report

A picture of health!

Foreword by Maddy Ruff, Accountable Officer and Dr Tim Moorhead, Chair

What a difference a year makes! It's often said but none the less true as we look back at all that we've achieved as a CCG during 2016-17.

Crucially for us, that difference is all about how we improve care and services for people living in Sheffield. Despite the considerable challenges and pressures the NHS is facing, that continues to be our focus and how we judge our success.

Over the past year, we've reduced waits for treatment, improved care for people with cancer and increased support for people experiencing mental health and wellbeing issues. We've worked to tackle the health inequalities in our city and to help keep people well and independent.

We've continued to focus on bringing more services into local communities so that people do not have to go to hospital unless they really need to. Strong primary care is at the heart of this approach and supporting our GP colleagues to work in different ways and investing in our excellent practices is essential to achieve this aim.

This has been achieved against a backdrop of significant challenges, as demand for services continues to increase and put even more pressure on areas such as A&E and primary care. As a CCG, we have also faced significant financial pressures this year and some difficult decisions about how we can use resources to best effect for people in Sheffield.

However, everything we do comes back to how we can make sure people get the best outcomes and experience. As our Chief Nurse Penny Brooks says on page xx, quality is the watchword and part of every discussion we have to keep the focus on what's best for patients.

And it's very much a shared focus in Sheffield as we are increasingly taking a team approach to achieving this. We've long had a strong team spirit in the city and this is at the fore of how we are working to maintain the quality and financial stability of the excellent health and care services we have in Sheffield, both now and for the future.

To do this, we need to think and work differently. This goes beyond joining up services more effectively to having a truly integrated approach and using our

collective resources to the greatest effect. We have made considerable progress on this, including working with Sheffield Council to integrate commissioning for mental health and children and young people.

During the year, we led the development of a single shared plan for Sheffield, that brings together work being done across the city to improve health and wellbeing and sets out shared priorities for transforming health and care.

Our plans for Sheffield have also helped inform the development of the Sustainability and Transformation Plan for South Yorkshire and Bassetlaw, which outlines how we will work as a region to deliver the reforms and efficiency savings set out in the NHS's Five Year Forward View.

These important strategies are our 'blueprint' for health and social care for the next five years and in this report you'll see more about the work that has taken place to develop them and what they will mean for Sheffield.

They say a picture is worth a thousand words so we hope our 'album' of 2016-17 will help show you the many ways we are working to make sure people in Sheffield get first class health care. A huge thank you is due to everyone involved in achieving these - our staff and clinicians, our members and our provider and council colleagues, our partners in the voluntary sector and local communities. Team Sheffield has a lot to be proud of!

Contents index

Photo 1: Shaping Sheffield

pic from latest event

During 2016-17, over 60 organisations in Sheffield joined together to commit to a single plan for improving health and wellbeing in the city.

Shaping Sheffield brings together and joins up the work we are all doing across the city, as well as looking at new ways of working to improve care and make services sustainable.

We already work together closely in many ways but this will rub out the boundaries between our organisations and mean managing our resources for health and care as a single account for the city. This will save time and money, and get things done quickly and effectively for people.

Priorities for 2017 to 2019 have been agreed based on discussions that have taken place with you over the last few years on what we need in Sheffield. Areas we will be investing in include preventing ill-health, helping people back to work, community support to promote independence and self-care, primary care and tackling inequalities by greater investment into our communities with greatest needs.

Work is continuing to agree how this will look, including regular planning events with partners and local community groups. Some will mean very minor changes, some will be on a bigger scale – we will share the details as they develop and give everyone an opportunity to influence the plans.

To get involved contact us at sheccg.engagementactivity@nhs.net

For text boxes (if space)

We want children, young people and adults – everyone – to live long and healthy lives. And we want everyone to have affordable and quality support in place to help them do that.

Did you know?

- Sheffield's population in 2014 was 563,749 – a growth of 10% since 2001. And people are living longer with the 85+ population increasing by 16% since 2001.
- 40% of the city's illness could be prevented or delayed
- By 2020-21 the combined health and social care budget for Sheffield will be £1,390 million – more than £230 million **less** than the city will need if we don't change how we work

About us: a quick guide to NHS Sheffield CCG

Who we are

We are an NHS organisation made up of the 81 local Sheffield GP practices and led by GPs and other healthcare professionals. Our Governing Body is a mixture of NHS clinicians, experienced NHS managers and lay members.

What we do

We are responsible for planning, buying and monitoring (otherwise known as commissioning) many of Sheffield's healthcare services. This includes hospital services and mental healthcare, as well as services that people receive in a community setting, such as district nursing. From April 2016, we also became responsible for working with NHS England to commission local GP services.

We are passionate about helping people to live healthier lives and work with other clinicians, healthcare professionals, patients and the public to improve the health and wellbeing of people in Sheffield and make sure they have high quality and cost effective healthcare services.

Our vision

By working together with patients, public and partners, we will improve and transform the health and wellbeing of our citizens and communities across Sheffield.

We intend to fundamentally change the balance of healthcare provided in hospital and in the community, so that many more patients receive care closer to home when that is the best place for them.

Our four key priorities

- To improve patient experience and access to care
- To improve the quality and equality of healthcare in Sheffield
- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
- To ensure there is a sustainable, affordable healthcare system in Sheffield

To find out more about us and our work, please visit www.sheffieldccg.nhs.uk

Photo 2: Social Prescribing

Photo tbc – Mick?

Over 7,000 people in Sheffield benefitted from a social prescription last year to help tackle the root cause of their ill-health.

Social prescribing is a 'prescription' for non-medical support or services that address a wide range of social, emotional or practical needs that can affect people's health and wellbeing. Coping with bereavement, trying to find a new job or struggling with carer's responsibilities can all impact on someone's health. In these situations, people often turn to their GP for help but usually it's a 'more than medicine' approach that's needed.

GPs and other primary care professionals can refer people to a range of local, non-clinical services, which are often provided by voluntary and community organisations. Prescriptions cover a wide range of activities and support, from advice and guidance to help accessing local activities to improve physical or mental wellbeing.

The benefits? Social prescribing helps people to get control back and improve their health and wellbeing, which also reduces demand on health services as Mick's story shows.

'Snapshot'

Mick's* GP referred him to Sheffield's Community Support Worker (CSW) service as she was concerned about the 73 year old's mobility and that this could lead to falls. The CSW worked with Mick to tackle his mobility problems, including sorting aids and adaptations for his home and helping him use community transport so he could get to the supermarket. Thanks to social prescribing, Mick has regained the independence he loves. His risk of falling is much lower and he feels far less isolated, both of which have helped to prevent further health issues.

*name changed

A team effort

Firm believers in 'no CCG being an island', we work closely with a wide number of other organisations and agencies to deliver our agenda. These include:

- The three NHS foundation trusts that provide our excellent services in Sheffield, as well as a range of other providers, including nursing and residential homes, NHS providers outside of Sheffield, independent sector providers and voluntary organisations.
- Our local **practices** and **primary care organisations**, such as the local professional committees and Primary Care Sheffield (PCS), an organisation with shareholding membership from local practices which provides services and also support for practices.
- **Sheffield City Council,** who we work jointly with to commission a large number of services.
- Sheffield's active **community and voluntary sector**, which makes a major contribution to the local health agenda
- **Patients and patient groups** – see page xx
- **NHS England,** who from April 2016 we worked with to co-commission GP services.

Strategic partnerships

We are members of a number of partnership boards and planning groups, some of which focus on particular health services and health conditions. Our main strategic partnerships are:

- **The Sheffield Health and Wellbeing Board (HWBB)** is a strategic partnership between the CCG and Sheffield City Council to improve health and wellbeing in the city. It brings together local GPs, councillors, senior managers in the local authority and NHS, and Healthwatch Sheffield and encourages integrated working and commissioning between health and social care to get the best offer for people in Sheffield. The HWBB is responsible for assessing the current and future health, care and wellbeing needs of local people, which is known as a Joint Strategic Needs Assessment. You can find out more about our work on page xx.
- In 2016-17, system resilience groups (SRGs) reformed as executive led **A&E Delivery Boards** to help implement improvement initiatives at a greater pace and progress five nationally-mandated improvement initiatives. The Sheffield A&E Delivery Board is chaired by our Accountable Officer, Maddy Ruff.

- The **Sheffield Transformation Board** was set up during the year to oversee the delivery of our place-based plan, Shaping Sheffield. Initially, this comprised the chief officers from health and social care partner organisations who met from December 2016 to discuss our progress towards developing a system-wide approach for delivering services in Sheffield. The priority for 2017/18 will be to formalise the governance arrangements and remit of the Transformation Board, including reviewing its membership.

STPs

A big focus of work for 2016/17 has been developing the sustainability and transformation plan for South Yorkshire and Bassetlaw. Known as STPs, these are five year plans for delivering the reforms and efficiency savings set out in NHS England's Five Year Forward View in local areas. Essentially, this is about how we can best meet people's changing needs and keep improving care while managing increasing demand for services. Treatments have changed, demand has changed and the NHS needs to change too.

This means looking at how we provide services in our local areas and also across the region. The emphasis is on bringing more services out of hospitals and into communities and also considering how hospitals can work together to provide specialist care.

Our STP sets out our shared vision, ambitions and priorities for health and care in South Yorkshire and Bassetlaw and is the result of many months of discussions across the partnership, including with patient representative groups and the voluntary sector. Our goal is for everyone to have a great start in life, with support to stay healthy and live longer. Prevention is at the heart of our plans, which focus on how we can help people to stay well in their own communities, introduce new services and improve coordination between those that exist, and have staff working in the best way to meet people's needs. This includes factors affecting health and wellbeing, such as education, employment and housing.

As well as reshaping and strengthening primary and community services, we want to improve access to specialist hospital care by working as a network, so that no matter where people live, they have excellent, high quality care and experiences.

Between February and April 2017, we discussed the plan with local people and staff in each of the partner organisations, working with Healthwatch and Voluntary Action Sheffield to ensure we had input from a wide range of communities. Feedback from these conversations is being used to help shape how we deliver these plans, with further engagement planned.

At the end of March 2017, South Yorkshire and Bassetlaw was identified as one of nine 'early adopter areas' for developing an accountable care system, recognising

the strength of our relationships and joint working. These are systems in which all NHS organisations, often with local authorities, take on collective responsibility for local resources and population health. During 2017/18, we will be working with NHS England and NHS Improvement to develop an individual model that meets the needs of our region, incorporating local place-based arrangements.

For more information about the STP or how to get involved, please visit www.smybndccgs.nhs.uk

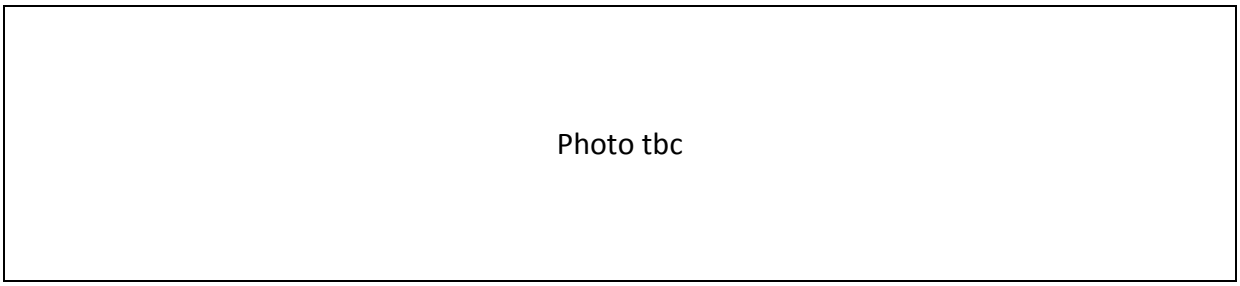
Working Together

Before developing our STP, we were already working with other CCGs across South and Mid Yorkshire, Bassetlaw and Derbyshire to look at areas where we could take a wider approach to commissioning to get the best results for patients.

Known as Commissioners Working Together, this collaborative partnership is working on regional approaches to improve care in a number of areas. Over the last year, we have focused on developing proposals for to improve critical care for people who have had a stroke and children's surgery and anaesthesia services. These were subject to a formal consultation between 3 October 2016 and 14 February 2017. Feedback from this will be used to inform a final decision, which we expect to be made in June 2017.

We also working on a project with Macmillan Cancer support in April 2016 to help improve the experience of people living with and beyond cancer and develop services to support them. For more information visit: www.smybndccgs.nhs.uk/.

Photo 3: We're on the CASE!



A simple new system has brought great benefits for hundreds of patients - and for your local NHS.

CASES stands for Clinical Assessments, Services, Education and Support. In six areas of care we have introduced a process where, if a GP feels a patient needs to be referred to hospital or a specialist clinic, the patient's case is reviewed by a GP with particular expertise in that area. Because of their knowledge and interest, the second GP may be able to suggest an alternative treatment, or confirm that the referral is the best way forward, helping patients get the most appropriate care as quickly as possible.

The benefits? Avoiding unnecessary outpatient appointments for patients and reducing avoidable referrals to hospital - so better streamlined care for patients and hundreds of thousands saved for your NHS. The approach is also providing valuable information to help us identify areas where we can develop more services in the community for patients and support GP education for the benefit of patients.

Patient power!

Working with patients and local people is essential to make sure we commission services that meet the needs of everyone living in Sheffield. Patient involvement has been central to many of the achievements featured in this report and we use a wide variety of ways to work with our local communities and make sure they have chance to influence our work.

And of course it's not just about asking you for your views, it's about really listening and responding to what people tell us. As well as reporting views and feedback for specific engagement projects, we produce a quarterly summary of the key themes arising from all our engagement work to help inform wider planning and decision-making. Outcomes from engagement work are also shared so that you can see how we've used your experiences and feedback to shape services.

Our work in these areas is overseen by our Patient Experience, Engagement and Equality Group (PEEEG), which includes representatives from Healthwatch and partner organisations. The group is responsible for ensuring engagement is carried out to a high standard and that feedback is used to influence planning and decision-making.

Our engagement snapshots

- **Practice Reference Groups (PRG) network**

We launched a new network for members of GP patient groups to give them opportunity to be more involved in our work and find out about local healthcare developments, as well as helping them to share learning and ideas on their work to support their practices. This is open to all groups from the 81 practices in Sheffield and topics discussed at the three meetings held so far included our primary care strategy, prescribing and the Sustainability and Transformation Plan. Feedback from attendees has been very positive, and at their request, we are holding a PRG conference in summer 2017.

- **Urgent care**

Our urgent care strategy was informed by feedback from people in Sheffield, which we worked with Healthwatch to capture. During the year, we carried out further engagement to inform the development of options for how urgent primary care services are provided. This focused on vulnerable groups and deprived communities and we worked with local support groups to get a wide range of valuable feedback on how people use current services and their specific needs.

- **Cancer**

An intensive engagement process was carried out to inform our cancer five year plan. This focused on screening and living beyond cancer, and targeted the more vulnerable communities identified in the equality impact assessment. A key part of the approach included training volunteers to carry out peer conversations to capture views, helping to support the development of skills in local communities.

- **Shaping Sheffield**

We are working with Sheffield Council, Healthwatch, Voluntary Action Sheffield and SOAR to develop plans for engaging local communities in delivering our Shaping Sheffield plans. Views from patients and the public have already played a key part in shaping the overall plan and we want to work in partnership with people in Sheffield to develop the detail and take forward the different programmes it comprises.

- **Patient Transport Service**

Sheffield CCG led the engagement for the procurement of a new patient transport service for South Yorkshire. Three patient representatives worked with us to evaluate the bids from providers, after receiving training on the process, helping to ensure patient needs were reflected in the questions.

- **Prescription Order Line**

Patients also helped us to develop the Prescription Order Line service, which is featured on page xx. Two representatives were part of the team developing the pilot and also helped to develop a user survey to evaluate its success.

- **Community conversation group**

We have established a 'conversation' group with graduates from the Introduction to Community Development and Health course run by Sheffield Council. The group provides a direct link with many of Sheffield's communities to help facilitate discussions on health and local health services. Meetings so far have discussed the role of the group, key areas of interest and Shaping Sheffield.

- **Regional projects**

We've worked with our partner organisations in South Yorkshire to make sure people in Sheffield have chance to influence work we are doing at a regional to level, namely developing the Sustainability and Transformation Plan and consultations on stroke care and children's anaesthesia services. More information about this can be found on page xx and at www.smybndccgs.nhs.uk/

- **In the hotseat!**

We used our annual public meeting last year as an opportunity to hear directly from people in Sheffield about key issues for them and answer questions about the work we do. Sheffield Star editor, Nancy Fielder, quizzed our governing body about the challenges and opportunities facing us, along with questions from Star readers and the 100 people who attended the meeting. The event received very positive feedback – and lots of requests for more similar meetings!

Involve me

Involve Me is our network of patients and the public who want to hear more about what we do or get involved in our work. We have over 700 members; some choose

just to receive our electronic newsletters and updates; others play a more active role, such as representing patient views on a particular group or committee. We also have a Readers' Panel who review documents and information we produce to help make sure it is clear and easy to understand.

If you would like to be part of Involve Me or the Readers' Panel, email us at sheccg.engagementactivity@nhs.net. You can also find out more about our work and get involved via social media – find us on twitter @NHSSheffieldCCG and Facebook/Sheffield CCG.

A big thank you to all of our patient and public participants

We really appreciate the time people have given to find out about our work and give us their views. We are also lucky to have a number of patient and public volunteers who give lots of time and energy to working with us on a regular basis as patient and public representatives. Your involvement really makes a difference and helps us to get services right for people in Sheffield – **thank you**!

Making sure we consider everyone's needs

People have different needs and access services in different ways. We want to ensure there is equality of access and treatment for all the services that we commission, both as a matter of fairness and as an essential part of our drive to reduce health inequalities and improve health and wellbeing.

We consider equality and diversity in all our commissioning, as well as how we can best engage with the diverse communities in Sheffield. To make sure equality and diversity is embedded in our work we also:

- Carry out equality impact assessments on plans and policies to make sure all communities and groups of people have been considered
- Provide training for our staff so that we all understand the diverse population we serve and our equality duties
- Chair the Sheffield Equality Engagement Group, which supports local NHS organisations to meet their equality duties.

In line with our statutory duty as a CCG, we publish equality information annually, demonstrating how we have met our duties in regard to both our staff and the Sheffield population. This is available on our website, along with the five equality objectives that we are working towards. www.sheffieldccg.nhs.uk/our-information/equality.htm

Tell us about it!

When we do something well or could do something better, we want to hear about it. If something has gone wrong or you are unhappy about your care, you can contact us to raise you concerns or to make a formal complaint. We want you to have first-rate health care so please do let us know when things go really well. It might be that a staff member has gone the extra mile or that the care you received exceeded your expectations so we can learn from both your good and not so good experiences.

Photo 4: Battling Type 2 diabetes

Photo – patient on programme?

We were one of 27 places in England selected to offer the world's first nationwide Diabetes Prevention Programme. This targets people at high risk of Type 2 diabetes and aims to help them avoid developing the condition by changing their lifestyles.

People referred by their GP get tailored, personalised support including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing type 2 diabetes.

Starting in October 2016, there were 650 referrals by the end of March, with numbers growing every month. Of these referrals, 60% have resulted in patients taking part in the programme – far above the national prediction of a 25-40% take-up rate.

The benefits? Giving people the opportunity to help reduce their risk of developing Type 2 diabetes, good for them and good for your NHS.

Quality: our main talking point *Chief Nurse Penny Brooks (photo)*

"Quality has to be – and is – our watchword. Every conversation we have should focus on quality, whether it's a discussion about a new service, or finance, or a complaint – anything. What's best for the patient and for good outcomes for health is considered in everything we do. We want patients to get a great experience not just a service.

"We talk about quality all the time: how people receive services, the quality of the environment, the quality of the staff, how they are spoken to – it all makes a huge difference.

"Our main challenge is ensuring that all our providers reach and maintain high quality standards in their services, particularly around infection control, so that patients get the best possible care. This includes a whole range of services including general practice, care homes, mental health and hospital trusts. Close working with healthcare providers is a key part of our work to support improvement wherever we can and make sure they get the support they need to give the highest quality service for patients and clients.

"We look at everything from infection control to how medicines are being dispensed, to the experience patients are getting and complaints received. We also work very closely with Sheffield City Council and Police on safeguarding both adults and children."

Quality guaranteed

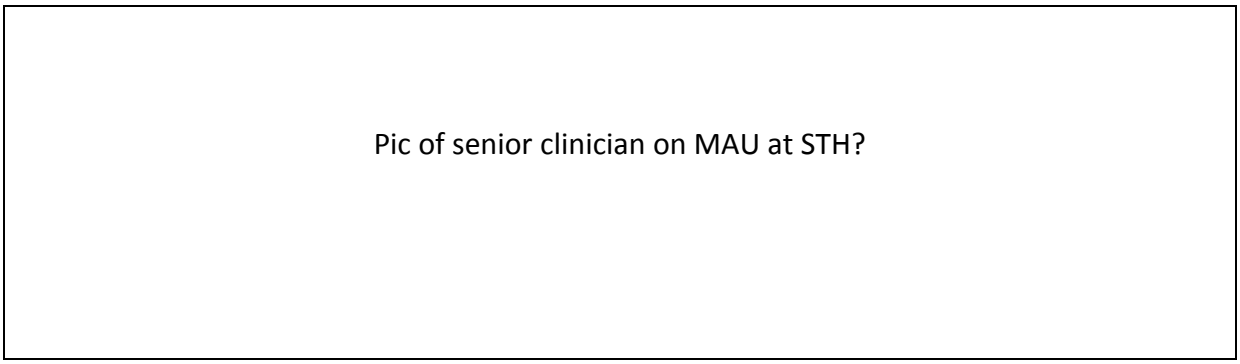
We assess performance against key local and national quality measures every month and report these to our Governing Body. This includes CCG and provider performance on patient experience, the prevention of infections resulting from medical care or treatment in hospital and serious incidents. We also provide quarterly reports on Safeguarding and Compliments and Complaints, as well as a monthly report on Serious Incidents and related learning.

Our Quality Assurance Committee oversees this work and monitors progress on any areas identified for improvement. All reports and committee minutes are available on our website in the Governing Body Meetings section: www.sheffieldccg.nhs.uk/

Snapshots *(with passport style photo strip)*

- We have worked closely with GP practices across the city providing targeted advice and support where it is needed, including helping two practices improve their Care Quality Commission ratings to '*good'.*
- Our team has worked with care homes across the city to help them improve infection prevention and control. All the care homes were audited and teams provided support for them where it was needed, including training and advice.
- The work we have done to manage health assessments for children in the care of the local authority, known as Looked After Children, has been adopted as national best practice.
- We have worked with NHS England to increase whooping cough vaccination rates in pregnant women. Whooping cough can be very dangerous for young babies, requiring hospital admission, and sometimes resulting in death in particularly severe cases. A 'pop up' has been installed on GP IT systems to flag the need for the vaccine for any pregnant women, which has increased uptake by 20%.

Photo 5: Streamlining care



An improved service for patients needing urgent assessment is helping to avoid unnecessary time in hospital and get people home as quickly as possible.

Sometimes patients end up being admitted to hospital when they don't really need to be or staying in hospital for longer than was necessary. Very often these are older patients with complex conditions. We have been working with our partners to stop this happening wherever possible.

The Medical Assessment Centre is playing a key role in tackling this problem, following a redesign of the service. As well as bringing all related services together in one place, the new approach means a senior clinician sees patients as soon as possible so they can decide whether they need to be admitted or treated and safely returned home.

GPs can refer patients directly to the unit instead of them needing to go via A&E and patients able to do so make their own way to the unit, rather than waiting to be taken by a non-emergency ambulance. This has reduced waiting time for patients and helped them get straight to where they need to be.

The benefits? Patients get to hospital faster and are seen more quickly by senior clinicians. The number of patients sent home instead of being admitted has increased to around 30%, improving their experience and helping to make sure beds are available for those that need them.

Quality cont'd

Listening to the experts (with photo of Pete?)

Listening to the experience of patients and their families is a powerful way for healthcare staff to look again at the services they deliver and make sure quality is at the front of their mind.

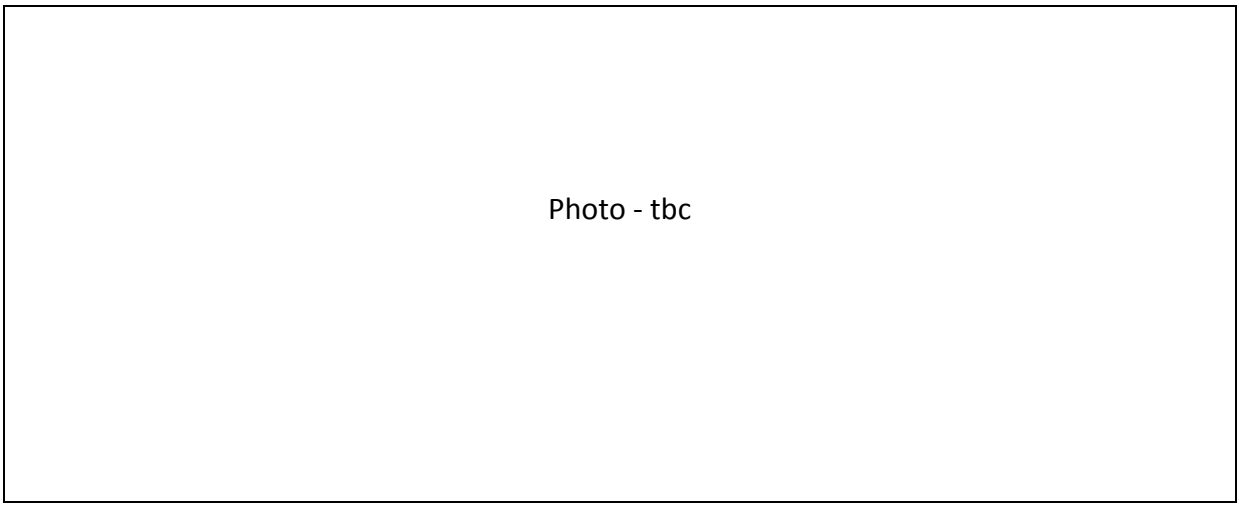
One family's story has been shared to do just that. Sue Lenthall's husband Peter sadly died of multiple sclerosis in 2016. In the last years of his life, he experienced care in a variety of settings and from a wide range of professionals and his family are keen to use their and Pete's experiences to make a difference across the health and social care system. "As his family we could see clearly the small things that some people did for him that made such a difference to his dignity and to his quality of life," explains Sue. "This could be a cup of tea, taking time to listen, ensuring he was comfortable, checking his radio was working or switching 'Pointless' on because they knew he loved listening to it."

Our Continuing Healthcare team is using Pete's story to help reinforce these messages and approach, and emphasise the importance of listening to patients and carers and learning from feedback to support new ways of working. As Clinical Head of Service Debbie Morton says "The main thing is to encourage people to put themselves in 'Pete's' shoes and think about the small changes that can make such a big difference."

Working together to reduce risk of suicides

Our safeguarding team worked with Sheffield City Council and other partners to develop a new suicide prevention strategy for young people. A number of young people from across the city were also involved in its development, including 20-year-old 'Becky', who wanted to use her own experience to help others. The strategy is aimed at frontline practitioners to help them support young people at risk of suicide. It is part of a raft of new local initiatives supporting children and young people's mental health, including developing a better link between child and adolescent mental health services and schools, creating a one-stop-shop for advice and setting up a counselling service for young people up to the age of 25, as well as providing training for schools on a range of mental health issues. As Becky says: "Suicide is a scary thing to talk about but this strategy will help to make sure that children and young people's needs are taken seriously."

Photo 6: Everybody loves good neighbours!



Our new neighbourhood approach is helping people to stay well and get the care they need as close to home as possible.

GP practices have joined together to form 16 groups across the city – known as neighbourhoods – along with their 'neighbours' from hospital, community, mental health, social care and housing services, and local voluntary groups. Each neighbourhood covers a population of around 30-50,000 people.

The practices work together to coordinate health and social care for people in their area, and consider how services are provided. The aim is to make the best use of resources for local communities, tackling the biggest health and social challenges facing their particular area. There is also a strong focus on reducing unnecessary hospital admissions and supporting people to keep well and remain at home where possible.

Whilst still in development, early successes include setting up specialist hospital clinics in the community and more proactive, joined-up care for older people returning home after a stay in hospital.

The benefits? People won't have to go into hospital unless they really need to as more clinics and services become available in the community. More people will be supported to take control of their own health and wellbeing through closer working between GP practices and the voluntary sector.

How we measure up *(Performance overview)*

Key successes (text box to go at side of intro)

- Waiting times for elective care – patients being seen with the standard times for their diagnosis and treatments.
- Waiting times reduced for psychological therapies.
- Meeting national standards overall for cancer treatments.
- Rated as a "Top Performer" for dementia care, with good performance around diagnosis in primary care and a high proportion of patients who have annual reviews of their care plans.
- Our one year cancer survival rate, and the proportion of people whose cancer is picked up early, contributed to our being assessed as "Performing Well" in this area.

Making sure that the services we commission meet local needs and national standards around quality, safety and access is a key part of our work. We monitor our performance against a variety of measures covering areas such as access to services and waiting times, effectiveness of services and quality standards, such as the rates of healthcare associated infections. These include:

- The patient rights and pledges set out in the NHS Constitution
- The NHS Outcomes Framework, which looks at a wide range of areas including health outcomes for people with long term conditions, premature mortality and patient experience;
- Financial management and sustainability;
- The NHS staff survey, to consider how well we perform as an employer
- The CCG Improvement Assessment Framework, which we are rated against annually by NHS England

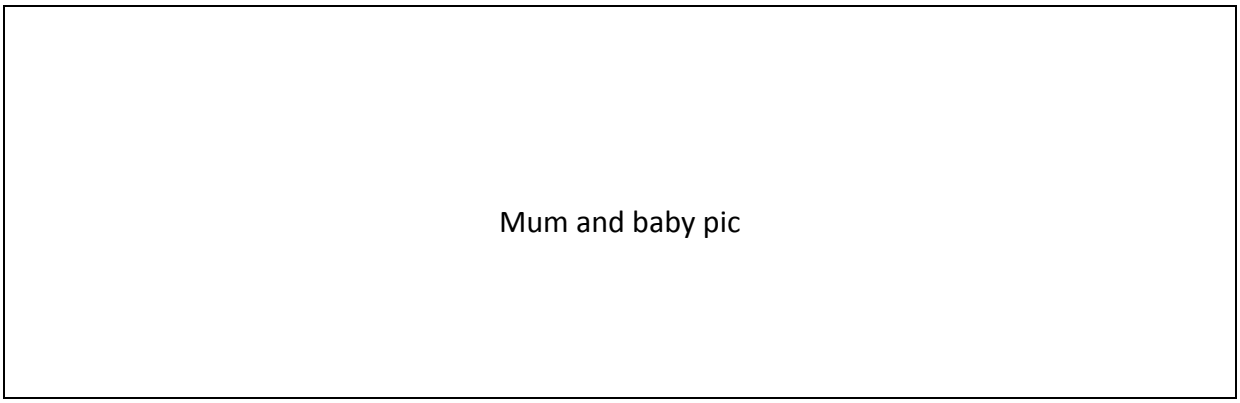
We also use these performance monitoring systems to influence our planning and priority setting, identify clinical learning opportunities and inform service re-designs.

How we measure others

Effective performance management and contract monitoring are vital to ensuring that our patients have timely access to quality services. We hold our providers to account through our contracts, which follow a nationally agreed format, and use local data on activity, finance and quality measures to ensure that we are delivering high quality care for patients and value for money. We have a Contract Management Board (CMB) for each provider which is led by an executive director and meets every month to review performance and all other aspects of the contract. Any concerns regarding performance are addressed with the provider and actions to ensure improvement are agreed and monitored. From 2016/17, we included a new CMB for primary care to support our new responsibilities for commissioning these services in partnership with NHS England.

The CCG uses a rigorous programme management approach to ensure that our decision-making processes are recorded, progress on projects can be tracked, risks identified and remedial action taken. During the year, we developed a staff training programme to support this approach and help us to work as effectively as possible.

Photo 7: A boost for a Healthy Start



In the last six months of 2016/17, we managed to double the uptake of Healthy Start vitamins, helping to improve the health of children, pregnant and breast-feeding women. This is thanks to a collective approach with health visitors, midwives, colleagues in Public Health and many more of our professional partners.

The Healthy Start scheme provides vouchers for people on lower incomes to help them eat a healthy diet, as well as free vitamins for pregnant and breastfeeding women and growing children. These contain contain vitamins A, C and D for children aged from six months to four years, and folic acid and vitamins C and D for pregnant and breastfeeding women. As well as helping to make sure these groups get the nutrients they need to keep healthy, the scheme helps to improve health inequalities by supporting families most in need.

The benefits? More children, pregnant and breast-feeding women are getting the vitamins recommended for healthy development and wellbeing.

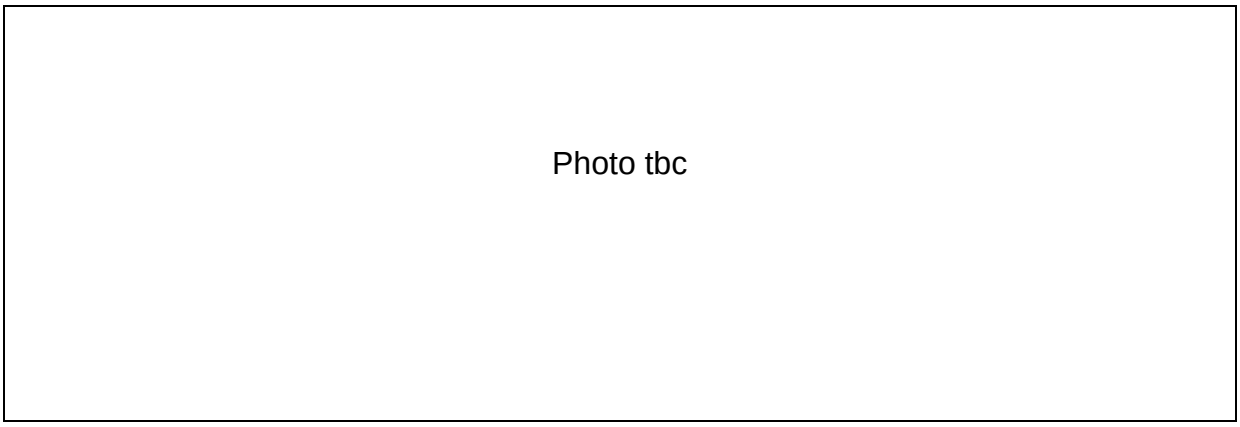
Performance cont'd - The CCG Improvement and Assessment Framework (IAF)

CCGs are assessed annually by NHS England and rated for how well they are fulfilling their function of commissioning safe, good quality, sustainable services and compassionate care. A new approach for assessing CCGs was introduced for 2016/17 - the CCG Improvement and Assessment Framework (IAF) – which rates CCGs as either "Outstanding", "Good", "Requires Improvement" or "Inadequate".

The framework covers three domains - better health and healthcare; quality of leadership; and financial sustainability – and also assesses CCGs against six clinical priority areas. To date, we have achieved 'good' for quality of leadership as at the end of quarter 2 and our baseline assessment against the clinical areas is below. Our full year-end assessment for 2016/17 will be available from July 2017 on the My NHS website at www.nhs.uk/service-search/Performance/Search.

Clinical priority area	**Baseline assessment (September 2016)**	**Comments**
Cancer	Performing well	Good one year survival rates for people with cancer
Dementia	Top performer	Sheffield has a high rate of diagnosis i.e. finding the people with the condition and ensuring they receive care
Diabetes	Performing well	Good rate of people with diabetes taking part in self-management education programmes, and receiving NICE based interventions
Learning disabilities	Needs improvement	The second half of the year saw accelerated progress towards fulfilling the "Transforming care Programme, which ensures that people are no longer cared for in institutional style settings, but supported in the community
Maternity services	Needs improvement	The CCG is working with the Local Authority to address two of the key areas of underperformance: tackling the underlying causes of still births and neonatal deaths, and commissioning a new stop service for pregnant women.
Mental health	In greatest need of improvement	We have improved on our recovery rate for people in IAPT and on access to early interventions since the baseline rating was issued.

Photo 8: It's good to talk



People suffering from mental health problems are finding it easier to get help, thanks to an improved online service.

We worked with Sheffield Health & Social Care Trust and Sheffield Council on a successful bid for national funding which was used to develop an improved website for the Sheffield IAPT service. The IAPT service – which stands for improving access to psychological therapies – provides a variety of talking therapies and advice and support to help people with conditions such as stress, anxiety and depression or who are experiencing emotional distress.

The new site is much more interactive and has increased choices available for patients, providing a range of advice and resources for self-help, as well as access to talking therapies.

We were also successful in a bid for further funding which will be used to develop tailored support for people with medical conditions, such as respiratory or heart problems or medically unexplained symptoms.

Increased investment, improved care (snapshots)

- We have doubled capacity for supporting people detained by the police for suspected mental health concerns by opening a second section 136 suite. These are designated places where people can be supported and assessed in a safe environment rather than held in police cells.
- More people with severe learning disabilities and complex needs are being helped to live more ordinary lives by providing community-based alternatives to hospital care. We exceeded the target for discharging patients into supported living and residential care under the national Transforming Care agenda.
- We have continued to reduce the amount of time people needing inpatient care have to spend in hospital. Over the past four years, this has decreased from an average stay of a year to six months.

Performance cont'd - NHS Constitution core rights and pledges

The NHS Constitution sets out a number of pledges to patients on how long they wait to be seen and to receive treatment. We have worked hard to deliver these for people in Sheffield: we have performed well against **11 of the 15** core rights but we believe that we need to make improvements in 4 areas (the full year data on the Improving Access to Psychological Therapies standards will not be available until June).

This is the position as at May 2017 - full data is not expected to available until July and will be updated on our website

NHS Constitution Rights and Pledges which we met in 2016/17		**Comparison with 2015/16**	**Achieved in 2015/16**	**Achieved in 2016/17**
Waiting times for elective treatment • 92% of all patients should wait less than 18 weeks for their treatment to start	✓	⇧		
Diagnostic waiting times • 99% of patients wait should 6 weeks or less for their test/s from the date they were referred	✓	⇧		
Waiting time for Cancer treatments and diagnostic tests • There are 9 separate waiting time pledges for Cancer which address how long patients should wait for various parts of their treatment journey	✓	⇧ **7** ⇩ **2**		
Mental Health • 95% of patients discharged from psychiatric inpatient care followed up by Mental Health Services within 7 days, to ensure that they have appropriate care and support. • 50% of people referred to the Early Intervention in Psychosis Services should be seen within 2 weeks • Proportion of Sheffield's population who are accessing local IAPT services (Improving Access to Psychological Therapies, i.e. talking treatments). This is about the expected number of our local residents experiencing conditions such as depression, and who could benefit from IAPT.	✓ ✓ ✓	⇩ ⇧ **(measure introduced Dec '15)** ⇧ **(as at Dec'16)** ⇧ **(as at Dec '16)**		

• 75% of people referred to IAPT should wait 6 weeks or less until their first appointment; 95% of people should been within 12 weeks.	✔			

Areas where we need to improve

Mental Health • 50% of people who receive IAPT services are moving towards recovery from their mental health condition.	Our service treats a higher than average number of people with complex and long-standing needs. The more severe nature of their problems can mean that it takes longer for them to improve, and that they may be less likely to complete the whole course of treatment. This impacted on achieving the standard but we still met it for over half the year and achieved 46-48% on the months where we did not meet it.
Treating and caring for people in a safe environment (healthcare associated infections) • MRSA – aiming for zero bloodstream infections • Clostridium difficile - ongoing reduction required, and no more than 194 cases in year	In 2016/17, one case was assigned to NHS Sheffield CCG. During the year, 218 cases were reported, meaning we exceeded our agreed commitment. Each case is investigated and any learning shared. We are continuing to support education for GPs around antibiotic prescribing, which is a key part of reducing Clostridium difficile
Waiting time in Accident and Emergency departments • 95% of patients who attend an A&E department are to be admitted to a hospital bed, discharged from the department or transferred to another hospital within four hours of arrival.	This target was our toughest performance challenge in 2016/17, similar to many other areas. Sheffield Children's Hospital met the standard but despite the best efforts of partners across the city, Sheffield Teaching Hospitals NHS FT's performance was below the 95% standard. In March 2017, the Trust were achieving 87.9%.. This remains a significant area of focus for the CCG and partners to ensure all parts of the system are working effectively to enable the standard to be delivered.

Improving A&E performance

We have faced a number of challenges around delivering the A&E four hour wait standard including: higher numbers of people presenting with complex needs (which can contribute to ambulance handover delays); and pressures in social care delaying discharges and reducing bed availability for patients who needed admitting to hospital.

We have worked with partners in health and social care to make every possible effort to address this and support STHFT to meet the target. This has included initiatives to create greater efficiency and produce more capacity in primary care, such as providing urgent appointments at evenings and weekends through our GP "hubs" to help reduce the number of unnecessary A&E attendances. Our clinicians and

managers have worked closely with STHFT to improve performance and also led the system-wide approach for Sheffield through the A&E Delivery Board and the weekly 'Flow Group' which oversees the safe and timely transfer of patients from hospital to other care settings or their homes.

In the later part of the year, we moved the GP out-of-hours service to be based alongside A&E, helping to make sure patients who could be more appropriately treated by a primary care clinician were seen as quickly as possible.

This has been supported with public campaigns around the theme of "Choose Well", signposting members of the public to the right source of information or treatment, ranging from local pharmacies, NHS Choices, 111 and walk in services.

Supporting a sustainable Sheffield *(Sustainable development)*

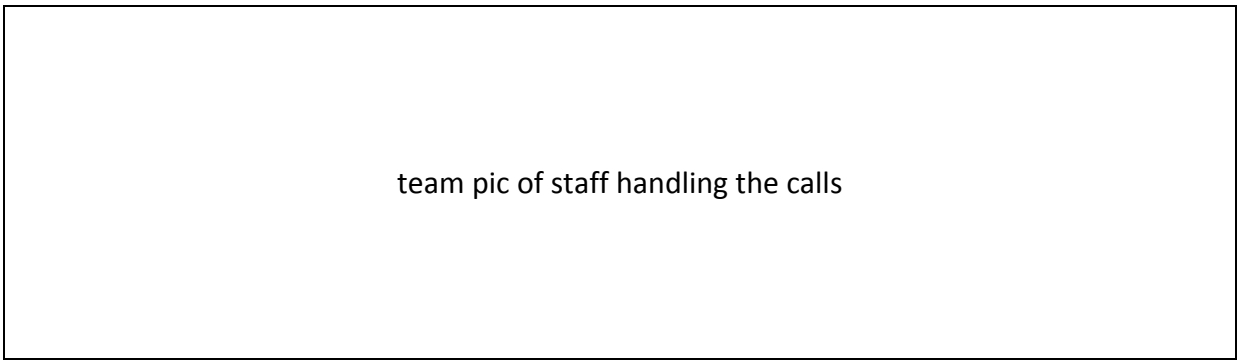
The CCG is a member of the city's Green Commission, which was set up to recommend how to make the city more sustainable. The Commission has provided the blueprint for Sheffield and covers four key areas transport and travel; energy efficiency; Sheffield as a green city; and continuous learning about improving sustainability.

We also work as an individual organisation to support these aims in a range of ways. Our over-arching approach of bringing care and services closer to people's homes will help to reduce travel and public transport links are an important consideration when planning new services or changes to service locations. This will also be supported by greater use of technology to deliver care and support patients in their homes.

We have worked with NHS England to support surveys of primary care premises, which included assessments of energy efficiency ratings, and findings will be used to develop recommendations for improvements. We also continue to support recycling and measures to reduce use of paper in our office

As well as our environmental impact, the CCG has developed a social value strategy to help our commissioning to support improvements in social and economic wellbeing in Sheffield. Social value is a way of thinking about how resources are used and looking at the benefits to a community when awarding contracts or delivering a service. Our strategy aims to ensure the contracts we commission not only meet the health care provision required but also help us to contribute to reducing health inequalities in Sheffield by addressing the wider determinants of health.

Photo 9: A great prescription!



A new prescription ordering line is helping patients get advice and help with their medication, as well as reducing waste. The telephone service is provided by trained healthcare staff who can discuss patients' needs and medications with them and help make sure that only items needed at that time are re-ordered. Initially tested at nine practices across the city, the service has received a big thumbs up from patients and saved over £200,000, so is now going to be rolled out more widely. Patients using the service have commented on its convenience and welcomed the chance to discuss any queries, with one even commenting that it was "the best idea the NHS has had in ages!"

The benefits? A convenient way for patients to get their repeat prescriptions and advice from healthcare professionals. It helps give patients more control over their health care needs and also reduces waste - saving money for your NHS.

"Fantastic idea, I get such a back log of medicines, this must be saving a fortune
"Lovely to have someone listen to me properly and help."
"This new service is brilliant, and gave very clear advice".

Bridging the divide

Text box : **Health inequalities**
Health inequalities are the unfair differences in health between different populations or individuals that are caused by differences in where people live and their social and economic conditions. These factors have a huge impact on people's health and wellbeing, as well as affecting how they use services, with people who are worst off experiencing poorer health and shorter lives. CCGs have a legal duty to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved.

Reducing health inequalities is a key priority for us as a CCG. People living in deprived areas in Sheffield experience far poorer health outcomes than those in more affluent neighbourhoods. Within the city there is a healthy life expectancy gap of almost 20 years for men and 25 years for women between the most and the least deprived areas. There are also inequalities relating to mental health, with a difference in life expectancy of 20 years for people with serious mental illness or learning disabilities.

Tackling this challenge is factored into our commissioning approach, and we also work on a range of specific initiatives that aim to reduce health inequalities, in close partnership the Public Health team at Sheffield Council. Some of our key achievements in 2016/17 include:

- Leading Sheffield's 'General Practice at the Deep End' programme, which brings together GPs working in the most deprived parts of the city and local voluntary sector anchor organisations to tackle health inequalities. This work has helped inform our primary care strategy and is shaping the inequalities agendas of our 16 neighbourhoods.
- Expanding the Healthy Start programme to help more families on low incomes (see page xx for more information)
- Increasing social prescribing across the city to support mental and physical wellbeing.

We will continue to embed health inequalities work through our place-based plan, Shaping Sheffield, which has set out the aim of distributing resources differently to prioritise communities with the greatest needs.

Planning for health and wellbeing

Our Joint Health and Wellbeing Strategy is a five year plan to ensure that local services meet the health and wellbeing needs of Sheffield people. It is based on the evidence of needs assessments and consultation with people in Sheffield. The strategy sets out our plans for improving health and wellbeing in the city. The five main outcomes we are working to achieve are:

- Making Sheffield a healthy and successful city
- Improving health and wellbeing
- Reducing health inequalities
- Making sure people get the help and support they need and feel is right for them
- An innovative and affordable health and wellbeing system that provides good value for money.

The strategy and a summary overview are available at www.sheffield.gov.uk in the Health & Wellbeing Board section.

Photo 10: Healthy minds for Sheffield's school children

Photo - Tapton School mental health champions or King Ecgbert School

Hundreds of Sheffield's pupils are set to benefit from an innovative approach to supporting emotional wellbeing and mental health.

One in 10 young people will suffer from some form of mental health concern in their adolescence. The 'Sheffield Healthy Minds' project aims to raise awareness and improve knowledge of mental health and wellbeing issues and help to identify and support children and young people at risk. We worked with Sheffield City Council and Sheffield Children's Hospital Trust to pilot the approach with 10 schools during 2016 and, following its success, we are now rolling it out to an additional 40 schools.

Work carried out with the schools piloting the project included staff training, developing stress-busting support groups, putting advice on dealing with stress in student planners, and assemblies highlighting signs that suggest someone might be suffering from stress.

The benefits? We can spot problems earlier and identify where support is needed for mental health and emotional wellbeing to help prevent problems becoming more serious and difficult to deal with later in life.

Making it all happen (Our Staff)

Our greatest asset is without doubt our superb staff. Throughout a very pressured, fast-paced year, they have remained committed to ensuring people in Sheffield get high quality care that meets their needs.

Supporting staff to carry out their work and deliver the many things asked of them is really important to us and we want to make sure the CCG is a good place to work. We offer a wide range of training and development opportunities for staff at all levels, including coaching skills and programme management training. Our management and leadership training scheme – MALTS – has proved extremely popular and is helping us equip staff with the skills they need to manage people effectively.

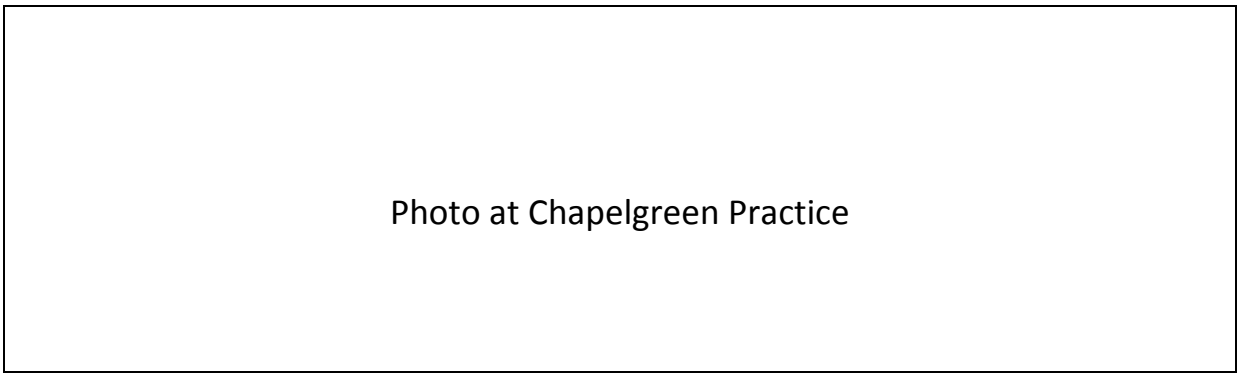
Working together
Staff views are hugely important and we have a range of ways to ensure staff are kept up to date on key issues and have chance to influence the way we work. Our Joint Staff Consultative Forum (JSCF) brings together CCG management and trade unions together to discuss initiatives or policies that involve or affect staff. We also have our Staff Forum, with representatives from all our teams, which acts as a sounding board for issues affecting staff, as well as helping to support staff health and wellbeing.

Keeping well
We run a lot of activities to support health and wellbeing, including pilates classes, lunchtime walks, resilience training, trained mental health first aiders, a weight management programme and an annual health and wellbeing month, organised by the Staff Forum.

What our staff say
"The CCG is full of committed and talented people working to improve healthcare in the city."
The latest results of our annual staff survey highlighted a number of areas where we are performing well as an employer. Staff rated the CCG highly for teamworking, feeling valued and embedding our values into our appraisal system. There were also a number of areas where we didn't score as highly as we would have liked including staff feeling clear about the responsibilities and having enough staff to carry out the work required. We will be working to improve these areas during 2017/18, as well as making sure we build on the strengths identified.

Health Hero
Our very own Business Manager, Michelle Oakes, was named a 'health hero' when she won the Operational Services Support Worker category in the Yorkshire and Humber Our Health Heroes Awards 2016. The regional awards recognise the contribution staff make to the health sector and Michelle was nominated for her work to improve staff health and wellbeing at the CCG. This included working with the Staff Forum to introduce an annual health and wellbeing week for staff.

Photo 11: Productive General Practice



Fifty of our GP practices are taking part in a special programme to help them work as effectively as possible and support the delivery of high quality services to patients.
We successfully secured funding for practices to take part in the Productive General Practice programme, which aims to improve efficiency and release more time to invest in patient care. It also helps practices to develop services to meet local needs and to improve patient experience.

General practices are facing significant pressures, with increasing demand and fewer GPs. Supporting them to manage these challenges and maintain strong primary care services for Sheffield is a priority for the CCG and the programme helps equip practices with a variety of tools to save both time and money, while improving patient care.

Mill Road Surgery is one of those taking part. Practice Manager Angi Hartley says: “As part of the programme we focused on reception and back office functions, looking at how we can best manage patient related correspondence, such as hospital and physio letters. We reviewed the process to understand what letters the GPs need to see and which ones can just be filed. This was then streamlined, with staff given a protocol to follow and training given to all involved. This has been a great benefit to the practice as staff are working in a uniformed way and GPs only see what they need to, allowing better use of GP time.”

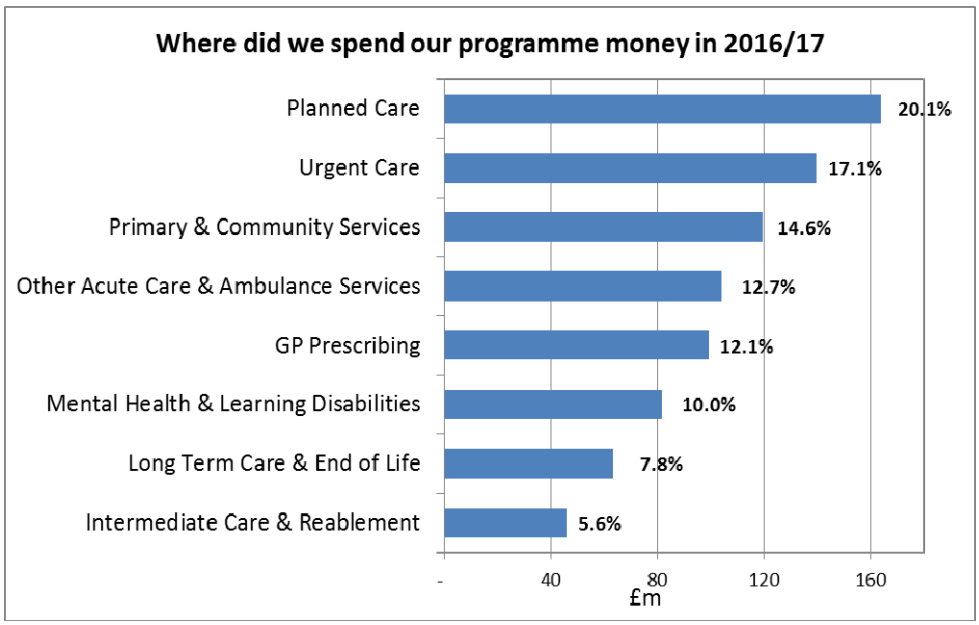
Maintaining sound financial health

2016/17 has proved a successful year in terms of compliance with our statutory duty of delivering financial balance against the resources allocated to the CCG by NHS England. Taking both our allocation for programme (commissioned) expenditure and our Running Cost Allowance (RCA) we reported a surplus of £11.6m or 1.4%. As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means. In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. To comply with this requirement, NHS Sheffield CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £8.1m (which when added to our planned surplus of £3.5m resulted in a total surplus of £11.6m). This additional surplus will be carried forward for drawdown in future years. The current expectation is that the £8.1m will start to be available for use locally towards the end of the current planning cycle, which extends to 2020/21.

Our programme allocation, which we use to commission health care services for the people of Sheffield was £823m. For the first time in 2016/17 this included c£75m for the CCG to co-commission primary care core services with NHS England.

Our running cost allowance was £12.7m. This is used to fund the commissioning and governance costs and clinical engagement activities of the CCG and its Localities. As a large CCG, Sheffield benefits from economies of scale. The allowance remained similar to the previous year and we were able to maintain our policy of underspending against the RCA, allowing the balance to be spent on patient care. In 2016/17 our actual spend was £11.4 m (£19.79 per head of population).

How did the CCG spend its Programme (Commissioning) Budget?
Overall, we spent an average of £1,388 per person on health care for the people of Sheffield including on primary care through the co-commissioned budget. If the latter is excluded the spend was £1,261 per person compared to £1,253 for 2015/16 on the same calculation basis, which reflects the small increase in funding and a very small change in GP registered population. The table below provides an analysis of how we invested our total resources in 2016/17. It includes spend against external income as well our revenue resources received from NHS England. The distribution is similar to 2015/16 if the figures are adjusted for the primary care co-commissioned budget.



The CCG publishes monthly details about any spend that is over £25,000.00. All organisations who provide services over this cost will be listed on this document: http://www.sheffieldccg.nhs.uk/about-us/spending-over-25k.htm.

Better Payment Practice Code

This requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. The CCG has not formally signed up to the payment code but details of our compliance are in the notes to the financial statements and reproduced below.

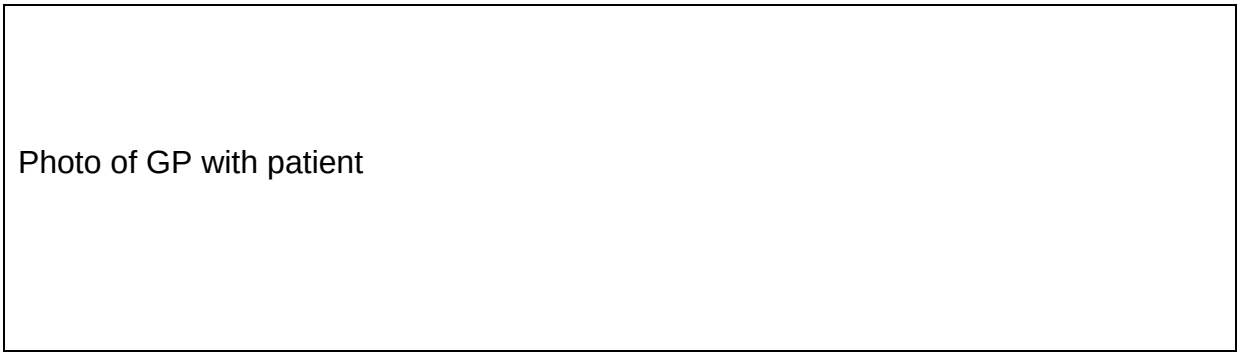
	2016-17 Number	**2016-17 £000**	Prior Year Comparator 2015-16 Number	Prior Year Comparator 2015-16 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**14,714**	**£206,139**	13,168	£107,909
Total Non-NHS Trade Invoices Paid Within Target	**14,511**	**£205,339**	13,011	£107,233
% of Non NHS Trade Invoices Paid Within Target	**98.62%**	**99.61%**	98.81%	99.37%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,179**	**£563,685**	3,447	£574,025
Total NHS Trade Invoices Paid Within Target	**4,171**	**£563,636**	3,418	£573,952
Percentage of NHS Trade Invoices Paid Within Target	**99.81%**	**99.99%**	99.16%	99.99%

Looking to the Future

CCGs were notified of their financial allocations for the 5 year period 2016/17 – 2020/21 in January 2016 and we have already started to plan for an increasingly challenging financial environment. For 2017/18 the cash uplift to general programme allocation is only 1.6%. This is lower than the national average 2.14% because Sheffield CCG is deemed to have historic funding in excess of its “fair shares” target. In order to deliver a planned surplus of £5.1m (0.7%) as part of an overall financial control total for the five South Yorkshire and Bassetlaw CCGs as part of the new STP arrangements in 2017/18 and to address areas of growth in activity and allow some investment in out of hospital services, the CCG has set itself an efficiency target of over £21 million (2.6%) which is greater than the target set and achieved in 2016/17.

From 2017/18 we will be working more closely with local CCGs as part of the STP arrangements particularly where joint strategic commissioning is required to deliver improvements and changes to services across the local region. At the same time, the CCG will be working with a range of key local partners in Sheffield to deliver the key outcomes set out in our Sheffield Placed Based Plan, which includes ensuring financial sustainability for our local health and care system.

Photo 12: Getting healthcare in a hurry



More out-of-hours GP appointments have been made available during the year to help people needing urgent healthcare.

Often people turn straight to A&E for help at weekends or evenings, when they could have been treated more quickly by a GP. To help people get the care they need as quickly as possible – and relieve the pressure on A&E - we moved the GP out-of-hours service next to the A&E department at Northern General Hospital. Patients arriving at A&E at weekends or evenings who can be treated by a GP are sent to the service, which means they get the help they need as quickly as possible and A&E can focus on the more seriously ill patients.

We also provided extra out-of-hours GP appointments over the Christmas and Easter periods to help manage demand at these busy times, and also piloted a scheme to offer patients at A&E who need primary care treatment transfers the city centre walk-in-centre.

Improving urgent care services in Sheffield has been a major focus throughout the year, as we set out our aim to simplify the system and make it easier for people to get the help they need as quickly as possible. We worked with practices, providers and the public to develop options for delivering urgent primary care services, which we will be consulting on in 2017/18.

Photo 13: A one-off treatment with major benefits

Eye picture either at STH or if not stock

One of the biggest causes of severe vision loss and blindness in people over 60 is Wet Age Related Macular Degeneration. People who have this condition need regular injections of a drug into the eye. Of course this is not pleasant for them and means frequent trips to outpatient clinics, which can be difficult and stressful for some older people. So we have worked with Sheffield Teaching Hospitals to provide Oraya therapy for patients, a one-off treatment which delivers painless, highly targeted, low-energy X-rays to the eye and reduces the number of eye injections needed. Since introducing Oraya therapy at the end of 2015/16, this has meant up to 45% fewer injections for patients

The benefits? Fewer injections and attendances at outpatient clinics for patients and a reduction in the use of expensive drugs, which saved more than £250,000 in 2016/17.

Photo 14

Pic from SHSC

Mental healthcare close to home

We have been working hard to ensure that people with mental health problems who need inpatient care (a stay in hospital) don't need to go out of the area – and wherever possible don't need to be admitted to hospital at all. Sheffield has a good track record in this area and we have worked with Sheffield Health and Social Care Trust and other partners to continue developing the support people need to be able to get the care they need at home. This has reduced the demand for inpatient beds in the last year and we have also secured funding to further develop the support and care available in the city for people with complex needs.

The benefits? Stops people being transferred out of the city wherever possible and get care in their own homes when appropriate.

Awards Success – 2 snapshot pictures (award pics)

GP Partnership of the Year

An innovative scheme which has changed the way community pharmacists and general practices in Sheffield work together received the GP Partnership of the Year Chemist and Druggist award in 2016. The scheme, which involves over 70 of the city's 81 general practices, is delivered in partnership with Primary Care Sheffield and supported by Community Pharmacy Sheffield. It brings together community pharmacists and pharmacy technicians with GPs and local practices, enabling pharmacy colleagues to undertake some of the tasks which have otherwise been delivered by a GP - easing the pressure on GP time and releasing them to focus on patients with more complex needs.

Sheffield patients who have a common heart rhythm disorder that puts them at high risk of suffering a stroke have benefited from a programme that has substantially increased the number of people receiving treatment. It provides pharmacist and nurse support to GP practices to identify patients who would benefit from the treatment. As a result nearly 1,400 more patients are receiving treatments in the city, which should prevent over 30 strokes.

Primary Care Development Nurses

The CCG's specialist nursing team has been recognised for their work in the General Practice Awards 2016.

The Primary Care Development Nursing team works closely with, and offers support to Sheffield GP practices to reduce inequalities in care, improve the quality of long term conditions management and support the reduction of unplanned admissions.

They have specialist skills and knowledge in hypertension, respiratory disease, diabetes, heart disease and stroke, including reducing stroke risk in patients with atrial fibrillation.

The team were finalists in two of the awards categories, for Nursing Team of the Year and Clinical Team of the Year – Respiratory.

Snapshot successes (to be used throughout report depending on space available)

Improved access to sexual health services
We are working with Sheffield City Council to improve access to women's sexual health services, such as the fitting of coils and contraceptive implants. These services are now available at a number of GP practices and clinics and we are working to make sure women can access them in each of the city's four localities.

The benefits? Improved access to routine services for women, closer to their home or their work.

Better value treatment
One of the major costs in healthcare is drugs – and some medicines are extremely expensive. We have been working with Sheffield Teaching Hospitals Trust to introduce 'biosimilar' drugs in some specialties. These are medicines that very closely resemble a licensed drug and offer the same quality, safety and effectiveness but are usually much cheaper.

Consultants have discussed this with patients and where appropriate their medication has been changed. Changes have only been made with their agreement and have had no detrimental impact on their care.

The benefits? Savings on high cost drugs have been made without compromising the results for patients. The money saved can then be spent on other care and treatment for patients.

Signposting for ambulance crews
Ambulance crews are vital to getting patients to the right place at the right time. And the right place often *isn't* A&E as you might think! We've worked with our partners at Yorkshire Ambulance Service to make sure their crews are fully up to speed with all the latest developments and alternatives available to make sure they take patients to the best service for their needs.

The benefits? The patient is taken straight to the best place for the care and support they need and we reduce the number of unnecessary attendances at A&E so they can focus on the people who need their help.

Women's health closer to home and work
We've worked with our four GP 'hubs' to provide a local service for women so that they don't need to go into hospital. Women who suffer from heavy bleeding sometimes need a test where sample of the womb lining is taken, which was traditionally carried out in hospital. After a successful pilot, this test is now available

in four areas of the city and we will be building on this work to make sure more gynaecology care and procedures are available for women in the community and closer to their homes.

The benefits? Improved access to care for women, without the need to go to hospital, and financial savings for your NHS to be re-invested in care.

Accountability Report

Corporate Governance Report

The Directors' Report

1.1 NHS Sheffield CCG Governing Body – Composition and Profiles

The CCG Governing Body is responsible for NHS clinical commissioning decisions across Sheffield and for the long term success of the CCG. Membership of the Governing Body is set out in the CCG's Constitution. The CCG's Member Practices and then NHS England approved changes to the Membership of Governing Body during 2016/17 which came into effect from November 2016. These changes were the inclusion of 3 new non clinical executive director posts: Director of Delivery – Care Outside of Hospital, Director of Strategy and Integration and the Director of Commissioning and Performance. At the same time 2 non clinical executive director posts were disestablished: Chief Operating Officer and Chief of Business Planning & Partnerships.

At 30 September 2016 all 4 Elected GP Members' terms of office were due to expire. The CCG's Constitution sets out a process for election, but the Constitution also allows that where there are the same number or fewer candidates who have applied and are suitable for appointment then the appointment will be automatic. The CCG had four applications. Dr Terry Hudsen and Dr Annie Majoka were appointed with effect from 1 January 2017 for a term of 3 years, replacing Dr Anil Gill and Dr Ted Turner, neither of whom chose to stand for re-election. Dr Nikki Bates and Dr Marion Sloan had their terms of appointment extended for the same 3 year period until 31 December 2019.

Appointment processes were held for the two Lay member posts as their terms of office came to an end during 2016/17. Both Professor Mark Gamsu and Ms Amanda Forrest were re-appointed for 3 year terms following a competitive interview process. Professor Devaka Fernando, Secondary Care Doctor resigned from his post as Secondary Care Doctor on 31 January 2017 and we are currently in the process of recruiting to this vacancy.

Governing Body Members (i.e. voting Members) with effect from 1 November 2016 were:

- CCG Chair
- Accountable Officer
- Director of Finance
- Medical Director
- Chief Nurse
- 4 elected GP Members
- 4 Locality appointed GP Members (one of which is currently the Chair)
- 4 Lay members (one of which is the Vice Chair)

- Secondary Care Doctor
- Director of Delivery – Care Outside of Hospital
- Director of Strategy and Integration
- Director of Commissioning and Performance

1.2 Member profiles

Members of our Governing Body during 2016/17 were as follows. If no dates are shown, this means the Member was in post all year:

Dr Tim Moorhead - Chair (Locality Nominated GP (West Locality))

Dr Tim Moorhead has been a GP for 22 years and is Senior Partner at Oughtibridge Surgery. He was elected Chair of NHS Sheffield CCG in 2012 and re-elected in 2015, a role which he does whilst also continuing to see patients at his practice.

Tim leads and inspires the CCG to improve health services in the city and he is particularly committed to making sure we accelerate improvement of health for those people who are most vulnerable or disadvantaged. Tim's GP experience enables him to understand what patients want and need, and it is because of this that he always makes sure patients are at the heart of our decisions.

Tim has a national profile through his work with NHS Clinical Commissioners and is dedicated to influencing government around key issues and challenges facing health and social care and patients. He is also co-chair of the Sheffield Health and Wellbeing Board with the Local Authority.

Maddy Ruff - Accountable Officer

Maddy Ruff was appointed as Accountable Officer for NHS Sheffield CCG in September 2015 and has over 25 years' NHS experience, having held a variety of board-level positions.

Maddy is passionate about delivering high quality healthcare services to improve the health of everyone in the city. She is committed to achieving organisational success and drives improvement through her own passion and energy, engaging and inspiring others. She is dedicated to developing staff, both within the CCG and across health and social care, to allow them to provide the best possible care for patients.

Maddy has significant experience in the development of clear and transformative strategies, and holds a MMedSci in Primary Health Care, a Certificate in Coaching Practice, and an Institute of Personnel Management Diploma (IPD).

Julia Newton - Director of Finance

Julia Newton was appointed as Director of Finance at NHS Sheffield CCG in July 2012. A Chartered Accountant, Julia has held a number of senior finance posts since joining the NHS in 1992. Julia oversees all aspects of financial planning, accounting and financial & corporate governance. During 2016/17 she also provided the lead finance role for all CCGs across South Yorkshire and Bassetlaw in the formulation of the five year Sustainability and Transformation plan and is the finance lead on the Working Together Joint Committee of CCGs

Dr Zak McMurray - Medical Director

Zak was raised in Sheffield after moving here with his family in 1975. He was educated at Silverdale and High Storrs schools, staying on in Sheffield to study medicine at Sheffield University. After qualifying in 1988 and completing the Sheffield GP vocational training scheme, Zak became a partner at Woodhouse Medical Centre and remained there for over 20 years.

He was elected to the South East Sheffield Primary Care Group in 1999 as a Board Member and acted as mental health and commissioning lead before taking over as the Professional Executive Committee (PEC) Chair. During that time Zak was most proud of leading the development of practice based counselling services for the south east of the city, rolling out across the whole city some years later. Zak became joint PEC Chair on the creation of the Sheffield Primary Care Trust, moving to Joint Clinical Director within Sheffield Clinical Commissioning Group. He left his practice in June 2014 to take up his current substantive post as Medical Director.

Zak is a member of the Quality Assurance Committee, the Primary Care Commissioning Committee and the Sheffield Health and Wellbeing Board. Zak is passionate about the NHS, preserving and championing its founding principles, to deliver the best possible care for the people of his adopted city.

Penny Brooks - Chief Nurse (from 1 September 2016)

Penny started her nursing career in the NHS in 1976 as a Nursing Cadet before qualifying as a Registered Nurse and District Nurse. She has experience in both acute, primary and community services before becoming Chief Nurse and Executive Director in 2001 in Doncaster West PCT. Penny has worked as Chief Nurse with wide portfolios of responsibilities in both Barnsley and Sheffield and as Chief Nurse for South Yorkshire and Bassetlaw cluster before the dissolution of PCTs. Latterly she was the Clinical Director for Primary and Community Services Care Group within Sheffield NHS Teaching Hospitals Foundation Trust responsible for a wide range of services and staff.

Penny is also a Trustee of Ashgate Hospice Care in North Derbyshire

Dr Marion Sloan - Elected GP Member

Dr Marion Sloan is senior partner within a large inner city practice offering person centred care. Marion has been involved with the PCT and now CCG over the past 10 years. Starting with development of training for GP teams in long acting reversible contraception, making sure the right incentives were in place, bringing chlamydia screening to national coverage levels, innovating gynecology clinics in primary care and latterly developing a primary care option for pipelle biopsies as recommended by the updated NICE guidelines for menorrhagia.

Marion worked with Central consortium offering a consultant led gastroenterology service in primary care that was safe, innovative, popular with patients and evaluated well financially. This was successful in bringing services previously only available in secondary care, into the community.

Along with other leading practices she has actively promoted 7 day working in primary care to take the pressure off Out of Hours services and the A&E departments of the city.

Marion believes that Sheffield is a great place to live and by working together with Sheffield City Council we can reduce the inequalities that still exist.

Dr Nikki Bates - Elected GP Member

Dr Nikki Bates has been a GP for 26 years. She is Senior Partner at Porter Brook Medical Centre. Nikki was elected by Sheffield GPs as one of their representatives to the CCG Governing Body in 2014.

Nikki has a special interest in the health of young people and students and works with the Children's and Young Peoples Portfolio within the CCG. She is also a partner governor at Sheffield Children's Hospital where she is keen to help develop services for Sheffield children. To give our children the best start in life is a key aim and priority for both Sheffield

CCG and Sheffield City Council.

Nikki is a GP appraiser and in this role she helps GPs review their work, celebrate excellence and prepare for revalidation with the GMC

Dr Terry Hudsen - Elected GP Member (from 1 January 2017)

Dr Terry Hudsen graduated in 2006 and started his medical career in anesthesia before switching to general practice training in Derbyshire. He is a GP Principal at the University of Sheffield Health Service and has a special interest in the health and wellbeing of young adults and university students.

Dr Hudsen has a keen interest and expertise in the use of information technology in improving people's health and health promotion, having produced mobile applications for patients and clinical computer systems for doctors. He is passionate about preventative health by encouraging healthier lifestyles to prevent the burden of disease, reduce health inequality and improve people lives.

Dr Annie Majoka - Elected GP Member (from 1 January 2017)

Dr Majoka has been working as a GP in Sheffield since 2006. She worked as a salaried and locum GP for several years before joining Abbey Lane Surgery as a GP partner in 2014. She enjoys all aspects of general practice and finds it very rewarding and satisfying. She strongly believes in the future of primary care, feels passionately about the NHS and is keen to be part of any changes to improve healthcare services in the region. Her special interests are sexual and women's health, and cardiovascular medicine.

Dr Ngozi Anumba - Locality Nominated GP (Hallam and South Locality)

Dr Anumba graduated in 1990 and started her medical career as a pediatrics trainee before a move to general practice and completion of the Northumberland vocational training scheme. She has been a partner at Woodhouse Health Centre since 2002 and became a GP trainer in 2014. Her interests include pediatrics, particularly child safeguarding and women's health. Ngozi is a member of the Audit and Integrated Governance Committee.

Dr Amir Afzal - Locality Nominated GP (Central Locality)

Amir is a Sheffield GP and has worked at Duke Medical Centre as a partner since 1994 working with some of the most vulnerable people in the city. He is now senior partner at the practice. Amir is also the Central Locality representative on the CCG Board. He is passionate about general practice and is interested in how his practice can work with surrounding practices to work more cooperatively for the benefit of patients. He is also interested in how GPs can educate and empower patients to make the health care system truly fit for the 21st century. Amir hopes to develop a system where the best of British general practice is passed on to the next generation whilst adapting to the changes that are needed, making sure that the art of medicine and human touch are not lost.

Dr Leigh Sorsbie - Locality Nominated GP (North Locality)

Dr Sorsbie qualified in 1990 and has been a GP partner at Firth Park Surgery for 20 years. She has been North Sheffield Locality representative on NHS Sheffield CCG since 2013, and continues her practice work alongside this.

She is passionate about ensuring high-quality evidenced-based clinical care is available for everyone within the city, regardless of postcode or background. Her work in Firth Park has enabled her to experience the challenges faced by communities in ethnically diverse areas of high deprivation, she is committed to working within the CCG to reduce health inequalities and address the factors which perpetuate them.

Leigh is experienced in the management of mental health and understands the significant impact this has on every area of an individual's life, families and in the wider community. She is a member of the mental health commissioning team, working together to ensure that mental health is given equal importance as physical health problems, both in terms of treatment and prevention. Leigh also works as a GP appraiser, providing ongoing support to practicing GPs throughout Sheffield.

John Boyington CBE - Lay Member

John worked for over 40 years in health services, both in the NHS and civil service. He originally trained as a nurse in Sheffield and has held chief executive posts in NHS Trusts and a PCT. He received the CBE in 2007 for leading national prisoner health care reforms. He was Director of the World Health Organisation (WHO) Collaborating Centre for prisons and public health for five years. John is Vice Chair of the CCG Governing Body and Chair of the Primary Care

Commissioning Committee and Remuneration Committee. He is passionate about change in the NHS to ensure that services deliver what people need in a way that is easily accessible.

Amanda Forrest - Lay Member

Amanda has worked in the voluntary and public service for over 30 years - predominantly working on issues around patient and public engagement, working in partnership, and service innovation. Until the end of July 2014 Amanda was Chief Executive of Sheffield Cubed - an organisation which enables voluntary sector organisations to work collaboratively. Amanda is Chair of the Quality Assurance Committee and Vice Chair of the Audit and Integrated Governance Committee, she is also a member of the Remuneration Committee and the Primary Care Commissioning Committee. She has a major role in patient and public involvement, supporting meaningful and effective engagement with the public and patients from a well thought through approach at all levels.

Mark Gamsu - Lay Member

Professor Mark Gamsu believes that if people's health and wellbeing is to improve, and inequalities are to be addressed, then it is essential to do this in collaboration with members of the public. In his career he has worked for a range of community organisations as well as local government and the civil service. He established 'Altogether Better', an award winning national health champions programme that continues to flourish. He chairs the Public Engagement, Experience and Equalities Group (PEEEG) which supports the CCG improve the way it consults, collaborates and engages with people in Sheffield. He is particularly interested in the way the CCG can help general practice and the voluntary sector work together better in the more disadvantaged parts of the city.

Phil Taylor - Lay Member

Phil was appointed as a lay member in March 2016 with responsibility for audit, governance and strategy. He is a Chartered Accountant and has worked in the NHS as a finance director and deputy chief executive for 10 years as well as gaining director level experience within the Department of Health. Phil joined the NHS in 1991 as Finance Director of the Northern General Hospital. He has been chair of the Healthcare Financial Management

Association and Senior Independent Trustee of the NHS Confederation. Phil believes that excellent governance is crucial for the quality of health and wellbeing services in Sheffield and is committed to improving value for money. He has a mentoring qualification and is currently the chair of the Sheffield Hospitals Charity. As well as the Audit and Integrated Governance Committee Chair, Phil is also the Conflicts of Interest Guardian.

Nicki Doherty Interim Director of Delivery - Care Outside of Hospital (From 1 November 2016)

Nicki is responsible for the Transformation and Delivery Directorate, her areas of responsibility include: Primary Care; Active Support and Recovery; Active Aging, Long Term Conditions and End of Life Care; Communications and Engagement; Equality and Diversity and Emergency Preparedness Planning and Resilience. Nicki worked with partners across Sheffield to produce the Sheffield Place Based plan.

Nicki has worked for the CCG since February 2015, prior to this she developed a broad range of operational and corporate experience in the acute hospital sector. She is passionate about the NHS and designing services that work for both people who need them as well as people who deliver them.

Peter Moore - Director of Strategy and Integration (from 1 November 2016)

Peter Moore is jointly funded by Sheffield City Council to lead our Integration agenda across the City. His remit includes executive director leadership of urgent care, mental health and children's agendas as these require cross organisational delivery. Peter also leads the Transforming Sheffield Programme and the Sheffield Place Based Plan.

Peter has worked at Board level within the NHS since 2010 and prior to that worked within Nissan and Toyota Manufacturing where he led a number of key model changes, he has a detailed knowledge of Lean and is keen on applying this thinking to making sure our patients receive the best service possible from our providers.

Matt Powls - Interim Director of Commissioning and Performance (From 1 November 2016)

Matt is responsible for a number of areas within the CCG including: commissioning of elective care, commissioning of

cancer care, contracting and procurement, provider performance, business intelligence and IM&T and QIPP Delivery (Quality, Innovation, Productivity and Prevention).

Matt has worked at executive level for a variety of provider and commissioning organisations over the last 20 years.

Profiles for those who ceased to be Members of Governing Body during 2016/17

Tim Furness Chief of Business Planning & Partnerships (to 1 September 2016)
Tim Furness was appointed to his Director role in the CCG in September 2012. He joined the NHS in 1990 and has held various senior management roles in commissioning and planning.

Idris Griffiths, Substantively Director of Delivery – Care Outside of Hospital and previously Chief Operating Officer (Currently seconded to NHS Bassetlaw CCG wef 1 October 2016)
Idris has been an Executive Director at the CCG since it was established in 2013 and has worked in the NHS for over 25 years. Prior to working in commissioning Idris held a number of senior roles in community services and acute hospitals. Idris has an MBA and holds Chartered Institute of Personnel and Development Post Graduate Diploma.

Dr Anil Gill, Elected GP Member (to 23 September 2016)
Dr Anil Gill has been a GP since 1999 and has worked in Sheffield since 2005. He is the Senior Partner at Selborne Road Medical Centre. He was elected by his GP colleagues across Sheffield to join the CCG from its inception in 1 April 2013.
His particular interests included acute care and his early work with the CCG involved developing IT connectivity between primary and secondary care enabling improved record sharing and patient care.

Dr Ted Turner, Elected GP Member (to 30 September 2016)
Ted graduated in 1988 and has been a GP at Shiregreen Medical Centre in Sheffield since 1995. Ted's interests include dermatology and skin surgery, cardiovascular medicine and care of the elderly. Ted was a member of the Remuneration Committee and the Sheffield Health and Wellbeing Board. His role included Governing Body lead for patient and public involvement.

Professor Devaka Fernando, Secondary Care Doctor (to 31 January 2017)
Professor Devaka Fernando is a consultant endocrinologist. He trained in clinical endocrinology, clinical epidemiology and. medical management. His posts have included service director, head of service and Associate Medical Director at Sherwood Forest Hospitals NHS Foundation Trust.

Kevin Clifford, Chief Nurse (to 31 August 2016)
Kevin Clifford was appointed to the Chief Nurse post in September 2012. He joined Sheffield PCT in March 2010 as Chief Operating Officer for Provider Services and from September 2012 was Chief Nurse at the CCG until his retirement on 31 August

2016. Kevin, a registered nurse since 1983, previously worked at Sheffield Teaching Hospitals NHS Foundation Trust where he was Nurse Director for Emergency Care and Director of Clinical Operations. Kevin's role included Vice Chair of the Quality Assurance Committee.

1.3 Committee(s), including Audit Committee

The Governing Body has four directly reporting committees: The Primary Care Commissioning Committee, Audit and Integrated Governance Committee, Quality and Assurance Committee and Remuneration Committee. The Governance Sub-committee reports to the Audit and Integrated Governance Committee. Highlights from each of the committees are detailed in the Governance Statement at page ●

Audit and Integrated Governance Committee

The core members of the Audit and Integrated Governance Committee are:

- Phil Taylor, Lay Member (Chair and Conflicts of Interest Guardian)
- John Boyington CBE, Lay Member
- Amanda Forrest, Lay Member (Deputy Chair)
- Dr Ngozi Anumba, CCG GP
- Dr Leigh Sorsbie, CCG GP

The Committee includes the following regular attendees:

- Director of Finance
- External Audit representative
- Internal Audit representative
- Counter Fraud representative
- Financial Accountant
- Corporate Services Risk and Governance Manager

1.4 Register of Interests of Governing Body Members

The CCG maintains a number of Registers of Interests. An extract of the Register giving the position for Governing Body Members at 31 March 2017 can be found at Appendix 1 on pages 58 to 63 of this Accountability Report. Details of all of the CCG's Registers of Interests can be found at http://www.sheffieldccg.nhs.uk/about-us/declarations-of-interest.htm

At the start of each meeting of the Governing Body and formal committee / sub-committee meetings, members are required to declare any conflicts of interests in the items for consideration on the agenda and these are formally recorded. The CCG has set out how it will formally manage any declared conflicts of interest within its Standards of Business Conduct and Conflicts of Interest Policy

1.5 Statement of Disclosure to Auditors

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

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

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 take all necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.

1.6 Information on personal data related incidents

The CCG has had no Serious Untoward Incidents relating to information on personal data in 2015/16 where these have been formally reported to the information commissioner's office.

1.7 Our Member Practices

The following is a list of all of NHS Sheffield CCG's 81 GP member practices listed by localities.

Central Locality (23)

Abbey Lane Surgery
Baslow Rd, Shoreham St & York Rd Surgeries
Carrfield Medical Centre
Clover City Practice
Clover Group Practice
Darnall Health Centre (Mehrotra)
Dovercourt Group Practice
Duke Medical Centre
East Bank Medical Centre
Gleadless Medical Centre
Handsworth Medical Centre
Heeley Green Surgery
Highgate Surgery
Manor Park Medical Centre
Norfolk Park Health Centre

Hallam and South Locality (22)

Birley Health Centre
Carterknowle Surgery
Charnock Primary Care Centre
Crystal Peaks Medical Centre
Falkland House Surgery
Greystones Medical Centre
Hackenthorpe Medical Centre
Jaunty Springs Health Centre
Manchester Road Surgery
Meadowgreen Health Centre
Mosborough Health Centre
Nethergreen Surgery
Owlthorpe Surgery
Richmond Medical Centre
Rustlings Road Medical Centre
Selbourne Road Medical Centre

Park Health Centre
Sharrow Lane Medical Centre
The Mathews Practice
The Medical Centre, Tinsley
The Sloan Practice
Veritas Health Centre
White House Surgery
Woodseats Medical Centre
Sothall Medical Centre
Stonecroft Medical Centre
The Avenue Medical Centre
The Hollies Medical Centre
Totley Rise Medical Centre
Woodhouse Health Centre

North Locality (22)

Barnsley Road Surgery
Burchanan Road Surgery
Chapelgreen Practice
Burngreave Surgery
Crookes Valley Medical Centre
Dunninc Road Surgery
Ecclesfield Group Practice
Elm Lane Surgery
Foxhill Medical Centre
Grenoside Surgery
Mill Road Surgery
Norwood Medical Centre
Page Hall Medical Centre
Pitsmoor Surgery
Sheffield Medical Centre
Shiregreen Medical Centre
Southey Green Medical Centre
The Flowers Health Centre
The Health Care Surgery
Upperthorpe MedicalCentre
Upwell Street Surgery
Wincobank Medical Centre

West Locality (14)

Broomhill Surgery
Deepcar Medical Centre
Devonshire Green Medical Centre
Dykes Hall Medical Centre
Far Lane Medical Centre
Harold Street Medical Centre
Oughtibridge Surgery
Stannington Medical Centre
The Crookes Practice
Tramways Medical Centre (Milner)
Tramways Medical Centre (O'Connell)
University Health Service Health Centre
Valley Medical Centre
Walkley House Medical Centre

1.8 Modern Slavery Act

NHS Sheffield CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

1.9 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 Maddy Ruff to be the Accountable Officer of NHS Sheffield 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 are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter and include:

- for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enables them to ensure that the accounts comply with the requirements of the Accounts Direction).
- for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- the relevant responsibilities of accounting officers under Managing Public Money
- ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the high quality services (in accordance with Section 14R of the National Health Service Act 2006 (as amended)).
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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 Group Accounting Manual 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 Group Accounting Manual 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 under the National Health Service Act 2006 (as amended), Managing Public Money and 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 CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aare of any relevant audit information and to establish that the CCG'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 judgements required for determining that it is fair, balanced and understandable.

Signed: Date:

Maddy Ruff

Maddy Ruff
Accountable Officer

Annual Governance Statement

1 INTRODUCTION

NHS Sheffield CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The Clinical Commissioning Group's (CCG) statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2016, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006

2 SCOPE OF RESONSIBILITY

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 under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

3 GOVERNANCE ARRANGEMENTS AND EFFECTIVENESS

3.1 The Clinical Commissioning Group Governance Framework

The main function of the Governing Body is to ensure that the CCG has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

3.2 NHS Sheffield Constitution

NHS Sheffield CCG is a member organisation comprising 81 member practices and has a responsibility to ensure that robust corporate, clinical and financial governance arrangements are embedded within the organisation in accordance with best practice. The geographical area covered by NHS Sheffield CCG is the City of Sheffield, each GP practice falls within one of four localities. Our Constitution has been approved by Member practices and NHS England and reflects how the organisation operates. It sets out the CCG's powers and functions, describes our

mission, values and aims and how these are delivered through the governance framework.

The Constitution includes the following information:

- Membership and the area we cover
- Our Mission, Values and Aims
- Functions and Duties
- Decision Making: The General Structure
- Roles and Responsibilities
- Standards of Business Conduct and Managing Conflicts of Interest
- The CCG as an Employer
- Transparency and Ways of Working
- Standing Orders, Scheme of Reservation and Delegation and our Prime Financial Policies.

The Constitution was reviewed and updated twice during 2016/17, the second update following a full review of governance arrangements within the CCG. The following key changes were proposed and agreed by our Membership and NHS England:

- Updated roles of Lay Members
- Committees of the Governing Body – updated to include reference to Auditor Panel
- Terms of Reference are no longer appended to our Constitution but will continue to be referenced within the document. This will enable them to be updated and amended quickly and effectively to reflect current circumstances. Terms of Reference of our high level committees are now available on the CCG's webpage

  http://www.sheffieldccg.nhs.uk/our-information/documents-and-policies.htm
- The Conflicts of Interest Protocol remains referenced in the Constitution but no longer appended to ensure that the document may be updated and amended to reflect changes following the issue of any future statutory guidance. The document has been replaced by the Standards of Business Conduct and Conflicts of Interest Policy and is published on the CCG's website.

  http://www.sheffieldccg.nhs.uk/our-information/documents-and-policies.htm
- Changes to reflect revised management structure
- Reference to the Commissioner's Working Together Joint Committee

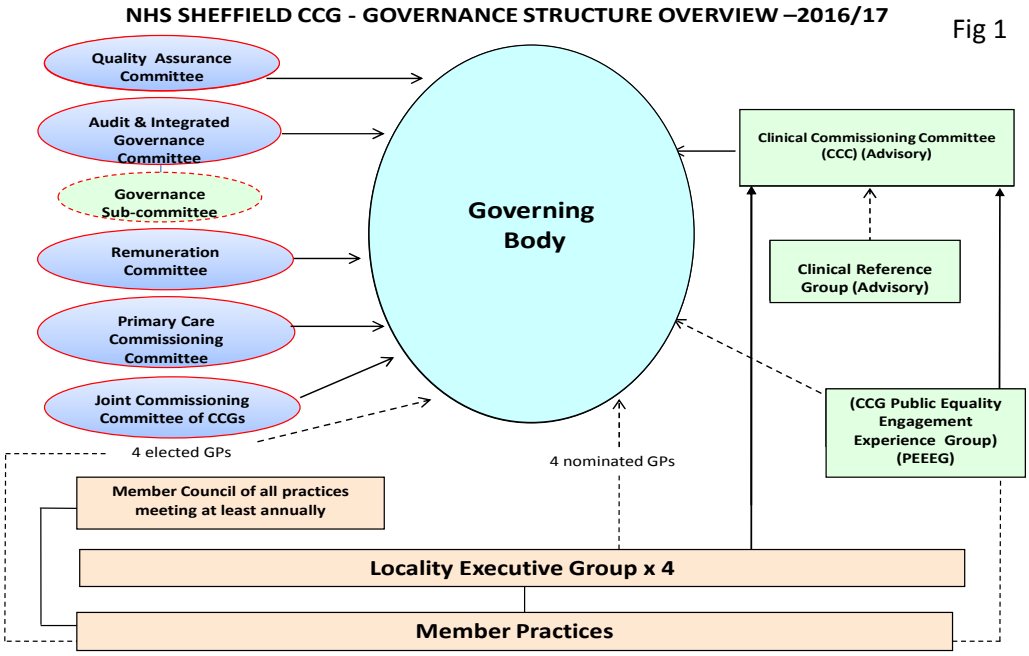
- Specific reference to the role of the Conflicts of Interest Guardian
- Changes to membership of the Primary Care Commissioning Committee
- Changes to the appointment process to clarify and strengthen the arrangements for Locality GPs.
- Changes to the Membership and quorum of the Governing Body
- Changes to make clear distinction between CCG and Governing Body

The Constitution, particularly through the Scheme of Reservation and Delegation, makes clear the respective responsibilities of the Members' Council (membership body), the Governing Body and its Committees. With the exception of changes to the Constitution, all powers and responsibilities have been delegated to the Governing Body.

The Constitution for NHS Sheffield CCG is available on the organisation's website www.sheffieldccg.nhs.uk

3.3 Governing Body, Committees, Sub-committee and Joint Committees of Governing Body

The governance or accountability structure (figure 1) outlines the systems and processes that allow us to achieve our strategic objectives and establish the extent to which services are commissioned in an appropriate and cost effective way.



NHS Sheffield CCG Governance Structure

The Governing Body comprises a diverse range of skills from Executive, Clinical and Lay members. There is a clear division of the responsibilities of individual's with no

one individual having unfettered powers of decision. The CCG Scheme of Delegation details how key CCG functions have been discharged through the organisation as agreed by its member practices in the CCG Constitution.

The CCG's governance arrangements, agreed by the Member practices and set out in the CCG's Constitution, gives the Governing Body the power to lead and manage the CCG on the Members' behalf.

The CCG Chair is responsible for the leadership of the Governing Body and ensuring the effectiveness of the Governing Body and that executives have access to relevant information to assist them in the delivery of their duties. The Lay members have actively provided scrutiny and challenge at Governing Body and Committee level. The Governing Body and its committees draw their membership from a broad pool of NHS Clinicians, staff and lay members, providing the appropriate balance of skills, experience, independence and knowledge of the organisation to enable them to discharge their respective duties and responsibilities effectively.

The Governing Body is collectively responsible for the long term success of the CCG and from November 2016 comprises:

- CCG Chair
- Accountable Officer
- Director of Finance
- Medical Director
- Chief Nurse
- 4 elected GP Members
- 4 Locality appointed GP Members (one of which is the Chair)
- 4 Lay members (one of which is the Vice Chair)
- Secondary Care Doctor
- Director of Delivery – Care Outside of Hospital
- Director of Strategy and Integration
- Director of Commissioning and Performance

3.3.1 Responsibility

The Governing Body has a responsibility to ensure there are appropriate healthcare services for the people of Sheffield. The CCG aspires to be a strong and forward thinking organisation. Its success depends on strong partnerships with constituent practices, local communities and external organisations. Members of the Governing body have proactively sought strong relationships collectively and individually through:

- Joint working through Partnerships Boards with the Local Authority and local NHS Foundation Trusts
- Joint working through partnership arrangements with neighbouring CCGs and Core City CCGs
- A joint arrangement with the Clinical Commissioning Groups from South Yorkshire and Bassetlaw, Hardwick and North Derbyshire for the CCG Collaborative Commissioning Network
- Joint working with NHS England at both national and local area team levels

The Governing Body is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. During 2016/17 it has maintained sound risk management and internal control systems as described in the Risk Management and Internal Control Framework sections.

3.3.2 Key Performance Highlights

A range of governance and strategic reports have been considered by the Governing Body including assurances on quality, finance and performance. Meetings are held in public and agendas, papers and minutes are published on the CCG website. All Governing Body agendas include the requirement for declarations of interest. The Governing Body receives information in a timely manner in a form and of a quality appropriate to enable it to discharge its duties.

The delivery of financial sustainability in the context of the CCG's Quality, Innovation, Prevention and Productivity (QIPP) challenge, enables the CCG Governing Body to continue to examine any risks to delivery of the significant financial challenge the CCG is facing.

The Governing Body continued to conduct the majority of its business in public, meeting seven times in public in 2016/17.

Executive directors, clinical leads and lay members are subject to formal assessment and appraisal processes. There is a comprehensive induction and bespoke development programme in place for all Governing Body members.

The Governing Body reviewed its governance arrangements in September 2016 which resulted in changes to the CCG's Constitution

3.3.3 Risk Framework

The Governing Body is committed to providing resources and support systems necessary to support the Risk Management Framework. The Governing Body Assurance Framework (GBAF) and Corporate Risk Register are reviewed by the Governing Body throughout the year. A development session on the GBAF was held for all Governing Body members in January 2017.

To support the Governing Body in carrying out its duties effectively, the following committees with delegated responsibility have been formally established:

a. Audit and Integrated Governance Committee

b. Remuneration Committee
c. Primary Care Commissioning Committee
d. Quality Assurance Committee

Each committee has formal Terms of Reference and provides summary reports to the Governing Body. The Terms of Reference for each of these committees were reviewed following removal from the Constitution, ensuring they remained fit-for-purpose and offered stringent governance assurance. Terms of Reference of each of the Committees and Governance Sub-committee are available on the CCG Website.

Attendance at Governing Body Meetings

Governing Body Member	Role	Attendance	
		Actual	Possible
Dr Amir Afzal	CCG GP Locality representative	5	7
Ngozi Anumba	CCG GP Locality representative	6	7
Dr Nikki Bates	CCG GP Elected City-wide Representative	7	7
John Boyington	Lay Member	5	7
Penny Brooks **(from 2.8.16)**	Chief Nurse	2	3
Kevin Clifford **(to 31.8.16)**	Chief Nurse	4	4
Nicki Doherty **(from 1.1.17)**	Interim Director of Delivery – Care Outside of Hospital	1	1
Devaka Fernando **(to 31.1.17)**	Secondary Care Doctor	4	6
Amanda Forrest	Lay Member	6	7
Tim Furness **(to 1.9.16)**	Chief of Business Planning and Partnerships	3	4
Mark Gamsu	Lay Member	7	7
Dr Anil Gill **(to 23.9.16)**	CCG GP Elected City-wide Representative	2	4
Idris Griffiths **(on secondment to NHS Bassetlaw CCG from 1.10.16)**	Chief Operating Officer	4	4
Dr Terry Hudsen **(from 1.1.17)**	CCG GP Elected City-wide Representative	1	1
Dr Annie Majoka **(from 1.1.17)**	CCG GP Elected City-wide Representative	1	1
Dr Zak McMurray	Medical Director	6	7
Peter Moore **(from 9.11.16)**	Director of Strategy and Integration	1	2
Dr Tim Moorhead	CCG GP Locality representative CCG Chair	6	7
Julia Newton	Director of Finance	7	7

Governing Body Member	Role	Attendance	
		Actual	Possible
Matt Powls **(from 1.11.16)**	Interim Director of Commissioning and Performance	2	2
Maddy Ruff	Accountable Officer	6	7
Dr Marion Sloan	CCG GP Elected City-wide Representative	6	7
Leigh Sorsbie	CCG GP Governing Body Member	3	7
Phil Taylor	Lay Member	7	7
Dr Ted Turner **(to 30.9.16)**	CCG GP Elected City-wide Representative	4	4

Audit and Integrated Governance Committee

Responsibility

This Committee is chaired by the Lay Member with responsibility for financial strategy and governance. The Chair of this committee is also the Conflicts of Interest Guardian. The AIGC has delegated responsibility for critically reviewing the CCG's financial reporting and internal control principles and for maintaining an appropriate relationship with internal and external audit and the CCG's Counter Fraud Service. A key responsibility of the Committee is to review the financial statements before submission to the Governing Body with recommendation for approval.

The Committee also has delegated authority to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the CCG's activities.

The AIGC is underpinned by the functions of the Governance Sub-committee and ongoing dialogue with internal and external auditors. It has met on four occasions during the year, considering relevant issues in line with its Annual Work Plan.

During 2016/17, the AIGC undertook its annual assessment using the checklist provided by its external auditors who were able to provide a report as how Sheffield AIGC self assessed compared with other CCG audit committees. The results of the self- assessment have been used to determine future actions e.g. additional training for committee members.

Key Performance Highlights

Key areas of the committee's work in 2016/17 included:

- Appointment of a new Chair from 1 April 2016 who is a qualified accountant with extensive experience of NHS finance, including chairing Finance and Audit Committees.
- Approval of the annual programme of work to be undertaken
- Receiving and reviewing updates from external audit
- Review of Internal Audit and Counter Fraud Services; in year monitoring and delivery against plans
- Review of policies against NHS Protect Standards for Bribery and Corruption

against the Bribery Act 2010

- Ongoing review of various aspects of internal control, including updates on key quality and performance issues from the Quality Assurance Committee
- Review of the Governing Body Assurance Framework with particular focus on ongoing identified gaps in control and/or assurance.
- Review of attendance at Governing Body and its committees
- Annual review of the CCG's Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies
- Establishing the Audit Panel to allow the successful appointment of external auditors with effect from 2017/18 financial year.
- Receiving and noting revised guidance on conflicts of interest including the appointment of the Chair of Audit and Integrated Governance Committee as the Conflict of Interest Guardian
- Reviewing the draft and final accounts, including the annual and quality reports and the CCG's Annual Governance Statement, prior to recommending approval by the CCG Governing Body
- Receipt and review of auditor's "ISA260" year end report

Quality Assurance Committee

Responsibility

This Committee is chaired by a Lay Member with a lead role in Patient and Public Engagement. The Committee has responsibility for seeking assurance that all providers with whom the CCG places service contracts are delivering high quality and safe care, and that a culture of continuous quality improvement is embedded within organisations and services. The committee meets quarterly and has provided exception reporting to Governing Body on quality concerns and good practice. During the year it has streamlined reporting and focused on specific clinical issues or service areas.

Key Performance Highlights

During 2016/17 the committee has continued to develop and deliver its responsibilities. Specifically, the committee has:

- Secured increased clinical representation, via a second GP Quality Lead.
- Systematically reviewed provider's performance in relation all areas of quality including performance against national reviews and priorities.
- Reviewed feedback relating to providers from the Care Quality Commission and other regulatory bodies and taken action with providers where appropriate.
- Monitored patient safety issues, including Serious Incident, Never Events, targets and plans to reduce hospital and community acquired infection.
- Monitored performance of providers relating to Clinical Quality and Innovation Schemes (CQUIN).
- Approved strategies for Commissioning for Quality and Patient Experience, and monitored delivery of the action plans.
- Monitored patient feedback from both provider and public websites.

- Reviewed and approved clinical policies and procedures.
- Received reviews from Internal Audit relating to the internal functions of the CCG's Quality Assurance systems.
- Provided Feedback to Governing Body on a Quarterly basis.

Remuneration Committee

Responsibility

The Remuneration Committee is chaired by a Lay Member. The Committee is delegated to oversee the appointment of all Governing Body members and to determine their remuneration and conditions of service, taking into account any national directions or guidance on these matters. The Committee also reviews the performance of the Accountable Officer and other senior CCG employees and determines any financial awards as appropriate. In addition, the Committee has delegated authority to consider the severance payments of the Accountable Officer and of other senior staff. The Committee advises the Governing Body on its determinations about allowances under any pension scheme it might establish as an alternative to the NHS pension scheme and on any other potential alternative remuneration and conditions of service for CCG employees outside of, or in place of, national Agenda for Change arrangements.

Key Performance Highlights

During 2016/17 key areas considered by the Committee included:

- Review of Remuneration Committee Terms of Reference
- CCG Senior Officers' On Call Arrangements
- Redundancy Business Cases
- Managing the Lay Members recruitment process
- Managing the Governing Body Elected GP Representative process
- Review of the remuneration of all Governing Body Members

Primary Care Commissioning Committee

Responsibility

The CCG formally took over delegated co commissioning responsibility for primary care medical services with effect from 1 April 2017 and hence 2016/17 was the first full year of operation of the committee. It strengthened its governance processes. This was recognised in an Internal Audit review which highlighted only a few minor

changes for consideration.

Key Performance Highlights

During 2016/17 key areas considered by the Committee included:

- Approval of a number of Locally Commissioned Services to support the CCG's wider Out of Hospital Strategy
- Conclusion of the Special Cases approach as part of PMS funding transitional arrangements
- Approval of the Estates and Electronic Transformation Fund (ETTF) bid to NHS England
- Approval of the Sheffield CCG GP Forward View (GPFV) submission to NHS England
- Supported the smooth transition of patients to alternative practices as a result of a practice closure
- Supported the development of a Primary Care Business Intelligence function
- Sponsored the CCG's approach to establishing a practice visiting programme

Committee Membership and Attendance

The table below sets out details of membership and attendance at each of the CCG's committees. All meetings of all committees were quorate throughout the year except for the Primary Care Commissioning Committee meeting on 29 June 2016 which was not quorate. However, decisions made at this meeting were subsequently ratified by core members following the meeting.

Committee	Membership	Role	Attendance	
			Actual	Possible
Audit & Integrated Governance *(Meets quarterly)*	Phil Taylor	Lay Member and Chair	4	4
	John Boyington	Lay Member	2	4
	Amanda Forrest	Lay Member and Vice Chair	2	4
	Ngozi Anumba	CCG GP Governing Body Member	4	4
	Leigh Sorsbie	CCG GP Governing Body Member	3	4
Quality Assurance *(Meets Quarterly)*	Amanda Forrest	Lay Member and Chair	4	4
	Amir Afzal (to 8.3.17)	CCG GP Lead for Quality	3	3
	Penny Brooks (from 1.9.16)	Chief Nurse and Vice Chair	2	3
	Kevin Clifford (to 30.8.16)	Chief Nurse and Vice Chair	2	2
	Devaka Fernando	Secondary Care Doctor	3	3

	(to 31.1.17)			
	Mark Gamsu (from 25.11.16)	Lay Member	2	2
	Jane Harriman (to 1.2.17)	Deputy Chief Nurse	2	3
	Terry Hudsen (from 9.3.17)	CCG GP Lead for Quality	0	1
	Zak McMurray	Medical Director	4	4
	Mandy Philbin (from 2.2.17)	Deputy Chief Nurse	0	1
	Marion Sloan (from 25.8.16)	CCG GP	2	2
Primary Care Commissioning (M*eets at least six times per year)*	John Boyington	Lay Member and Chair	9	9
	Penny Brooks (from 1.9.16)	Chief Nurse	5	5
	Kevin Clifford (to 30.8.16)	Chief Nurse	3	4
	Nicki Doherty (from 2.2.17)	Director – Care Outside of Hospital	1	1
	Amanda Forrest (from 2.2.17)	Lay Member	1	1
	Mark Gamsu	Lay Member and Vice Chair	9	9
	Julia Newton	Director of Finance	7	9
	Maddy Ruff	Accountable Officer	6	9
Remuneration Committee *(Meets quarterly)*	John Boyington	Lay Member and Chair	3	3
	Amanda Forrest	Lay Member and Vice Chair	2	3
	Amir Afzal	CCG GP Governing Body Member	3	3
	Nikki Bates	CCG GP Governing Body Member	2	3
	Mark Gamsu	Lay Member	1	3
	Annie Majoka (from 15.3.17)	CCG GP Governing Body Member	0	1
	Ted Turner (to 30.9.16)	CCG GP Governing Body Member	1	2

Governance Sub-committee

Responsibility

The Governance Sub-committee was established as a sub-committee of the Audit and Integrated Governance Committee (AIGC) with a remit to ensure that a sound system of integrated governance, risk management and internal control is in place to support the achievements of the CCG's objectives and to provide the AIGC, and ultimately the Governing Body, with assurance as both an employer and a statutory body.

It receives reports on high level risks, reviews the risk register and scrutinises any new organisational risks and their associated risk scores. The Sub-committee receives reports from a number of sub groups including information governance, freedom of information and health and safety. Reports to the Sub-committee include quarterly updates in relation to workforce planning, finance, and legal claims and litigation and compliments and complaints. The Sub-committee also receives reports with regard to the review and implementation of CCG policies for which it has delegated responsibility including corporate and HR policies.

Membership of the Governance Sub-committee includes deputy directors from each directorate who represent the executive directors.

Key Performance Highlights

During 2016/17 key areas considered by the Sub-committee included:

- Governing Body Assurance Framework (GBAF) reviewed at each meeting.
- Principal risks reviewed and challenged and in particular identified gaps in controls and/or assurances were challenged by its members.
- Operational risk register reviewed at each meeting and the scores of all new risks scrutinised.
- Incident reporting reviewed at each meeting, providing assurance that actions were taken following reported incidents in order to minimise the likelihood of future re-occurrence.
- Assurance received with regard to Information Governance systems and processes, including IG toolkit and Freedom of Information requests
- Positive assurance received in support of health and safety initiatives, premises inspections and fire risk assessments.
- On-going review of the policy management system for the review and updating of all corporate, human resources, clinical and financial policies
- Reviewed the Sub-committee Terms of Reference

Joint Committee

To enable Sheffield CCG to collaboratively commission with partners the Governing Body at its meeting on 6 October 2016 resolved to become a member of a new Working Together Joint Committee of CCGs (JCCC). The JCCC consulted with the public on proposals to change the way Hyper Acute Stroke Services and Children's

Surgery & Anaesthesia are provided across South and Mid Yorkshire, Bassetlaw and North Derbyshire between 3 October 2016 and 14 February 2017. The Committee currently has delegated authority to only make decisions on these two service areas. It held its first formal meeting in public on 18 April 2017 and currently intends to consider the business cases for the two service areas in June 2017.

The CCG has also become a partner in the Sustainability & Transformation Plan (STP) across South Yorkshire & Bassetlaw; published in November 2016. This plan builds on strong partnerships already in place across South Yorkshire and Bassetlaw to review services better commissioned "at scale". An STP Collaborative Partnership Board has been established which is currently a collaborative non-decision-making forum where commissioner and provider partners across South Yorkshire and Bassetlaw meet to discuss STP progress. Assurance is provided via Chief Officer representation and receipt of minutes and recommendations to Governing Body. New governance arrangements for the STP will be established during 2017/18.

4 UK CORPORATE GOVERNANCE CODE

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the Clinical Commissioning Group and best practice.

From 1st April 2016 and up to the date of signing this statement, the CCG has complied with the provisions set out in the NHS Clinical Commissioning Group's Code of Governance and applied the principles of the Code.

Principle of Leadership

NHS Sheffield CCG is headed by an effective unitary Governing Body comprised of Clinical Leads, Executive Directors and Lay Members each with clear understanding of individual and collective responsibilities. There is a clear division of responsibilities with no one individual having unfettered powers of decision.

The Chair is responsible for leadership of the Governing Body and ensuring its effectiveness on all aspects of its role and in particular a clear process for decision making. Our four Lay Members are valued for their impartial focus and expertise, their role is to oversee key elements of governance including audit, remuneration, and engagement, and conflicts of interest. We rely on their constructive challenge as well as their assistance in the development of strategy. All committees are chaired by a Lay Member.

The Governing Body sets the Clinical Commissioning Group's strategic aims and, with a revenue resource limit of £748.1m for CCG programme spend, £75.0m for primary care co commissioning and £12.7m for running costs for 2016/17, ensures that the necessary financial and human resources are in place for the organisation to meet its objectives.

Principle of Effectiveness
The Governing Body and its committees draw their membership from a broad pool of NHS staff, clinicians and lay members, providing the appropriate balance of skills, experience, independence and knowledge of the organisation to enable them to discharge their respective duties and responsibilities effectively. There is a formal process of reviews where time commitment of members is appraised.

A comprehensive organisational development programme is in place, primarily targeting the needs of Governing Body members, but also those of the CCG's Clinical Directors, enabling them to regularly update and refresh their skills and knowledge and support the CCG's programme for succession planning.

To enable the Governing Body to discharge its duties, information is received in a timely manner well in advance of meetings, with a choice of formats (hard or electronic). All papers presented at Governing Body and Committee meetings follow a recommended format including a standard front sheet, with three important functions:

- quickly draws members' attention to the key issues and recommendations.
- clearly states how the main body of the paper provides assurance that identified risks are being controlled
- provides evidence of the CCG's compliance with the requirements of the Equality Act 2010 and its duty to secure public involvement in the planning of commissioning arrangements.

The Governing Body reviews its own performance and that of its committees annually, with findings and recommendations being formally reported in its public facing meetings. Executive directors and lay members are subject to formal assessment and appraisal processes.

Principle of Accountability
The Governing Body undertakes a balanced and understandable assessment of the organisation's position and prospects via a number of routes including:

- papers presented to each Governing Body meeting, (e.g. Finance, Quality and Outcomes reports)
- development and publication of an Annual Plan
- development and publication of an Annual Report
- Annual Public Meeting
- meetings of the Members' Council.

The Audit and Integrated Governance Committee (AIGC) is chaired by an independent Lay Member with relevant financial experience. The AIGC is responsible for reviewing the CCG's internal control and risk management systems.

Principle of Remuneration

The Remuneration Committee oversees the appointment of all Governing Body Members and has delegated authority to determine their remuneration and conditions of service, taking into account any national directions or guidance on these matters. The Committee has the delegated authority to review the

performance of the Accountable Officer and other senior CCG employees and determine any financial awards as appropriate.

Principle of Relations with Stakeholders

All Governing Body members actively engage in some form of dialogue with our stakeholders, be they constituent practices, Clinical Director meetings with practices, partner organisations or our citizens.

We seek to cultivate a mutual understanding of objectives and undertake this by sharing information in a variety of ways including:

- Publishing an Annual Report
- Annual Public Meeting
- Cross organisation Board Meetings
- Members' Council Meetings
- General Public Meetings
- Public facing web site
- Our "Involve Me" engagement network

5 DISCHARGE OF STATUTORY FUNCTIONS

In light of recommendations of the 1983 Harris Review, the CCG 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.

Quarterly assurance reviews with NHS England continue, which also cover the discharge of statutory functions with positive outcomes in 2016-17.

In July 2016, the Accountable Officer commenced an assessment and review of the organisational and leadership structures and operating model for delivery set against the organisational strategic direction, ambitions and aims. This was undertaken using feedback from partners, Governing Body diagnostics and a better understanding of the range of portfolios to support the operating model.

The review indicated the requirement for strengthening clarity on the remit, autonomy and responsibility of roles and a structure of portfolios that supports the operating model required to deliver. As such an appropriate consultation was undertaken and a revised leadership structure was implemented. In support of these changes, a full review of the CCG's Constitution was undertaken in the autumn of 2016 this was followed by NHS England approval in November 2016.

6 RISK MANAGEMENT ARRANGEMENTS AND EFFECTIVENESS

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

We have effective controls in place to enable risk to be assessed and managed. The Risk Management Strategy sets out the aims of the CCG to ensure that staff, patients, visitors, reputation, and finances associated with the CCG are protected through the process of risk identification, assessment, control and elimination/reduction. The strategy also sets out accountability arrangements in terms of risk management, including roles and responsibilities. The Director of Finance is designated as the lead officer for implementing the system of internal control, including the Risk Management Strategy.

The objective of the CCG's Risk Management Strategy is to create a framework to achieve a culture that encourages staff to:

- identify and control risks which may adversely affect the operational ability of the CCG
- compare risks using the 5 x 5 grading system (see table 2 below)
- eliminate or transfer risks or reduce them to an acceptable and cost effective level wherever possible, otherwise ensure the organisation openly accepts the remaining risks
- provide the Governing Body with assurance that risk is being effectively managed through appropriate risk management escalation mechanisms for the purposes of decision making

Risks are identified from a number of sources, including the Governing Body, Executive Directors, staff, Governing Body Assurance Framework (GBAF), internal and external audit reports and risk assessments. Monitoring, evaluation and control have been further developed throughout the year and all identified risks are included on the Corporate Risk Register or GBAF and more recently the introduction of Team Risk Logs. The Governance Sub-committee receives a report on all new risks and progress on addressing the high level risks at every meeting.

The CCG's Risk Management Framework is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives and statutory duties and therefore provides reasonable rather than absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- Identify and prioritise risks to the achievement of the organisation's policies, aims and objectives;
- Evaluation the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The evaluation of risks to achieving the organisation's five high level objectives are set out in the GBAF which is regularly reviewed and scrutinised by the Governance Sub-committee, A AIGC and ultimately the Governing Body.

The GBAF forms part of the CCG's key assurance process and its purpose is to provide the Governing Body with 'reasonable' assurance that internal systems are functioning effectively. It is a high level document that is used to inform and give assurance to the Governing Body that the potential risks to achieving key objectives are recognised and that controls are in place or being developed to manage these potential risks.

The CCG's Risk Management Strategy and Action Plan, together with its policies and procedures, have been in place throughout 2016/17, and are reviewed annually. Responsibility for approval of the CCG's risk management arrangements is delegated to the AIGC. Preparation and review of the GBAF and operational Risk Register with recommendations for action to AIGC and Governing Body is delegated to the Governance Sub-committee.

There are a range of controls in place within the CCG which include risk prevention ie ensuring the risk does not occur and includes for example the Scheme of Delegation and Reservation and financial authorisation and authorisation levels. In addition, the CCG produces a range of detection controls ie performance monitoring and quality reports to Governing Body. The CCG also has a statutory and mandatory training regime which is a significant aspect of internal control. Finally, the CCG has in place directive controls which include a suite of policies and standard operating procedures which are monitored by the Governance Sub-committee at each of its meetings, such controls reduce the likelihood of a risk occurring.

The CCG reviews its compliance with the Public Sector Equality Duty annually and publishes details about the progress we have made towards meeting the requirements on our website. We also publish data on the make-up of our workforce, those affected by our policies and procedures, as well as our objectives for improvements in equality across all areas of our work. More information can be found on our website www.sheffieldccg.nhs.uk/our-information/Public-Sector-Equality-Duty

Incident reporting and serious incident reporting is openly encouraged from all staff and there is a process in place for the reporting, management, investigation and learning from incidents. We have a Senior Information Risk Owner (SIRO) to support our arrangements for managing and controlling risks relating to information/data security.

Attendance at risk management training, which includes the importance of incident reporting, is mandatory for all staff.

All papers presented at Governing Body and committee meetings follow a recommended format including a standard front sheet that provides a clear summary of:

- Assurance that identified risks are being controlled
- Evidence of the CCG's compliance with the requirements of the Equality Act 2010

- How the report supports involving patients, carers and the public

The CCG values the involvement of public stakeholders in its local and collective decisions, and we utilise various engagement approaches to ensure an inclusive approach to involving the diversity of our citizens. To this effect, we have considered a number of key elements for involving public stakeholders set out in:

- The White Paper, '*Equity and Excellence: Liberating the NHS'*
- Health and Social Care Act 2012
- The NHS Constitution

Two Lay Members are identified with responsibility for public engagement and who attend the Governing Body, the Quality Assurance Committee, Remuneration Committee and Primary Care Commissioning Committee to ensure there is a voice for patients and the public.

In addition to direct regular contact with our citizens through the Involve Me network and City-wide Patient Participation Group meetings, we hear directly from harder to reach communities through tailored approaches and partnership working. We consult with relevant Overview and Scrutiny Committees and NHS England and work alongside our local Healthwatch, as well as the voluntary, community and faith sector in the City.

6.1 Capacity to Handle Risk

The CCG has sought to ensure that risk assessment and management is embedded throughout the organisation, with risks being identified from a number of sources, including the Governing Body, senior management, staff and reports from internal audit. Monitoring, evaluation and control systems have been reviewed and improved throughout the year and includes deputy directors taking an active role in reviewing corporate risks to ensure consistency in reporting across the organisation. All identified operational risks are included on our operational Risk Register and all strategic risks on the GBAF. The Corporate Services Risk and Governance Manager is responsible for overseeing the risk management process within the CCG.

The Governance sub-committee has delegated authority to routinely receive a report of all new risks and progress on addressing high level risks and any identified gaps in assurance and control at each meeting. There is a system in place to ensure lead directors, with their managers, from each directorate take responsibility for regularly reviewing and updating both the GBAF and the Risk Register.

The AIGC has responsibility for oversight of the CCG's risk management arrangements and receives update reports at each of its quarterly meetings. The Governing Body considers specific risk issues and receives minutes from its committees. The Governing Body also routinely receives information on Serious Untoward Incidents (SUIs) including lessons identified and learned.

A meeting of senior risk owners was held on 3 March 2016 to discuss the content of the GBAF in relation to the organisation's 5 year strategic ambitions and to ensure that risks remained relevant for the financial year ahead. This was followed by a 'Confirm and Challenge' session attended by Directors who reviewed and challenged

the scores of all principle risks highlighted on the refreshed GB Assurance Framework. The Governing Body was provided with details of the refreshed GBAF at its meeting in May 2016 which included details of the changes to be taken forward for 2016/17. The Governing Body has received further update reports throughout the year.

Overall responsibility of the CCG's systems of internal control and preparation of the Annual Governance Statement is delegated to the Accountable Officer. The Director of Finance has delegated responsibility for ensuring that the CCG has in place a system for checking and reporting breaches of financial policies, together with a proper procedure for checking the adequacy and effectiveness of the control environment.

6.2 Risk Assessment

The CCG has adopted a local and systematic method of identifying, analysing, assessing, treating, monitoring and communicating risk. This process included the context in which risk had been managed. Front cover sheets of reports to the CCG's Governing Body and Committees and sub-committees make the link to any associated risks to the achievement of the organisation's objectives.

Risk management is embedded within the organisation through delivery of the Risk Management Strategy and also through assessments of specific risks including information governance, equality impact assessments, incident reporting and business continuity. We have a clear process for reporting, managing, investigating and learning from incidents captured via Datix our incident reporting system and as set out in our Incident Reporting Policy. Risk identification, assessment and monitoring is a continuous process in ensuring that we work within the legal and regulatory framework, identifying and assessing possible risks facing the organisation and how we respond to these.

The process of risk management covers the following 5 steps to risk assessment:

- Identify
- Assess
- Evaluate
- Record
- Review

Risks are scored using the standard 5 x 5 risk matrix together with controls identified in order to address or mitigate the risks. Gaps in control and/or assurance are noted and action plans to close gaps summarized and updated. The matrix incorporates both consequence and likelihood as detailed below:

Table 2

Risk Matrix		Likelihood				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Consequence	1 Negligible	1	2	3	4	5
	2 Minor	2	4	6	8	10
	3 Moderate	3	6	9	12	15
	4 Major	4	8	12	16	20
	5 Extreme	5	10	15	20	25

1 to 3	Low
4 to 9	Medium
10 to 14	High
15 to 19	Very High (Serious)
20 to 25	Critical

In accordance with the CCG's Risk Management Strategy, senior managers have initial responsibility for identifying and managing operational risks within their areas of responsibility and all staff are required to report potential risks to their line manager. When a risk has been confirmed it is added to the operational Risk Register and rated using the standard NHS 5 x 5 scoring system. During 2016/17 this has been via web based reporting software. The system ensures risks are reviewed by the risk owner, senior manager and senior risk owner during the 13 week review cycle. Teams are encouraged to review their risks at monthly team meetings.

Every new risk identified is reviewed by the Governance Sub-committee who will confirm any actions required in order to reduce the level of risk, together with the risk rating. A protocol in support of the Risk Register has been established, which sets out the requirements and the reporting arrangements, and is regularly updated and circulated to risk owners

Risks are assigned a score based on a combination of the **likelihood** of a risk being realised and the **consequences** if the risk is realised.

The CCG uses three risk scores:

- **Initial Risk Score**: This is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risks and is used as a benchmark against which the effect of risk management will be measured.

- **Current Risk Score**: This is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans to mitigate the risks are developed and implemented.

- **Target (Appetite) Risk Score**: This is the score that is expected after the action plan has been fully implemented and which the CCG deems to be an acceptable level of risk.

An Annual Risk Management Report was presented to the Governance Sub-committee in August 2016 and AIGC in September 2016 providing assurance of the continued progress throughout the year with regard to risk management. The report identified that Directors and senior managers who develop business plans were attuned to the importance of risk management and played a pivotal role in identifying risk to the achievement of objectives at both team and organisational level.

6.3 Governing Body Assurance Framework (GBAF)

The GBAF identifies our five strategic objectives (the first four taken from our Prospectus and the fifth from the authorisation process), the principal risks to delivery of these and any gaps in assurance and control. The five objectives are:

- To improve patient experience and access to care
- To improve the quality and equality of healthcare in NHS Sheffield CCG
- To work with Sheffield City Council to continue to reduce health inequalities in NHS Sheffield CCG
- To ensure there is a sustainable, affordable healthcare system in Sheffield
- Organisational development to ensure the CCG meets organisational health and capability requirements set out in the 6 domains (Annex C NHS England CCG Assurance Framework)

In addition to the organisation's objectives eight further goals were identified, each of the goals is linked to the 5 key objectives. The Goals identified include:

1 Deliver timely and high quality care in hospital for all patients and their families

2 Become a person-centred city: promoting independence for our citizens and supporting them to take control of their health and health care.

3 Tailor services to support a reduction in health inequalities across the Sheffield population.

4 Integration of physical and mental health, ensuring parity of esteem for people with mental health needs.

5 Supporting people living with and beyond life threatening or long term conditions

6 Give every child and young person the best start in life

7 Prevent the early onset of premature disease and avoidable deaths

8 We will work in collaboration with partners for sustainable care models by playing an active role in regional sustainability and be recognised as a system leader for public sector reform.

The GBAF is designed to meet the requirements of the Annual Governance Statement, providing a structure and process to enable the organisation to focus on the high level strategic and reputational risks with the potential to compromise the achievement of its strategic objectives. The framework is a dynamic tool that maps out key controls and highlights any gaps in controls and assurances to mitigate the risks, and provides a mechanism to assure the Governing Body of the effectiveness of these controls. It is part of the wider governance and assurance framework to ensure the CCG's performance across the full range of its commissioning activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for patients. Crucially, the GBAF provides the Governing Body with confidence that systems and processes in place are operating in a way that is safe and effective.

Management of the GBAF is the responsibility of the Corporate Services Risk and Governance Manager and is formally reviewed by each Risk Lead (Executive Directors) quarterly. This is to ensure the controls and assurances remain valid and any identified gaps are mitigated by timely implementation and are clearly defined. During the year, two additional worksheets have been added to the GBAF framework which include:

- Identification of gaps in control/assurance and details of action plans in order to close the gaps/assurances, together with a target date for closure of the gap;
- Details of action plans identified in order to mitigate the level of risk which are RAG rated.

At the end of the monitoring period there remained 16 risks identified on the GBAF – the level of risk is set out below. No new risks were added during the year and no risks closed during this period. This is compared, in the table below, to the position reviewed in the previous quarters.

Review period	Critical	Very High	High	Medium	Low
Up to and including 20 March 2017	0	2	1	13	0
Up to and including 15 November 2016	0	6	2	8	0
Up to and including 26 October 2016	0	6	5	5	0
Up to and including 30 August 2016	0	5	6	5	0

At 31 March 2017, the Governing Body Assurance Framework identified the following outstanding gaps in control.

Risk Ref	Principal Risk	Identified Gap in Control
2.3	That the CCG fails to achieve Parity of Esteem for its citizens who experience mental health conditions, so reinforcing their health inequality and life expectancy	1 As an organisation, we do not yet have a coherent response to Parity Of Esteem through the work that is being delivered on Health Inequality overall. 2 Insufficient corporate equality activity to highlight this agenda, alongside other inequality agendas and work. 3 We need a higher degree of scrutiny of Equality Impact Assessments for all CCG activity. 4 Ongoing engagement within this CCG with existing partners to embed MH into structure and context of our organisational delivery plans.
5.2	Unable to secure timely and effective commissioning support to enable us to adequately respond and secure delivery to existing and new emerging requirements. Quality of externally purchased commissioning support (IT and data management) falls below required levels.	Limited contractual mechanisms available via the LPF contract to drive performance improvement.

The above gaps in control have robust action plans and have been built into the 2017/18 Framework

6.4 Operational Risk Register

Current Risks

At 31 March 2017 there were 23 risks identified and added to the Operational Risk Register. Of these, 13 risks were classified as high and 2 risks identified as Very High (serious);

- Inability to meet NHS Constitution pledge on A&E waits, flow through Sheffield Teaching Hospitals NHS FT and impact on elective waiting times.

- Impact of outstanding Joint Packages of Care: There are approximately 50 patients who have become eligible for a joint package of care. Some of whom had their care solely funded by the LA and others solely funded by the CCG.

The funding responsibilities are still being agreed. This could lead to an increase in costs overall, including the backdating of any payments to the Local Authority.

4 risks were rated moderate and 4 low level.

The Governance Sub-committee receives a quarterly report highlighting progress of all open risks at each of its meetings. The Sub-committee also reviews the level of risk of all new risks identified as well as recommending additional controls and challenging any continuing gaps in control and/or assurance.

Whilst the Governance Sub-committee has paid particular attention to risks ranked 15 or above, where possible, action is taken to reduce risks at all levels as many of the lower level risks can be mitigated with limited resources and it is considered good practice to address rather than accept these. Accordingly, rather than setting a single risk appetite, all individual risks are given a target ranking considered appropriate to that risk.

The Risk Report to Governance Sub-committee now includes details of those risks which have remained static in score for two or more cycles.

7 OTHER SOURCES OF ASSURANCE

7.1 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.

Our control framework is articulated through our Constitution, Standing Orders, Scheme of Reservation and Delegation and Detailed Financial Policies. The risk assessment component of our internal control framework is contained in our Risk Management Strategy.

The GBAF provides an overview of the controls and assurances in place to ensure that the CCG's principal objectives are achieved and that risks identified are managed. The template for Governing Body papers further adds to our control mechanisms.

7.2 Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

Our Internal Auditors have carried out our annual internal audit of conflicts of interest and the findings of the audit were:

Scope area	Compliance level
Governance arrangements	Compliant
Declarations of interest and gifts and hospitality	Compliant
Registers of interest, gifts and hospitality and procurement decisions	Partially Compliant
Decision making processes and contract monitoring	Partially Compliant
Identifying and managing non-compliance	Compliant

Each of the 5 agreed actions identified by internal audit have now been completed.

7.3 Data Quality

All reports received by Governing Body provide information on how they link to the Governing Body Assurance Framework. The Governing Body receives a monthly Performance and Quality Report which contains a significant range of data which officers' ensure is the most up to date available and from reliable sources such as contract data sets, nationally published data etc. The Governing Body, as part of its monthly discussions on all reports, seeks reassurance on the accuracy and timeliness of the data and has found it acceptable.

7.4 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.

Sheffield CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have a named Senior Information Risk Owner (SIRO), Caldicott Guardian and Information Governance Lead and access to information governance subject matter expertise from our external providers. The CCG has an Information Governance Group that reports to the Governance Sub-committee and addresses information governance matters for the CCG.

We have ensured all staff undertake annual information governance training and have implemented an information governance framework, to ensure that staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents.

The level of compliance demonstrated by completion of the 2016/17 Information Governance (IG) Toolkit is 70% with all standards at a score of at least two, which is deemed by NHS Digital to be satisfactory. Our IG Toolkit was also reviewed by our Internal Auditors, and this audit resulted in an outcome of significant assurance. The areas covered include:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance

There were no Serious Untoward Incidents relating to data security breaches in 2016/17.

The CCG operates effectively with pseudonymised data for secondary uses. In common with all Yorkshire and Humber CCGs our Data Services for Commissioners Regional Officers DSCRO services are contracted from North East Commissioning Support (NECS).

As a result of the NHS England led Lead Provider Framework (LPF) procurement exercise, in common with the majority of Yorkshire and Humber CCGs, Sheffield CCG contracted its IT Services from eMBED/Kier Healthcare with effect from April 2016. This contract includes the provision of specialist Information Governance support.

7.5 Business Critical Models

An appropriate framework and environment is in place via our Business Continuity Policy and our Business Continuity Plan to provide quality assurance of business critical models - inputs, methodology and outputs. We have no business critical models which meet the threshold criteria as outlined within the Macpherson Report 2013.

7.6 Third party assurances

Service Organisations (including CSUs) do not generally allow access to client auditors, as this is an inefficient approach to providing assurance, costly for clients commissioning the work and disruptive to the Service Organisation. Service Auditor Reports (SARs) are an internationally recognised method for Service Organisations to provide details of controls and their operation in a specified period to their clients. A SAR typically includes a high level description of the governance and assurance arrangements in place at the Service Organisation, a high level description of the Service control environment, an assertion by the Service Organisation management regarding the design of internal controls over the process, and a low level description of the Service's control objectives and supporting key controls.

The CCG received and reviewed the following SARs after the submission of the draft accounts:

- North East Commissioning Services (NECS) relating to Data Management and Integration. Assurance is received through the contract which we hold with NECS and through the oversight of the flow of data by an Information Sharing Contract which we hold with NHS Digital and an Information Sharing Agreement.
- From NHS Shared Business Services for the provision of Financial and Accounting Services
- From McKesson / IBM for the Electronic Staff Records Programme (ESR)
- From NHS England/Capita over GP Co-Commissioning Recharges
- From NHS Business Service Authority regarding Prescription Services.

In addition to the above Service Auditor Reports, the CCG takes additional assurance from its own internal control procedures. For example, for GP Co-commissioning expenditure is monitored against budgets on a monthly basis and is reported to the Primary Care Commissioning Committee. The CCG also holds contracts for third party support with eMBED Health Consortium. Assurance is received through the contract which we hold with eMBED in relation to minor services such as our Registration Authority. Certain support services are shared with local CCGs in South Yorkshire & Bassetlaw on a hosted basis. All partnership arrangements were overseen by NHS England at establishment, and are supported by Memorandums of Understanding. Each hosted service has established formal arrangements through their Memorandum of Understanding for review and assurance of the service. All CCGs in South Yorkshire and Bassetlaw contract with the same internal audit partner, 360 Assurance. Internal audit plans incorporate the assurances required for all partners in relation to hosted services.

The Director of Finance reviews all internal audit reports, considers the implications of any deficiencies in control which are highlight, and advises the Audit and Integrated Governance Committee accordingly. Reports are presented quarterly to the AIGC of all high and medium level risks.

8 CONTROL ISSUES

The CCG has reviewed its control arrangements and concluded that there were no significant control issues facing the organisation.

9 REVIEW OF ECONOMY, EFFICIENCY & EFFECTIVENESS OF THE USE OF RESOURCES

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 external auditors in their management letter and other reports.

The Governing Body Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit and Integrated Governance Committee and Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

There are procurement processes in place to which the CCG adheres. There is a Scheme of Reservation and Delegation which ensures that financial controls are in place across the organisation.

The roles of accountable and delegated committees and groups are clearly articulated in Section 3 (Governance Arrangements and Effectiveness) of this Statement. The Scheme of Reservation and Delegation has been reviewed, and approved in year.

As detailed in Section 11 below, the CCG actively deters risk through the adoption of robust counter-fraud methodology.

NHS England assess the CCG's Quality of Leadership within the CCG Improvement and Assessment Framework. NHS England have advised that the year end results for the Quality of leadership Indicator will be available from July 2017 at www.nhs.uk/service-search/scorecard/results/1175. The latest available results for Quarter 2 2016/17 confirm that for NHS Sheffield CCG the Quality of Leadership is 'Good'.

The Director of Finance, who is a member of Governing Body, is responsible for providing financial advice and for supervising financial control and accounting systems. She presents a monthly finance report to Governing Body, encouraging open debate and understanding from its members. This report provides members with information on cumulative expenditure against the approved budgets, together with a forecast of the likely year end position, and any risks or actions required to manage the overall financial position. The CCG contained expenditure within allocated resources, both for Programme (including primary care Co-commissioning) and Running Costs and has ended the year with a surplus of £11.6million (£3.5m planned surplus plus release of a 1% (£8.1m) reserve which all CCGs were required to hold throughout 2016/17 as uncommitted,

The Director of Commissioning and Performance, who is a member of Governing Body, is responsible for providing advice to the Governing Body on the progress of the CCG's Quality, Innovation, Productivity and Prevention (QIPP) programme. He presents a monthly QIPP report to Governing Body outlining the progress of the key programmes and projects, and the impact that these initiatives are having on the delivery of improved quality, efficiency and effectiveness.

Third party assurance is provided by Internal Audit in relation to the effectiveness of the CCG's key financial systems and External Audit provide an opinion in relation to the CCG's use of resources in their Value for Money (VFM) conclusion.

10 DELEGATION OF FUNCTIONS

We have collaborative commissioning arrangements for 999 and 111 services across CCGs in the Yorkshire & Humber region. Assurance is provided via a Memorandum of Understanding and local representation at the Joint Strategic Commissioning Board. This Commissioning Board will become a Joint Committee of CCGs in due course. Limited delegation is in place to the Commissioning Board through a Memorandum of Understanding.

11 COUNTER FRAUD ARRANGEMENTS

We have in place a Fraud, Bribery and Corruption Policy which is agreed and monitored by AIGC. Our Counter Fraud Service is provided by 360 Assurance and provides regular update reports to AIGC to ensure members are made aware of work undertaken by the Local Counter Fraud Specialist (LCFS). The content is formatted to report upon compliance with NHS Protect's Standards for Commissioners: Fraud, bribery and corruption, covering the following areas:

- Strategic Governance
- Inform and Involve
- Prevent & Deter
- Hold to Account

All staff are required to attend mandatory Fraud Awareness sessions. Staff are notified of the quarterly Fraudulent Times Newsletter which is available on the CCGs intranet.

12 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:

"In providing an opinion for the financial year, it is important to reflect on the environment in which the organisation has been required to function and the impact of an on-going need to meet quality challenges whilst reducing costs, along with responding to the sustainability and transformation agenda. This will undoubtedly impact on the operation of control, however, the system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure. From my review of your systems of internal control, primarily through the operation of your Governing Body's Assurance Framework in the year to date, and the outcome of individual assignments also completed in the year to date, I am providing a ***Significant Assurance*** *that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.*

It should be recognised that the organisation's current systems of control and arrangements for governance and the management of risk will need to continue to

develop in the coming year, particularly reflecting on increasing cross-organisation and sector partnerships, as these arrangements will bring additional challenges in terms of the management of risk and ensuring that all partners understand the inter-relationships."

During the year, Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
Continuing Healthcare	Significant
Primary Care Co-commissioning	Significant
Information Sharing	Significant
QIPP Review	Limited
Budgetary Control and Key Financial Systems	Significant
Information Governance Toolkit	Significant
Conflicts of Interest	**Compliant:** • Governance • Declarations of Interest and Gifts and Hospitality • Identifying and managing non-compliance **Partially Compliant:** • Registers of interests, gifts and hospitality and procurement decisions • Decision making processes and contract monitoring
Patient and Public Engagement	To be confirmed
Payroll	Significant
Better Care Fund	To be confirmed

13 REVIEW OF THE EFFECTIVENESS OF GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

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

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

I have been advised on the implications of the result of this review by:

- **The Governing Body:** responsible for providing clear commitment and direction for risk management within the organisation and approving the CCG's risk management arrangements. It is responsible for determining the nature and extent of significant risks it is willing to take in achieving its strategic objectives. During 2016/17 it has maintained sound risk management and internal control systems as described in the risk management section of this statement.

- **The Audit and Integrated Governance Committee:** responsible for providing an independent overview of the arrangements for risk management within the CCG, with specific responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews all internal and external audits.

- **The Quality Assurance Committee:** has a responsibility for ensuring clinical risks are identified and reported on the risk register, escalating to the Assurance Framework where necessary. The Committee provides assurance to the Governing Body that appropriate clinical risk management arrangements are in place across the organisation. Its work programme addresses safeguarding, infection control, quality in contracts, incidents and medicines management.

- **Primary Care Commissioning Committee:** is a committee of the Governing Body. The Committee has been established to enable the Members to make collective decisions on the review, planning and procurement of primary care services in Sheffield under delegated authority from NHS England. In performing its role, the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG. Minutes of each meeting of the PCCC are forwarded to NHS England for information, including the minutes of any sub-committees to which responsibilities are delegated.

- **Internal audit:** reviews of systems of internal control and progress reports to Audit and Integrated Governance Committee have supported my review, especially with regard to the Assurance Framework and Conflicts of Interest Reviews.

- **Executive Directors:** Each director is responsible for ensuring that risks have been properly identified and assessed across all their work areas. They are responsible for reviewing risks entered onto the corporate risk register and that each risk owner is actively managing their risks and escalating as appropriate. Directors are responsible for the management of all high level risks facing delivery of the organisations objectives. Directors also play a crucial role in ensuring that risk related issues are adequately dealt with when policies are developed within their area of work.

- **Director of Finance:** is responsible for ensuring that the organisation complies with the Standing Orders to achieve financial balance and reporting of financial risk to the Governing Body.
- **Senior Managers and Clinical Leads within the CCG** who have responsibility for the development and maintenance of the internal control framework
- **Performance information** – Quarterly Quality and Performance reports to Governing Body
- **External Auditors** - Comments in their Annual Audit Letter and other reports

My review was also informed by:

- Delivery and audit plans by External and Internal Auditors
- Results from the Staff Survey
- Results from the NHS England survey
- Annual Operational Plan
- Information Governance Toolkit Assessment
- Monthly delivery and performance reports
- Regular reviews of risk registers
- Regular reports to the Governing Body from each of the formal committees
- Quarterly Assurance reports to NHS England
- Results of the 360 Stakeholder Review
- NHS England Assurance review

14 CONCLUSION

My review confirms that NHS Sheffield Clinical Commissioning Group has a generally sound system of internal control which supports the achievement of our policies, aims and objectives and that no significant internal control issues have been identified.

Signed: Date:

Maddy Ruff

Maddy Ruff
Accountable Officer

Remuneration and Staff Report

Remuneration Report

1. Remuneration Committee

Details of the membership of the Remuneration Committee can be found within the Annual Governance Statement (page 23). The Committee is responsible for advising about the appropriate remuneration and terms of service for the Accountable Officer, executive directors and other senior managers, as well as monitoring and evaluating their performance.

2. Senior Managers' Remuneration and Terms of Service

For the purposes of the Remuneration Report, Senior Managers are defined as:

'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Clinical Commissioning Group. This means those who influence the decisions of the Clinical Commissioning Group as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members'

The Accountable Officer of the CCG has determined that this definition applies to all voting members of Governing Body as set out in the CCG's Constitution. NHS England approved changes to the CCG's Constitution which included changes to job titles for certain directors and also the number of voting members with effect from November 2016. While some directors may have used a locally agreed title before the approved changes to the Constitution, for the purposes of this Annual Report we have only used the titles set out in the Constitution. For the relevant directors remuneration information is provided from the date they became a voting member. Profiles of each Governing Body member can be found in the Members' Report section of this Annual Report.

There is an assumption that information about named individuals will be given in all circumstances and all disclosures in the Remuneration Report will be consistent with identifiable information of those individuals in the Financial Statements. Following a case arising under the Freedom of Information Act, the Information Commissioner determined that consent is not needed for the disclosure of salary and pension details for named individuals.

Senior Managers' remuneration for 2016/17 was determined by the Remuneration Committee and took account of national guidance, the prevailing economic climate, local market conditions and the requirement to obtain best possible value for money. The costs of posts are met from the notified Clinical Commissioning Group running cost allowance.

The information and guidance used to determine senior manager pay comprises a combination of:

- The Agenda for Change guidance from NHS Employers including the staffing body pay and employment conditions in relation to senior managers' remuneration to ensure parity as far as reasonably practicable. Staff engaged on Agenda for Change payscales received a 1% pay increase.
- The work and recommendations of the Senior Salaries Review Body.
- Recommendations made in 2012 by HM Treasury and HMRC regarding tax arrangements in relation to Governing Body members and senior officials.
- National guidance set out in "*Clinical commissioning group governing body members: Role outlines, attributes and skills"* (October 2012).
- NHS England guidance regarding the remuneration of clinical commissioning group Chief Officers (Accountable Officers) and Chief Finance Officers (Directors of Finance). This covers basic salary, recruitment and retention premia where deemed applicable and additional payments for additional duties.

These sources of data will continue to form the basis of the Remuneration Committee's annual review of salaries.

Senior Managers' performance is subject to evaluation in the same way as the main staffing body in line with the NHS Sheffield CCG appraisal policy. Performance measures are set by the line manager of each employee and Governing Body member and are subject to annual review in accordance with the appraisal policy of the CCG.

The CCG's Accountable Officer and Director of Finance are engaged on Very Senior Manager contracts which include a requirement for an annual review.

The Remuneration Committee sets the framework within which the terms and conditions of the Very Senior Managers are developed and agreed. It also receives reports on performance against standards set in relation to local and national targets from the CCGs strategic and operational plans for the Accountable Officer and Director of Finance. The remuneration is set through a process that is based on a consistent framework and independent decision of performance measures against an individual's performance with due consideration to comparative salary data, the labour market, the financial circumstances of the organisation plus any national guidance. Performance related pay was paid to the Accountable Officer of 3% of basic salary (paid pro rata based on the start date of 1.9.2015) following assessment of individual performance in 2015/16 and a subsequent recommendation by the Remuneration Committee. The Director of Finance received a 5% consolidated increase to basic salary with effect from 1st April 2016 following a review of salary and assessment of individual performance in 2015/16 and a subsequent recommendation by the Remuneration Committee.

Very Senior Managers are on permanent contracts. Six months' notice is required by the organisation to terminate the contract and three months by the individual. Directors engaged under Agenda for Change have a three month notice period on either side to terminate the contract. All other Governing Body members are appointed for a period of up to three years, with a notice period of three months. Further information on can be found in the CCG's Standing Orders which are available on our website as part of our constitution:

http://www.sheffieldccg.nhs.uk/about-us/our-constitution.htm

There are four senior managers on the Governing Body whose salary exceeds £142,500 per annum when adjusted to reflect a full time annualised equivalent post. Two of these posts are filled by GPs on a part time basis and they are providing expert leadership and clinical advice to the CCG, the level of remuneration reflects this specialist input. The other posts are for the Accountable Officer and a Director post which is paid for on an off-payroll basis due to the CCG at the time being unable to recruit substantively because of the specialist skills and knowledge required. The CCG followed NHS England's national approvals process for this temporary off payroll appointment. This arrangement will cease in May 2017 following a substantive appointment to the Director of Commissioning and Performance.

The table below provides, for each senior manager who has served on the Governing Body in 2016/17, further information on their service contract.

Name	**Title**	**Contract Commencement**	**Contract expiration**
Dr Tim Moorhead	Chair Locality Appointed GP	1st April 2013 1st November 2014*	31st October 2018 31st September 2017
Mrs Madeline Ruff	Accountable Officer	1st September 2015	Substantive post
Mr Kevin Clifford	Chief Nurse	1st April 2013	31st August 2016
Mrs Penny Brooks	Chief Nurse	1st September 2016	Substantive post
Mr Tim Furness	Chief of Business Planning & Partnerships	1st April 2013	1st September 2016
Mr Idris Griffiths *	Chief Operating Officer Director of Delivery – Care Outside of Hospital *on secondment to Bassetlaw CCG with effect from 1 October 2016 to 30 September 2017	1st April 2013 1st November 2016	30 October 2016 Substantive post
Miss Julia Newton	Director of Finance	1st April 2013	Substantive post
Ms Nicola Doherty (internal secondment)	Director of Delivery – Care Outside of Hospital (interim)	1st January 2017	30th September 2017
Mr Matthew Powls (interim)	Director of Commissioning & Performance (interim)	1st November 2016	19th May 2017
Mr Peter Moore (external secondment)	Director of Strategy and Integration	1st November 2016	25th October 2017
Dr Zak McMurray	Medical Director	1st April 2013	Substantive post
Dr Nikki Bates	GP Elected Member	1st January 2017*	31st December 2019
Dr Anil Gill	GP Elected Member	1st October 2013	23rd September 2016
Dr Marion Sloan	GP Elected Member	1st January 2017*	31st December 2019
Dr Ted Turner	GP Elected Member	1st October 2013	30th September 2016

Dr Amir Afzal	Locality Appointed GP	1st November 2014*	31st October 2017
Dr Ngozi Anumba	Locality Appointed GP	14th May 2015	13th May 2018
Dr Leigh Sorsbie	Locality Appointed GP	1st November 2014*	31st October 2017
Dr Qurat-ul-Ain (Annie) Majoka	GP Elected Member	1st January 2017	31st December 2019
Dr Terry Hudsen	GP Elected Member	1st January 2017	31st December 2019
Prof Devaka Fernando	Secondary Care Doctor	16th July 2015	31st January 2017
Mr John Boyington	Vice Chair & Lay Member	1st July 2013	31st March 2018
Ms Amanda Forrest	Lay Member (re-appointed in year for further 3 years) Lay Member	1st July 2013	31st March 2020
Prof Mark Gamsu	(re-appointed in year for further 3 years) Lay Member	1st July 2013	30th June 2019
Mr Phillip Taylor		1st March 2016	28th February 2019

* Contract commencement relates to the commencement date of the current contract not necessarily the initial appointment date for GP members.

3. Salaries and Allowances (subject to audit)

The table at Appendix Bi details the salaries and allowance for all the senior managers of the CCG, as defined above. Prior year comparators are shown for 2015/16 within Appendix Bi.

4. Payments for Loss of Office (subject to audit)

During the year no senior managers received a payment for loss of office.

5. Payments to Past Senior Managers (subject to audit)

No payments have been made to past Senior Managers (i.e. individuals who are no longer a senior manager of the CCG) during the financial year.

6. Pension Benefits (subject to audit)

The table at Appendix Bii details their pension entitlements. It is important to note that the pension values for the clinical members of the Governing Body relate to their Non Practitioner employment only as provided by the Business Services Authority. Whilst this will include, from 1st April 2014, the work undertaken in their capacity as a senior manager of the CCG, it might also include other, non-practitioner work. These pension values will also include contributions made in previous employments in a non-practitioner role. Prior year comparators are shown within the main pensions table for 2015/16.

7. Fair Pay disclosure (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid member of the CCG and the median remuneration of the organisation's workforce.

Total remuneration includes salary, non-consolidated performance-related pay and benefits in kind. It does not include any severance payments, employer pension contributions and the cash equivalent transfer value of pensions. It also annualises the salary of the employees, so where an employee starts or leaves during the year or works part-time hours then the salary is grossed up to reflect the salary as if that person worked full-time for 12 months. The exception to this is the non-executives and GP representatives on the Governing Body, where we do not pro-rata their salaries. It also includes temporary and agency staff, the remuneration for interim staff is an estimation, with deductions being made for VAT, agency fees and National Insurance.

The remuneration of the highest paid member in NHS Sheffield Clinical Commissioning Group in the financial year 2016/17 was £165,400 (£163,800 in 2015/16). This was 4.75 (4.68 times in 2015/16) times the median remuneration of the workforce which was £34,800 (£35,009 in 2015/16). There has been no material change year-on year to the remuneration of the highest paid member of the CCG, or to the median remuneration of all CCG staff.

There has been a change in the composition of the workforce. The size of the total workforce headcount including temporary staff that worked during the 12 month period in 2016/17 rose from 298 employees in 2015/16 to 369 employees in 2016/17. The main reasons for this were an increase in the number of interim staff and an expansion of the medicines management team required to deliver a new central prescription ordering system.

There was a 1% pay increase for all staff on Agenda for Change terms and conditions in 2016/17.

In 2016/17 no employees received remuneration in excess of the highest paid member of the Governing Body.

Remuneration for CCG employees ranged from £6,600 to £165,400 where the salary is calculated on an annualised, full-time equivalent basis.

Staff Report

1. Senior Managers

The number of senior managers on the Governing Body is summarised in the table below:

Pay Band	No. of Employees
Senior Managers	**11**
Of which; Very Senior Managers (VSM)	**2**

2. Staff Numbers

The table below summarises the average number of people employed by Sheffield CCG in 2016/17, calculated on a whole time equivalent basis, together with the net employee benefits costs. 'Other' relates to staff on secondment and temporary staff.

	Total	Permanently employed	Other
Average number of Employees	**246**	**235**	**11**
Net employee benefit costs In £'000s	**13,248**	**11,886**	**1,362**

The table at Appendix Biii shows employee benefit costs in more detail.

3. Staff Composition

The table below provides an analysis of the number of persons of each sex who were Governing Body members, Very Senior Managers or total employees of the CCG as at 31 March 2017.

	Female	Male
All Employees	**233**	**58**
Of which; Very Senior Managers (VSM)	**2**	**0**
Of which; Members of the Governing Body	**12**	**13**

4. Sickness absence data

The sickness absence rate for the organisation is 3.95%. Sickness absence is managed in accordance with agreed policies and procedures which include employee wellbeing services of Occupational Health, counselling and physiotherapy.

5. Staff policies applied during the financial year:

5.1. Equality Impact Assessment

Equality Impact Assessments (EIAs) have been carried out on all relevant policies and over the next year we will be monitoring the impact of the implementation of our workforce policies on our staff to ensure that we are proactively identifying and addressing any inequalities.

We recognise that in order to remove the barriers experienced by disabled people, we need to make reasonable adjustments for our disabled employees. We do this on a case by case basis and involve occupational health services, refer to the sickness absence management policy and liaise with health and safety specialist colleagues to arrange work station assessments as appropriate.

5.2 Training

CCG staff members have participated in mandatory equality and diversity training, with senior management team members and staff directly involved in commissioning work attending a bespoke training session which described the implications of the Public Sector Equality Duty for people commissioning health services; and other staff completing an e-learning course.

5.3 Equality of Opportunity

The organisation is committed to equality of opportunity for all employees and potential employees. It views diversity positively and, in recognising that everyone is different, the unique contribution that each individual's experience, knowledge and skills can make is valued equally. The promotion of equality and diversity will be actively pursued through policies and procedures which will ensure that employees and potential employees are not subject to direct or indirect discrimination. NHS Sheffield Clinical Commissioning Group has been re-awarded the 'Disability Confident' Symbol by Job Centre Plus for a further 12 months in recognition of meeting the commitments regarding the employment of disabled people.

The commitments are as follows:

- Ensure recruitment processes are inclusive and accessible
- Communicate and promote vacancies
- Interview all applicants with a disability who meet the minimum criteria for a job vacancy and consider them on their abilities
- Anticipate and provide reasonable adjustments as required for employees and interview candidates
- Support any existing employees who acquire a disability or long term health condition, enabling them to stay in work
- Implement employment opportunities that will make a difference for disabled people by offering work experience

6. Expenditure on consultancy

Sheffield CCG spent £1.13m on consultancy services in 2016/17 but received income from other partner organisations such as Sheffield City Council, the 3 Sheffield Foundation Trusts and other local CCGs towards this totalling £506k, leaving the net spend by Sheffield CCG at £607k.

£524k of gross spend was in relation to developing both our Sheffield Placed Based Plan and the wider South Yorkshire and Bassetlaw Sustainability & Transformation Plan (STP). Sheffield CCG has played a leading role in this work and hence hosted certain areas of expenditure.

A further £76k expenditure was incurred on behalf of Better Care Fund with Sheffield City Council. Income of £47k was received to contribute to this.

7. Off-payroll engagements

Following the Review of *Tax Arrangements of Public Sector Appointees* published by the Chief Secretary to the Treasury on 23 May 2012, CCGs must publish information on their highly paid and/or senior off-payroll engagements. Highly paid is defined as off-payroll engagements for more than £220 per day and that last longer than six months. The CCG has determined that this applies to work undertaken by a named individual, whether or not the payment is made directly to them or via a company/GP practice.

The CCG is actively seeking clinical engagement from a wide range of its GP membership in a variety of our agreed priority work areas and as a result has agreed appropriate remuneration for this work. This is not necessarily a regular pattern of work hours and hence does not fit with payroll arrangements.

The off payroll engagements as of 31 March 2017 for more than £220 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2017	35
The number that have existed:	
• For less than one year at the time of reporting	9
• For between one and two years at the time of reporting	5
• For between two and three years at the time of reporting	8
• For between three and four years at the time of reporting	13
• For four or more years at the time of reporting	0

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

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017.	12
Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to income tax and national insurance obligations.	12
Number for whom assurance has been requested (new and existing engagements)	50
Of which the number:	
• For whom assurance has been received	50
• For whom assurance has not been received	0
• That have been terminated as a result of assurance not being received.	0

	Number
Number of off-payroll engagements of Governing Body members during the financial year.	3
Number of individuals on payroll and off-payroll of Governing Body members during the financial year (this figure includes both off-payroll and on-payroll engagements).	25

8. Exit Packages

The table below details the number and value of the exit packages agreed in 2016/17 (2015/16 £nil).

Table 1: Exit Packages

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £s	Number of other departures agreed	Cost of other departures agreed £s	Total number of exit packages	Total cost of exit packages £s	Number of departures where special payments have been made	Cost of special payment element included in exit packages £s
Less than £10,000								
£10,000 - £25,000								
£25,001 - £50,000								
£50,001 - £100,000								
£100,001 - £150,000	2	222,908		24,859	2	247,767		
£150,001 - £200,000								
> £200,000								
Totals	**2**	**222,908**	**0**	**24,859**	**2**	**247,767**		

Redundancy costs have been paid in accordance with the provisions of the NHS Pension Scheme with the full cost being met by Sheffield CCG. Other Departure costs are shown in Table 2 below.

Table 2: Analysis of Other Departures

	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice	1	24,859
Exit payments following Employment Tribunals or court orders		
Non-contractual payments requiring HMT approval		
Total	1	**24,859**

The exit packages detailed in the tables above relate to a) a compulsory redundancy for a senior manager of the CCG who is not a Governing Body member and b) a compulsory redundancy and a contractual payment in lieu of notice for a Governing body member. The 'Salaries and Allowances' table within the Remuneration Report includes a reference regarding disclosure of the exit payments payable to the individual named within that report.

Signed: Date:

Maddy Ruff

Maddy Ruff
Accountable Officer

Appendix A

REGISTER OF INTERESTS
GOVERNING BODY 2016/17

(Historic interests will be retained by the CCG for a minimum of 6 years after the date on which the interest expired. To submit a request for this information, please contact Carol Henderson, Committee Secretary, on 0114 305 1102 or carol.henderson2@nhs.net)

Name	Current position(s) held i.e. Governing Body, Member practice, Employee or Other (specify)	Declared Interest (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Dr Amir Afzal	CCG GP Locality representative	• Senior Partner, Duke Medical Centre	✓					1/8/94		Always declared
		• GP Appraiser		✓				1/1/00		Not really relevant Declaration if it becomes relevant
		• Director, Central Care Sheffield Ltd (not trading)						1/2/10	1/2/14	No longer exists
		• Director, Saihara Care Ltd (Care agency based in London)	✓					1/1/06		
		• B-TAK Enterprise Ltd (Rental of furnished offices		✓						Ad hoc meeting

		company run by brother) • Chair of Medical Education meeting, Astra-Zeneca • Various pharmaceutical companies provide lunch to weekly practice nurses / GP meetings at practice • GP out of hours ad hoc shifts, Care UK	 ✓	✓				1/1/10 1/7/94 1/1/11		personal capacity. Personal/ Practice capacity only
Dr Ngozi Anumba	CCG GP Locality representative	• GP Partner, Woodhouse Health Centre • Director, Woodhouse Healthcare Services Ltd (community pharmacy) • Trustee, City Hearts (unpaid)	✓ ✓		 ✓					
Dr Nikki Bates	CCG GP Elected City-wide Representative	• GP Partner, Porter Brook Medical Centre • Practice is provider of Occupational Health Services for students at Sheffield Hallam University • GP Appraiser • Minority stakeholder in Rivelin Healthcare Ltd • Partner Governor, Sheffield Children's NHS Foundation Trust	✓ ✓ ✓					1990 1990 2010 2007 2013		Declare as appropriate
John Boyington CBE	Lay Member	• Chairman (2 days per week paid), Bury GP Practices Ltd, a Company Limited by shares which is a provider of health services in Bury, Greater Manchester • Chairman (unpaid) of Masonic Care Ltd, a charitable Company providing residential care to 12 people with a learning disability in Thorne, South Yorkshire • Trustee (unpaid), Croft House Settlement a registered charity providing premises and facilities for voluntary groups to meet in Sheffield city centre	✓	 ✓ ✓				2015 2014 2000		Company situated 40 miles away and no established or planned links with CCG. Member would be excluded from any decisions where a conflict might occur Home situated in Thorne, Doncaster. Not personally involved in or able to influence any decisions about client placement. This role predates appointment to

		• Trustee of the Masonic Charitable Foundation, a charity providing local, national and international support to Freemasons and to the community at large o Member of the Charitable Support Executive Committee o Member of the Community Support sub-committee o Member of the Medical Research sub-committee • Director of the Royal Masonic Benevolent Institution Care Company, a subsidiary charity of The MCF providing care to 1,000 people in 17 homes across England and Wales. The position is non-remunerated. The nearest care home is situated in York	 ✓	✓				2016 2014		CCG by many years and there are no evident links in related business. MCF is a grant-making charity which neither commissions nor takes commissions from CCGs or other commissioners Nearest care home situated in York does take residents from Sheffield but I have no involvement or influence on admissions policy or practice
Penny Brooks	Chief Nurse	• Trustee (unpaid), Ashgate Hospice Care • Director, PJ Brooks Consulting Ltd			✓					Out of area provider
Nicki Doherty	Interim Director of Delivery – Care Outside of Hospital	• Parent is Director of Planned and Unplanned Care at the Yorkshire Ambulance Service NHS Trust (YAS)				Indirect		1/1/17		Declare interest in meetings where topic relevant and not discuss CCG private issues directly.
Amanda Forrest	Lay Member	• Partner Governor, STHFT • Team Associate, University of Durham (2 year contract freelance) • Team Associate, University of Sheffield (2 year contract freelance) • Stage 2 Complaints Independent Investigator	✓ ✓ ✓					21/4/15 Sept 15 Jan 16 Oct 14	 July 17 Dec 17 2018	

		(Children Act) Sheffield City Council (freelance) • Co-opted Trustee Sheffield Carers Centre			✓			14/2/17		
Mark Gamsu	Lay Member	• Director, Local Democracy and Health Ltd (public health consultancy) • Trustee - Chair, Sheffield Citizens Advice (organisation does receive contract funding from the CCG) • Committee Member, Darnall Wellbeing (health project) (organisation does receive contract funding from the CCG) • Trustee, Citizens Advice (national voluntary organisation) • Professor Institute for Health Development, Leeds Beckett University (academic institution) (part time paid role) • Chair, Chance to Dance (voluntary organisation) • Co-ordinator of European Health Equity Programme, UK Health Forum (national voluntary organisation) (to 4.1.17) • Trustee, Voluntary Action Sheffield • Trustee, Sheffield Mental Health CAB (organisation does not receive contract funding from the CCG) • Trustee, Community Legal Advice Service South Yorkshire (organisation does not receive contract funding from the CCG) • Trustee, INVOLVE Yorkshire and Humber	✓ ✓		 ✓ ✓ ✓ ✓			2013 2013 2013 2013 2016 2012	 31.3.17 4.1.17 4.1.17 4.1.17 4.1.17 4.1.17	Declared Declared Declared Declared Declared Declared
Dr Terry Hudsen	CCG GP Elected City-wide Representative	• GP Principal, University of Sheffield Health Service	✓					May 14		
Dr Annie Majoka	CCG GP Elected City-wide Representative	• GP Principal								

Dr Zak McMurray	Medical Director	• Shareholder, Woodhouse Health Care Services Ltd – 10% holding (Woodhouse Pharmacy) • Trustee, Talbot Trusts • Spouse is Director of North East Derbyshire Healthcare	✓	✓		Indirect		06/14 10/12/12 02/16		Declare and abstain from discussion if needed. Declare and abstain from discussion if needed. Declare and abstain from discussion if needed.
Peter Moore	Director of Strategy and Integration	• Director of Strategy and Integration, Sheffield City Council (SCC) (50% SCC funded post)		✓				Oct 15	Sept 17	
Dr Tim Moorhead	CCG GP Locality representative CCG Chair	• Senior Partner, Oughtibridge Surgery • Minority shareholder, Rivelin Healthcare Ltd • Member of Local Medical Committee	✓ ✓	 ✓				 12/16		Declaration of Interest Declaration of Interest Declaration of Interest
Julia Newton	Director of Finance	• No Interests to Declare								
Matt Powls	Interim Director of Commissioning and Performance	• Director, Pentland Healthcare Consulting (dissolved)						27/11/13	14/7/15	
Maddy Ruff	Accountable Officer	• Spouse works for Royal Mail						2017		
Dr Marion Sloan	CCG GP Elected City-wide Representative	• GP Principal, Sloan Medical Centre • Sessional GP, GP Collaborative • Clinical Assessor, STHFT • Lead GP, Gastroenterology Community Service	✓ ✓					1978 1995	 30.11.16 30.11.16	
Leigh Sorsbie	CCG GP Locality representative	• GP Partner, Firth Park Surgery • Partner Governor, SHSCFT	✓					1/3/17 18/12/14	 31/3/17	

Phil Taylor	Lay Member	• Managing Director, Phil Taylor Associates Ltd (Management Consultancy) • Chair and Trustee, Sheffield Hospitals Charity (NHS Charity) • Chair and Trustee, Sheffield Hospitals Charity (independent charity) • Chair and Director of Sheffield Hospitals Charity Trading Ltd (dormant organisation not in operation) • Honorary Fellow of the Healthcare Financial Management Association (HFMA) • Chair of the HFMA Non Executive Director and Lay Member Faculty (unpaid)	✓		✓ ✓ ✓ ✓ ✓			1/3/16 1/3/16 30/9/16 30/9/16 1/3/17 1/3/17		

Remuneration Report: Senior Managers: Salaries and Allowances 2016/17

This statement is subject to review by External Audit and will inform their Audit Opinion

	2016-17					
Name and Title	**Salary**	**Expense Payments (taxable)**	**Performance pay and bonuses**	**Long term Performance pay and bonuses**	**All Pension Related Benefits**	**TOTAL**
	(bands of £5k)	**(rounded to the nearest £100)**	**(bands of £5k)**	**(bands of £5k)**	**(bands of £2.5k)**	**(bands of £5k)**
	£000	**£00**	**£000**	**£000**	**£000**	**£000**
T Moorhead	**95 - 100**	**0**	**0**	**0**	**17.5 - 20.0**	**115 - 120**
Chair of the Governing Body						
M Ruff	**140 - 145**	**51**	**0-5**	**0**	**55.0 - 57.5**	**200 - 205**
Accountable Officer						
I Griffiths	**45 - 50**	**0**	**0**	**0**	**0**	**45 - 50**
Chief Operating Officer (to 30 September 2016)						
N Doherty	**15 - 20**	**0**	**0**	**0**	**25.0 - 27.5**	**40 - 45**
Director of Delivery - Care Outside of Hospital (Interim) (from 1 January 2017)						
K Clifford	**40 - 45**	**1**	**0**	**0**	**0**	**40 - 45**
Chief Nurse (to 31 August 2016)						
P Brooks	**30 - 35**	**0**	**0**	**0**	**0**	**30 - 35**
Chief Nurse (0.6 wte from 1 September 2016)						
*T Furness	**40 - 45**	**0**	**0**	**0**	**7.5 - 10.0**	**50 - 55**
Chief of Business Planning & Partnerships (to 1 September 2016)						
J Newton	**110 - 115**	**1**	**0**	**0**	**15.0 - 17.5**	**125 - 130**
Director of Finance						
Z McMurray	**110 - 115**	**0**	**0**	**0**	**0**	**110 - 115**
Medical Director						
*P Moore	**40 - 45**	**1**	**0**	**0**	**75 - 77.5**	**115 - 120**
Director of Strategy & Integration (voting rights from November 2016)						
*M Powls	**70 - 75**	**0**	**0**	**0**	**0**	**70 - 75**
Director of Commissioning & Performance (Interim) - (voting rights from November 2016)						
N Bates	**10 - 15**	**0**	**0**	**0**	**2.5 - 5.0**	**15 - 20**
GP Elected Member						
A Gill	**5 - 10**	**0**	**0**	**0**	**0 - 2.5**	**5 - 10**
GP Elected Member (to 23 September 2016)						
T Hudsen	**0 - 5**	**0**	**0**	**0**	**0 - 2.5**	**0 - 5**
GP Elected Member (from 1 January 2017)						
A Majoka	**0 - 5**	**0**	**0**	**0**	**0 - 2.5**	**0 - 5**
GP Elected Member (from 1 January 2017)						
M Sloan	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
GP Elected Member						
T Turner	**5 - 10**	**0**	**0**	**0**	**0 - 2.5**	**5 - 10**
GP Elected Member (to 30 September 2016)						
A Afzal	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
Locality appointed GP						
N Anumba	**10 - 15**	**0**	**0**	**0**	**2.5 - 5.0**	**15 - 20**
Locality appointed GP						
L Sorsbie	**10 - 15**	**0**	**0**	**0**	**17.5 - 20.0**	**30 - 35**
Locality appointed GP						
D Fernando	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
Secondary Care Doctor (to 31 January 2017)						
J Boyington CBE	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
Vice Chair and Lay Member						
A Forrest	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
Lay Member						
M Gamsu	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
Lay Member						
P Taylor	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
Lay Member						

Notes

Taxable benefits relate to travel reimbursement and are rounded to the nearest £100s.

Pension related benefits is the increase in the annual pension entitlement determined in accordance with the HMRC method. This compares the accrued pension and the lump sum at age 60 at the end of the financial year against the same figures at the beginning of the financial year. The difference is then multiplied by 20 which represents the average number of years an employee receives their pension (20 years is a figure set out in the CCG Annual Reporting Guidance).

It is important to note that the pension values for the GPs of the Governing Body relate to their Non Practitioner employment only as provided by the Business Services Authority. Whilst this will include, from 1st April 2013, work undertaken in their capacity as a senior manager of the CCG it might also include other, non practitioner work. These pension values will also include contributions made in previous employments in a non practitioner role.

Executive Directors on Very Senior Manager contracts can be considered by the CCG's Remuneration Committee for a performance bonus. The Accountable Officer is on such a contract and the perfomanance bonus paid in 2016/17 relates to the 2015/16 financial year.

*The salary relating to M Powls is paid on an off-payroll basis via an Agency. To ensure the salary is comparable to the salaries of employees the value shown is exclusive of VAT, agency fees and employers national insurance costs.
*The salary relating to P Moore is a joint post with Sheffield City Council and 50% of the stated salary is recharged to that organisation.

Remuneration Report: Senior Managers: Salaries and Allowances

Appendix Bi

This statement is subject to review by External Audit and will inform their Audit Opinion

	2015-16					
Name and Title	**Salary**	**Expense Payments (taxable)**	**Performance pay and bonuses**	**Long term Performance pay and bonuses**	**All Pension Related Benefits**	**TOTAL**
	(bands of £5k)	**(rounded to the nearest £100)**	**(bands of £5k)**	**(bands of £5k)**	**(bands of £2.5k)**	**(bands of £5k)**
	£000	**£00**	**£000**	**£000**	**£000**	**£000**
T Moorhead Chair of the Governing Body	**95 - 100**	**0**	**0**	**0**	**22.5 - 25.0**	**120 - 125**
M Ruff (1 Sept 2015 to present) Accountable Officer	**80 - 85**	**24**	**0**	**0**	**27.5 - 30.0**	**110 - 115**
I Griffiths Accountable Officer (acting 1 April 2015 to 31 August 2015) Chief Operating Officer (1 September to present)	**50 - 55** **55 - 60**	**0** **0**	**0** **0**	**0** **0**	**117.5- 120.0**	**230 - 235**
K Clifford Chief Nurse	**95 - 100**	**2**	**0**	**0**	**15.0 - 17.5**	**110 - 115**
T Furness Chief of Business Planning and Partnerships	**95 - 100**	**1**	**0**	**0**	**17.5 - 20.0**	**115 - 120**
R Gillott (1 April 2015 to 31 August 2015) Chief Operating Officer (acting)	**35 - 40**	**0**	**0**	**0**	**32.5 - 35.0**	**70 - 75**
J Newton Director of Finance	**105 - 110**	**1**	**0 - 5**	**0**	**27.5 - 30.0**	**135 - 140**
Z McMurray Medical Director	**110 - 115**	**0**	**0**	**0**	**0**	**110 - 115**
N Bates GP Elected Member	**10 - 15**	**0**	**0**	**0**	**0 - 2.5**	**10 - 15**
*A Gill GP Elected Member	**10 - 15**	**0**	**0**	**0**	**(80.0 - 77.5)**	**(70 - 65)**
M Sloan GP Elected Member	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
T Turner GP Elected Member	**10 - 15**	**0**	**0**	**0**	**0 - 2.5**	**10 - 15**
A Afzal Locality appointed GP	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
N Anumba (14 May 2015 to present) Locality appointed GP	**10 - 15**	**0**	**0**	**0**	**2.5 - 5.0**	**10 - 15**
L Sorsbie Locality appointed GP	**10 - 15**	**0**	**0**	**0**	**7.5 - 10.0**	**20 - 25**
D Fernando (16 July 2015 to present) Secondary Care Doctor	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
J Boyington CBE Vice Chair and Lay Member	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
A Forrest Lay Member	**10 - 15**	**1**	**0**	**0**	**0**	**10 - 15**
M Gamsu Lay Member	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
Philip Taylor (1 March 2016 to present) Lay Member	**0 - 5**	**0**	**0**	**0**	**0**	**0 - 5**

Notes

Taxable benefits relate to travel reimbursement and are rounded to the nearest £100s.

Pension related benefits is the increase in the annual pension entitlement determined in accordance with the HMRC method. This compares the accrued pension and the lump sum at age 60 at the end of the financial year against the same figures at the beginning of the financial year adjusted for inflation. The difference is then multiplied by 20 which represents the average number of years an employee receives their pension (20 years is a figure set out in the CCG Annual Reporting Guidance).

It is important to note that the pension values for the GPs of the Governing Body relate to their Non Practitioner employment only as provided by the Business Services Authority. Whilst this will include, from 1st April 2013, the work undertaken in their capacity as a senior manager of the CCG it might also include other, non practitioner work. These pension values will also include contributions made in previous employments in a non practitioner role.

*The reduction in the pension related benefits for Dr A Gill is due to the salary of the individual decreasing in the current financial year compared to the previous financial year
The salary relates to Non Practitioner work outside of the Governing Body member role.

Executive Directors on Very Senior Manager contracts can be considered by the CCG's Remuneration Committee for a performance bonus. The Accountable Officer and the Director of Finance are on such contracts. The performance bonus paid in 2015/16 relates to the 2014/15 financial year and because the Accountable Officer was not in post in that year he was not eligible to receive a bonus.

Pension Benefits - 2016-17 **Appendix Bii**

This statement is subject to review by External Audit and will inform their Audit Opinion.

Name and Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2017 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Cash Equivalent Transfer Value at 1 April 2016 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £'000
T Moorhead, Chair of the Governing Body	0 - 2.5	2.5 - 5.0	20 - 25	60 - 65	404	354	49	0
M Ruff, Accountable Officer	2.5 - 5.0	7.5 - 10	45 - 50	135 - 140	880	794	86	0
I Griffiths, Chief Operating Officer (to 30 September 2016)	(0 - 2.5)	(2.5 - 5.0)	30 - 35	100 - 105	642	665	(12)	0
N Doherty, Director of Delivery - Care Outside of Hospital (Interim) (from 1 January 2017)	0 - 2.5	0 - 2.5	10 - 15	25 - 30	130	116	3	0
*K Clifford, Chief Nurse (to 31 August 2016)	(0 - 2.5)	(0 - 2.5)	40 - 45	130 - 135	0	895	(375)	0
* P Brooks, Chief Nurse (from 1 September 2016)	0	0	0	0	0	0	0	0
*T Furness, Chief of Business Planning & Partnerships (to 1 September 2016)	0 - 2.5	0 - 2.5	30 - 35	100 - 105	0	667	(281)	0
J Newton, Director of Finance	0 - 2.5	2.5 - 5.0	30 - 35	95 - 100	634	591	42	0
*Z McMurray, Medical Director	0	0	0	0	0	0	0	0
P Moore, Director of Strategy & Integration (voting rights from November 2016)	0 - 2.5	0	10 - 15	0	126	81	19	0
*M Powls, Director of Commissioning & Performance (Interim) - (voting rights from November 2016)	0	0	0	0	0	0	0	0
N Bates , GP Elected Member	0 - 2.5	0 - 2.5	5 - 10	20 - 25	153	136	17	0
A Gill, GP Elected Member (to 23 September 2016)	0 - 2.5	0 - 2.5	5 - 10	25 - 30	209	197	6	0
T Hudsen, GP Elected Member (from 1 January 2017)	0 - 2.5	0	0 - 5	5 - 10	41	39	1	0
A Majoka, GP Elected Member (from 1 January 2017)	0 - 2.5	0	0 - 5	5 - 10	34	33	0	0
*M Sloan, GP Elected Member	0	0	0	0	0	0	0	0
T Turner, GP Elected Member (to 30 September 2016)	0 - 2.5	0 - 2.5	10 - 15	30 - 35	205	192	6	0
*A Afzal, Locality appointed GP	0	0	0	0	0	0	0	0
N Anumba, Locality appointed GP	0 - 2.5	0	0 - 5	5 - 10	54	48	6	0
L Sorsbie, Locality appointed GP	0 - 2.5	(0 - 2.5)	10 - 15	25 - 30	203	180	23	0
*D Fernando, Secondary Care Doctor (to 31 January 2017)	0	0	0	0	0	0	0	0

*P Brooks, Dr McMurray, M Powls, Dr Sloan, Dr Afzal and Dr Fernando do not make contributions to the NHS Pension Scheme and hence no information is available to the CCG.
*T Furness and K Clifford ceased making contributions during the year 2016/17 and drew down their pensions, the Cash Equivalent Transfer Value at 31 March 2017 is therefore nil.

It is important to note that the pension values for the GPs of the Governing Body relate to their Non Practitioner employment only as provided by the Business Services Authority. Whilst this will include, from 1st April 2013, the work undertaken in their capacity as a senior manager of the CCG it might also include other, non practitioner work. These pension values will also include contributions made in previous employments in a non practitioner role.

Lay Members do not receive pensionable remuneration and hence there are no entries in respect of pensions for Lay Members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in the CETV reflects the increase in the CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of period. Where an employee commences in post part way through the year the real increase in CETV is adjusted to reflect the part year effect.

EMPLOYEE BENEFITS 2016/17

2016-17	Grand Total			Admin			Programme		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	11,009	9,696	1,313	7,422	6,685	737	3,587	3,011	575
Social security costs	1,054	1,031	24	724	723	1	331	308	22
Employer Contributions to NHS Pension scheme	1,306	1,280	26	870	870	0	436	411	26
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	223	223	0	223	223	0	0	0	0
Gross employee benefits expenditure	**13,592**	**12,231**	**1,362**	**9,239**	**8,500**	**739**	**4,354**	**3,730**	**623**
Less recoveries in respect of employee benefits	(344)	(344)	0	(300)	(300)	0	(44)	(44)	0
Total - Net admin employee benefits including capitalised costs	**13,248**	**11,886**	**1,362**	**8,939**	**8,200**	**739**	**4,309**	**3,686**	**623**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**13,248**	**11,886**	**1,362**	**8,939**	**8,200**	**739**	**4,309**	**3,686**	**623**

2015-16	Grand Total			Admin			Programme		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	8,122	7,250	872	5,821	5,500	321	2,301	1,750	551
Social security costs	655	637	18	503	498	5	152	139	13
Employer Contributions to NHS Pension scheme	979	963	16	721	716	5	258	247	11
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**9,756**	**8,850**	**906**	**7,045**	**6,714**	**331**	**2,711**	**2,136**	**575**
Less recoveries in respect of employee benefits	(365)	(365)	0	(275)	(275)	0	(90)	(90)	0
Total - Net admin employee benefits including capitalised costs	**9,391**	**8,485**	**906**	**6,770**	**6,439**	**331**	**2,621**	**2,046**	**575**