SHEFFIELD CCG

NHS
Sheffield
Clinical Commissioning Group

ANNUAL REPORT & ANNUAL ACCOUNTS

2019-20

Contents

PERFORMANCE REPORT

Lesley Smith

Accountable Officer

18 June 2020

Performance Overview

The purpose of this overview is to give you a summary of our organisation, our purpose, the key risks to the achievement of our objectives, and how we have performed during the year.

Message from Lesley Smith, Accountable Officer and Dr Terry Hudsen, Chair

It has been another challenging year for the CCG. We continued to develop and transform services to improve the health and wellbeing of the people living in Sheffield. Throughout this report, you will find facts and highlights about the CCG, as well as information on what we do, our performance over the last year, and the challenges we faced.

We have welcomed the opportunity to reflect on what we have achieved as an organisation over the past 12 months, as well as thinking more where we need to focus our efforts in 2020/21 and beyond.

One constant in life is that the NHS is always changing and last year was no exception for the CCG. The CCG ended the year responding to the global coronavirus outbreak. The CCG worked hard in our pre-pandemic and pandemic response to the virus, setting up internal command and control structures with the CCG.

We focused on our statutory role of ensuring the continuity of primary care in Sheffield and supporting the wider system in responding to the pandemic. This meant we stopped operating business as usual and re-prioritised our work protecting the people of Sheffield during these extremely difficult times.

Staff across the CCG worked hard responding to the outbreak and we'd like to publically thank each and every one.

Another challenge that we faced which also bought change and improvement was responding to the 360 assessment report (March 2019) by introducing our improvement plan in June 2019. Last year, one of our biggest priorities was to deliver the improvement aims identified in the plan – to ensure the CCG becomes a great place to work and our status as a leading healthcare organisation.

We fully accepted that we needed to make improvements in several different areas and we are fully committed to improving the leadership and culture of the organisation. To do this, we actively engaged staff and partners on what needed to be in our improvement plan.

It's early days, but we believe we started to see a shift in culture – senior managers engaged staff more, we appointed the Pacific Institute to work alongside us to develop a culture where everyone is clear on the value they add, feel valued for what they do and has a great experience of working at the CCG. Governing body members became more visible and we refreshed our vision, objectives and intentions with our staff and partners.

Some other highlights over the past year are: we continued to be rated as a 'good' CCG by NHS England, we continued to deliver the national pledge on the 18 week wait from referral to treatment across Sheffield, we surpassed the national target for completion of continuing healthcare assessments for ongoing care within 28 days, and did better than

the target for completion of assessments in out of hospital settings, and our GP practices were consistently diagnosing dementia in their patients at, or above, expected level. At the same time, we managed our finances so that we have delivered against our statutory duty of remaining within our funding for the year.

The CCG's vision is to make Sheffield healthier. This is something that we can't do on our own – we need to work with partners across the city and South Yorkshire and Bassetlaw. In Sheffield, we made good progress in working more closely with Sheffield City Council and in 2019 we set up a joint commissioning committee together.

We also continue to work with our partners as a member of Sheffield's Accountable Care Partnership (ACP), which brings together seven partners in the city to focus on issues that can only be addressed collectively.

An example of work undertaken as an ACP is our urgent care campaign which was launched this year. The campaign dubbed 'Stop. Think. Plan B not A+E' aimed to improve the awareness of how people access urgent care services in the city.
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In 2019/20 we refreshed our vision and objectives and set out a programme of work in our commissioning intentions. Before the pandemic, we were in the early stages of developing a new CCG strategy. The strategy will set out detailed changes for the CCG, which will be how we organise staff and resources to deliver our priorities to improve the lives of Sheffield people.

2020/21 will be a year of managing the next phases of covid, striking a balance between managing current and future peaks in cases and moving into the "new normal".

This means we'll need to focus on, for example, mental health and wellbeing and managing the health of people with long term conditions such as respiratory conditions. We'll need to build up confidence in the NHS that it's safe to receive services and we'll need to manage all the people whose health has been affected as they have been staying away or have had monitoring stopped or slowed down.

Last year, we had a change in leadership with both of us starting our roles at the CCG part way through the financial year, taking over from Maddy Ruff and Tim Moorhead. Finally, we'd like to take this opportunity to thank Maddy and Tim for their dedication to the CCG during their time in posts.

We hope you enjoy reading about our achievements from the past 12 months in our annual report.

Lesley Smith	Dr Terry Hudsen
Accountable Officer	Chair

About us: NHS Sheffield CCG at a glance

Who is Sheffield Clinical Commissioning Group (CCG?)

We are a membership organisation made up of 79 GP practices. The CCG uses the clinical expertise of local doctors and nurses, supported by experienced managers and lay members, to commission (plan, monitor, and fund) health services.

On behalf of Sheffield people, we plan, buy, and monitor the majority of local health services that you need and use, such as those from hospitals and community 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.

In 2019/20, working with our staff and the public, we refreshed our vision and objectives.

Our vision

Our new vision is “working with you to make Sheffield healthier”.

Our organisational objectives

Our new five objectives are:

1. Reduce the impact of health inequalities on peoples’ health and wellbeing through working with Sheffield City Council and partners
2. Lead the improvement of quality of care and standards
3. Bring care closer to home
4. Improve health care sustainability and affordability
5. Be an excellent employer and maximise the potential of our people.

The objectives will focus on tackling the big challenges in Sheffield that are our gift to fix. These are:

We need to**:**

- Address current lifestyle factors/patterns of behaviour that are contributing to poor outcomes for the Sheffield population.
- Increase the number of people who have their health and related needs identified and supported early enough.
- Increase the number of people who are effectively supported to manage their health needs to optimal levels.
- Improve the capacity and capability of Primary and Community services (including Voluntary sector).

Commissioning principles

To help tackle these challenges, our staff forum and governing body members developed and refined a set of commissioning principles that will underpin all our decisions. These describe how we will seek to fulfil our role as health commissioners:

- We will design services and support people most in need of health and care to live a quality, healthy life which will include differentially investing to tackle health inequalities
- We will have a greater focus on prevention, and work with partners to help people make healthier choices, which will be supported by our commitment to integrate health and social care
- As a major custodian of the Sheffield pound, we will make the best use of the money we spend and will commit to increasing social value and safeguarding the environment
- We will focus on things that have the biggest impact, are sustainable and make a difference
- We will be the driving force of our values for our staff, stakeholders, and the public by being progressive, empowering, fair, honest, responsive accountable, compassionate and caring and embracing innovation.

Our 2019/20 priorities

- Cancer Care
- Care Closer to Home
- Commissioning for Quality and Safety
- Mental Health, Learning Disability and Autism
- Improving Patient Pathways
- Person Centred Care
- Primary Care Transformation
- Sustainable and Affordable Health Care
- Urgent Care in Primary Care

Key Issues and Risks

The Governing Body Assurance Framework (GBAF) is the key mechanism for identifying and ensuring the management of risks affecting the achievement of our strategic objectives. It draws together the high level risks from a variety of sources and enables the governing body to focus on making sure that the impact of these risks is minimised through appropriate management action. The Framework sets out how those risks are mitigated, the likelihood of occurrence and their potential impact. At 31 March 2020, there were 18 risks identified on the GBAF. No new risks were added during the year, however, two risks have been closed. The GBAF is supported by the Corporate Risk Register that provides a record of all potential or actual operational risks.

Further information about our key issues and risks is given in the Governance Statement which is part of the Accountability Report set out later in this document and can be found at page 39.

The identified major strategic risks throughout 2019/2020 included:

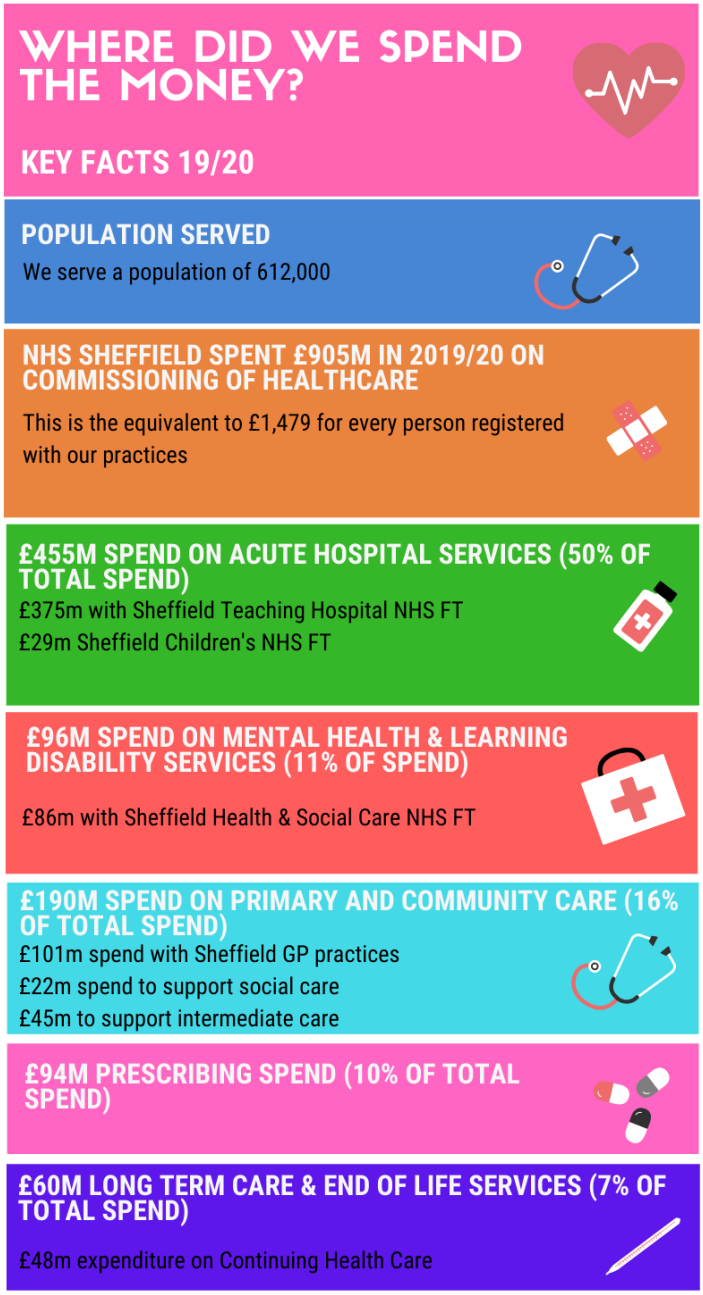
- Our inability to deliver the QIPP (efficiency) savings plan
- System wide or specific provider capacity problems emerge in secondary and/or primary care to prevent delivery of statutory requirements of the NHS Constitution and requirements of the NHS Longer Term Plan (published January 2019)
- Financial Plan with insufficient flexibility and resilience to meet investment requirements and in year pressures
- Joint Commissioning arrangements (to encompass existing BCF) do not progress sufficiently to allow the release of savings across the system, to support the transfer of funding to ensure sustainable social and community care
- Ability to resource and deliver sustainable out of hospital services to support a preventative and proactive model of care that minimises avoidable emergency admissions and reduces delayed transfers of care
- Insufficient capacity and resources to support the development of neighbourhoods and primary care at scale working.
- Unable to secure timely and effective shared services in light of required running cost reduction, to enable us to adequately respond and secure delivery to existing and new emerging requirements.
- Insufficient internal workforce, talent management and succession planning
- Inability to support the development of neighbourhoods and primary care at scale

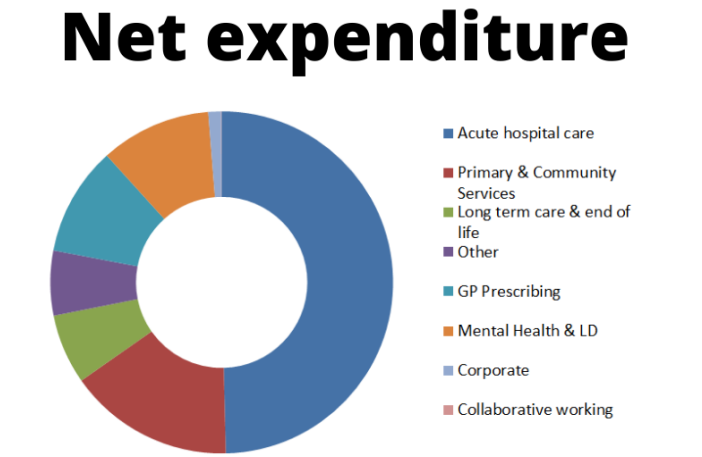
Finance at a glance

Despite the financial constraints and demands placed upon the local health and social care system, the CCG is pleased to report that we achieved our statutory financial duties as an NHS commissioning organisation.

We delivered our financial plan of in year breakeven, that is containing our expenditure within the funding (allocation) issued to us by NHS England. In our financial accounts, we are reporting a £3,840k in year surplus, of which £117k relates to CCG activities and £3,723k relates to the surplus of the South Yorkshire and Bassetlaw Integrated Care System (ICS) for which Sheffield CCG is the host organisation.

CCGs are expected to maintain a minimum 1% cumulative (historic) surplus (£8.5m for NHS Sheffield CCG). Sheffield CCG, like many CCGs across the country, has a surplus over this amount due to the national financial framework operated by NHS England in prior years which required CCGs to hold back 1% or 0.5% of their funding to contribute to national risk pool arrangements. As a result, in total Sheffield CCG has a £21.9m surplus carried forward into 2020/21 (which is made up of £18.1m historic surplus brought forward from previous years and the 19/20 in-year surplus of £3.8m), although, under the NHS financial regime, the CCG cannot access this cumulative surplus without the prior agreement of NHS England/NHS Improvement.





Financial Performance 2019/20

We spent £905m to commission health care services for the people of Sheffield and a further £7.5m on behalf of the South Yorkshire and Bassetlaw ICS.

Overall, we spent an average of £1,479 per person on health care for the people of Sheffield (compared to £1,422 in 2018/19). The table at the side provides a summary of where the money was spent. It includes spending against external income as well as our revenue resources received from NHS England.

Our running cost allowance was £12.3m. This is used to fund the commissioning, governance costs and clinical engagement activities of the CCG and its localities. In 2019/20, our actual spend was £11.1m (an underspend of £1.2m). This equates to £18.20 per head of population (compared to £16.43 in 2018/19). We used this underspend to support our commissioning of health services.

The CCG publishes monthly details about any spending that is over £25,000 on our website: http://www.sheffieldccg.nhs.uk/aboutus/spending-over-25k.htm

A look back over our year

Over the past year, we've done lots of work at the CCG and with our partners and stakeholder across the city. It's impossible to capture all this work into one document but we want to give you a flavour – here's a quick look back at some of the achievements of 2019/20.

Promoting good health in Sheffield

In April 2019, along with Sheffield City Council, we formally launched our health and wellbeing strategy.

The strategy recognises that health inequalities affect everyone and that it is not right that some people can expect to live a less healthy life because of who they are or where they live. It highlights the three main areas that contribute to a healthy life: starting well, living well and ageing well.

The work of the strategy is being led by the Sheffield Joint Health and Wellbeing Board, a partnership between the CCG, Sheffield City Council and a range of partners in the city. Work will focus on the person from birth to going to school; how a child develops, has a good education and then transitions to independence, how important it is for that person to have access to a home that supports their health and to have the opportunity for fulfilling work and the resources to support their needs. It will also focus on how that person should be able to walk or cycle in their local area whatever their age or ability, have access to care and support, meaningful social contact and an end to their life with dignity in a place of their choice.

There will be an action plan for each ambition of the strategy and the Health and Wellbeing Board will own these and make sure that the agreed actions are carried out.

Health inequalities remain a significant challenge for Sheffield, and we understand that the solution to this will not just be found within health and social care services alone. Therefore the strategic vision is for improving the health and wellbeing of residents, not just about health and care services.

Patients in Sheffield to benefit from more services delivered in their local GP practice

Primary care networks (known as PCNs) were rolled out of across the city helping more health and wellbeing services delivered in their communities.

The networks see GP practices working together to coordinate health and social care for people in their local area and consider how to make the best and most effective use of local services.

The primary care network model is an important component of the Sheffield neighbourhoods model which the city has been undertaking for over two years, whereby GP practices have joined together to form groups across the city to work more closely together, to enhance the services available and meet the needs of patients locally in their communities.

We approved 15 primary care networks across the city which will continue to support the model of neighbourhood working and continue positive working relationships with partners in the voluntary and community sector.

Each network has a set of priorities based on the health and social needs of their particular area. There is also a strong focus on preventing ill health, reducing unnecessary hospital admissions and supporting people to gain control of their health and wellbeing.

Community pharmacy management of hypertension

We piloted a 2 year scheme to benefit patients living with hypertension. Hypertension, also known as high blood pressure, is a long-term medical condition in which the blood pressure in the arteries is persistently high. If not treated correctly, hypertension can lead to cardiovascular disease. With the correct treatment and preventative action, hypertension can be managed and cardiovascular disease prevented.

The pilot in Sheffield sees community pharmacists providing care to patients identified as requiring management of hypertension by their GP. Patients will be offered the choice to see the community pharmacist who will support the patient to manage their hypertension through; optimising medication, performing health checks and providing support and advice on lifestyle changes.

With an ageing population and increasing pressures on GPs, this new service will utilise the wealth of skills of pharmacists, reduce pressure on practices and make the service more accessible to patients within their community.

The initial pilot includes 10 practices and pharmacies across Sheffield. If the two year pilot is successful then the service will be considered for roll out across all practices.

Improving diabetes care in Sheffield

We invested an additional £500,000 into improving diabetes care in Sheffield, taking the total amount to £1.9 million over the last 3 years. The investment was part of a national NHS England diabetes transformation fund, which has been improving treatment and care for the 32,000 adults and children in Sheffield diagnosed with type 1 or type 2 diabetes.

The funding was invested in education to help patients to be better informed about how to manage their diabetes and specialist teams have been expanded to improve diabetes care within hospitals and communities.

Over the past three years, Sheffield CCG and diabetes care providers in the city have worked together to secure additional health care investment in Sheffield through the diabetes transformation fund and ensured this resource works into key areas which have been improving outcomes for patients in Sheffield.

Some of the funding has been used to provide more primary care development nurses, who are specialised in the treatment of diabetes and have been working with GP practices across Sheffield to help them to better manage their patients in trying to reduce their blood pressure, cholesterol, and blood sugar levels.

Other areas the funding has been used for is the expansion of a multi-disciplinary foot care team to support early intervention and identification of foot problems amongst patients with diabetes. Now, substantially fewer people are presenting with severe ulcers and average healing times of ulcers have fallen.

Sheffield GPs top national average for patient satisfaction

Results from a GP patient survey undertaken in 2019 showed that practices in Sheffield scored higher than the national average for patient satisfaction. Sheffield GPs also ranked highly on specific experiences of care, such as managing long term conditions.

8,669 patients from across 79 GP practices in the city completed the survey, which was conducted by independent social research institute Ipsos MORI.

The results show that the vast majority of people in Sheffield are satisfied with the care they receive from their GP with 8 in 10 patients rating their GP as ‘good’. 90% of Sheffield patients surveyed said the last healthcare professional that they saw at their practice was ‘very good’ or ‘good’ at listening to them and 96% of respondents had confidence and trust in the healthcare professional they saw or spoke to.

The survey also asked patients about their experiences of NHS services when their GP practice is closed. Patients in Sheffield reported higher levels of satisfaction than nationally, and an improvement in experience since last year with 94% saying they had confidence and trust in staff providing services when GP practice is closed.

All GP practices in Sheffield are members of the CCG, the GP patient survey helps to identify key opportunities and influence the CCG’s decision making around primary care for the future.

Sheffield named as a trailblazer for supporting young people’s mental health in schools

We worked in partnership with Sheffield City Council, Sheffield Children’s NHS Foundation Trust and Learn Sheffield to develop and pilot mental health support teams in schools to support young people’s emotional wellbeing and mental health.

NHS England announced that pupils struggling with mental health were to benefit from more joined up care and support across schools, colleges and specialist NHS services, in a national roll out of a £9.3 million training scheme.

Locally, Sheffield was awarded the status of "trailblazer" following a successful bid to NHS England for a share of the national funding. The funding is helping to pilot two new mental health support teams in several Sheffield schools. The teams will be operational by January 2021 and work to support children and young people’s mental health by delivering interventions in schools and working to identify need and support as early as possible.

Becoming a “trailblazer” is fantastic news for Sheffield, we are one of a few areas in the country to be offered this status for the work we are doing. We will work with our partners to deliver this scheme and continue to improve mental health support for children and young people in Sheffield.

Work already underway in Sheffield includes the Children and Adolescent Mental Health Service (CAMHS) Healthy Minds Programme, led by Sheffield Children’s, which is being rolled out across Sheffield’s primary and secondary schools.

Alongside Healthy Minds, there is also the Door 43 Service for 13-25 year olds based at Star House in the city centre. There is also the online counselling service Kooth, which any 11-18 year old can self-refer to.

CCG rated ‘good’ for the third year running

In July 2019 we were rated as ‘good’ by NHS England for the third year running as part of an annual assessment known as Improvement Assessment Framework.

The results showed that Sheffield had improved in several areas, including waiting times for a diagnostic test, appropriate prescribing in primary care and reducing infant deaths and stillbirths.

As part of the process, the CCG had an annual review where we were commended by NHS England for our continued work to improve mental health services in the city.

The review also shows that the CCG has made improvements with fewer patients being delayed leaving hospital which has, in turn, helped the NHS in Sheffield manage the busy winter period.

The CCG has also improved public engagement, going from requires improvement to good.

In addition to this, GP practices in Sheffield were consistently diagnosing dementia in their patients at, or above, the level that could be expected to lead to earlier interventions and treatments which can potentially improve outcomes for these patients.

NHS England also commended the CCG on balancing the books and managing taxpayer’s money by delivering all the financial standards.

New plans to support people with dementia to 'live their lives to their potential'

Sheffield’s vision is to make sure people with dementia are supported to live life to their full potential. A new plan to make this vision a reality was developed with our health and care partners in the city.

The plan highlighted how there is city-wide agreement that improving the care and support for people of all ages living with or caring for those living with dementia is of vital importance. Around 7,000 people aged 65 and above, 1% of the city’s population, currently live with dementia and it’s estimated that by 2035 that figure could rise to over 9,000 for that age group.

Key priorities for the plan included that people living with dementia will be able to live in a dementia friendly community, where people with dementia are understood, respected and supported - meaning that they can live well at home for as long as possible. It will be easier to know where to go to seek information, advice, and help. Because dementia is not an inevitable part of ageing, there will also be a focus on preventing or delaying the onset of dementia by raising awareness of the importance of maintaining a healthier lifestyle, across all ages.

Public, voluntary, community and private sector organisations all committed to working together to do this. Consultation with those living with dementia, their carers and family, as

well as professionals involved in their care has resulted in a set of 13 commitments for how dementia care is delivered in the city.

Stop. Think: New NHS campaign helps people to get quicker urgent care

A new campaign was launched by NHS services in Sheffield aiming to help people get quicker urgent care and in the most appropriate place.

The campaign, dubbed 'Stop. Think: Plan B, not A+E,' aimed to highlight the Walk-in Centre, the Minor Injuries Unit, GP hubs and pharmacies as the main urgent care services in the city.

The five-month advertising campaign will also attempt to relieve pressure on A+E and GP practices in the city by encouraging patients to seek advice from NHS 111 or their local pharmacist. The campaign highlights the experience and supports these healthcare professionals can offer close to people's homes.

The research found that when in need of urgent care, often people in Sheffield use A+E if they are unable to get an appointment with their GP. The main reason was convenience and speed, with many people believing that they'll be seen quicker if they skip all other options and head straight to A+E. In reality, patients with minor illnesses or injuries can be seen much quicker by visiting an alternative service.

A new website was developed which includes information about the services available and when to use them, as well as information on waiting times for each of the urgent and emergency services in Sheffield.

£600k for GP neighbourhoods' innovative projects

GP practices in Sheffield were given extra funding to help improve the health and wellbeing of people in their areas.

We gave practices £600k as part of the CCG's primary care transformation fund. The GP practices are working together in different groups known as 'neighbourhoods' to support the needs of their residents. This is in addition to the £718K that the CCG awarded to neighbourhoods last year.

The money was used to fund several neighbourhood projects including supporting young people with mental health and emotional wellbeing advice, early intervention for mental health illnesses in teenagers and adolescents, identifying reasons for early deaths, improving the lives of people with dementia, social prescribing and tackling loneliness and reducing isolation in older people.

In Sheffield, practices, community and voluntary groups as well as social care and schools have joined together to form neighbourhood groups across the city, to bring together services and staff.

Each neighbourhood covers a community of around 30,000 to 50,000 people. This means that neighbourhood teams are small enough that they know each other as well as their patients; it means they can provide seamless care and a mix of skills from hospital staff, mental health services, GPs and social care to name a few.

Sheffield cancer hub extends service offered

The Sheffield Cancer Information Hub expanded its service to offer information and advice about other long term conditions, as well as cancer.

The hub which opened in October 2017 is based in The Moor Market and provides shoppers with cancer information and support in an informal, non-medical setting. The CCG funded hub is run by the Cavendish Centre and there are plans for other charities and services to man the stall regularly to provide information, advice and signposting for a range of other conditions such as diabetes and COPD.

Having the shop at the Moor Market is an ideal place for people to talk about cancer and other conditions and find out about some of the fantastic services available across the city. Some people find going to their GP scary but the hub offers a relaxed, informal place for people to get information and support.

The Cancer Information Hub is based at units 56 and 58 of The Moor Market, Sheffield and is open from 10 am to 4 pm, Monday to Friday.

General practice nurses celebrated at awards

General practice nurses and health care assistants working in GP practices across Sheffield were recognised for their inspirational commitment to patient care in an award ceremony.

The General Practice Nurse, Health Care Assistant and Practice Team Awards 2020 were developed by the CCG to recognise the often unsung work nurses and health care assistants do in primary care.

General practice nurses and health care assistants work in GP practices and are an essential part of the primary care team. They plan and provide nursing care, treatment and health education for patients of all ages.

Around 120 people attended the event that took place at Owlerton Stadium in Sheffield in February. Several key figures in healthcare from across Sheffield attended to present awards alongside local patient representatives who attended to present the Compassionate and Caring Practice Team award.

The awards recognised the dedicated individuals and teams who work in general practice and each nomination we received is a testament to the extraordinary work that goes on in practices. This is the second year we have held the awards, we have developed them this year to add in an additional team category as we had so many nominations mentioning teams last year.

2020 is the Year of the Nurse and Midwife and this event has been an excellent start of many celebrations taking place throughout the year.

Performance analysis

Delivering on our performance standards

In common with other CCGs and NHS trusts, we follow the guidance and frameworks set out by NHS England, which helps to ensure that our local services reflect national standards and priorities.

The CCG regularly monitors how the services we commission are performing, to ensure that they are meeting national standards. We monitor and report around key themes access, quality and safety. These include the national standards set out in the NHS Constitution, which sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

The monthly "Performance, Quality and Outcomes" report is published on our website, alongside the papers for our Governing Body. The report includes a dashboard which provides an at a glance overview of where we are meetings standards, and where we are currently falling short, together with an explanation of how we are working to improve things.

The CCG engaged in ongoing dialogue with our providers about quality, safety, and access, for example: waiting times for routine surgery; Accident and Emergency (A&E) waiting times; health care acquired infections; ambulance handover times; cancelled operations; delays in transfer from the hospital; access to mental health services. Standards such as these are embedded in the national contract framework, which we use as the basis of our relationships with provider NHS Trusts. This includes ensuring that we have contracted for, and can fund, an appropriate level of activity to meet local need and comply with standards for how long people should wait for their treatment.

Some key successes in 2019-20

There are several areas where Sheffield has performed well over the past year. These achievements reflect the hard work of our partners and local providers, including our member practices:

- We delivered the national pledge on the 18-week wait from referral to treatment across Sheffield at CCG level for eleven months of the year, although the later months of the year saw Sheffield Children's NHS FT miss the standard, partly due to the national issue around doctors' overtime pay. In March 2020, the government required all hospitals to reduce their planned activity in order to free up the maximum possible inpatient and critical care capacity, in order to respond to the COVID-19 pandemic. As was expected, performance on waiting times dipped in March because of this.
- Capacity problems in a small number of specialities at Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) led to the CCG missing the 6 week diagnostic wait standard for a few months of the year; however, effective recovery plans were put in place and the trust went on to deliver the standard for the remainder of the year right up until March 2020, when the trust reduced their elective diagnostic capacity to respond to COVID-19.
- Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) delivered the two week wait for the early intervention in psychosis service throughout the year.
- We surpassed the national target for completion of continuing healthcare (CHC) assessments for ongoing care within 28 days and performed better than the target for completion of assessments in out of hospital settings (national guidance suggests that assessments which take place outside hospital lead to a more realistic picture of the person's ongoing care needs).

- Our practices are consistently diagnosing dementia in their patients at, or above, the level that could be expected using local disease prevalence data (this means that GPs are skilled at detecting and diagnosing dementia in the numbers that we should expect for a city like ours).

Waiting time challenges for cancer treatments

There are nine waiting time standards for cancer which address different patient pathways and stages of the cancer journey (for example, from GP referral to diagnosis, and from diagnosis to first treatment, with specific targets for suspected breast cancer). Sheffield CCG performs well against some standards, for example, the 14 day wait from GP referral to first outpatient appointment; however, some other standards pose a major challenge (e.g. the 31 day wait from diagnosis to the first radiotherapy).

The CCG and STH work with the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance to find strategic solutions to many challenges faced by the system, which include: the need to install new radiotherapy equipment (STH plans to install its eighth linear accelerator in the summer of 2020); national workforce shortages e.g. in radiology and radiotherapy; complex pathways of care; delays caused because of patient choice or patients who are not well enough to proceed to the next stage of treatment, and high numbers of people coming forward for treatment following national publicity campaigns.

Cancer remains a huge priority for us as we seek to not only to deliver the constitutional standard waiting times, but also ensure that patients are coming forward for screening, diagnosed earlier, and having better clinical outcomes and survival rates. Sheffield Teaching Hospitals maintained as much access to urgent cancer treatments as possible due to COVID-19, however performance did dip further at the end of the year, due to prioritising the response to the pandemic.

Quality and access standards in primary care

There are a wide range of quality standards which we use to monitor our local general practices and to drive improvements. Examples of key issues in general practice include:

- Ease of getting a GP appointment
- Ensuring that people who have diabetes are supported to control their blood sugar, and newly diagnosed diabetics attend a structured education course
- Appropriate prescribing of antibiotics
- Ensuring the people with learning disabilities and severe mental illness receive an annual physical health check
- The development of the primary care workforce.

Many of these standards are also monitored nationally, and we are benchmarked against other CCGs which share similar characteristics with us. These form part of the National Oversight Framework, which for 2019/20 replaced the previous CCG Improvement and Assessment Framework.
The CCG supports clinical improvement in general practice in several ways, notably:

- Staff from our medicines optimisation team visit practices and provide advice and support on medication, focusing on patient safety (as well as eliminating waste and over-prescribing);
- Primary care development nurses provide education and support for practices, using their specialist knowledge and skills in clinical areas such as hypertension, respiratory disease, diabetes and stroke;
- The CCG runs city wide education sessions (known as “protected learning”) for staff in general practice, on a wide range of subjects each year, to update clinical knowledge. Recent topics have included children and young people’s mental health; infection prevention and control; neurology, early detection of cancer, and enhancing safety in primary care.

The CCG’s performance – how we measure up

Our overall performance and effectiveness is overseen by NHS England and NHS Improvement, and is measured through the NHS Oversight Framework – this has replaced the CCG Improvement and Assessment Framework (IAF) and the provider Single Oversight Framework, and will inform the assessment of CCGs in 2019/20.

The Oversight Framework sets out the standards where we as a CCG are held to account, across the themes of new service models; preventing ill health and reducing inequalities; quality of care and outcomes; leadership and workforce; and finance and use of resources. This provides a balanced overview of how the CCG organises its work and discharges its duties. We are measured against a wide range of indicators; some examples include:

- Anti-microbial resistance and appropriate prescribing;
- How well we communicate and engage with our local citizens;
- Activities we have undertaken to raise awareness of Sepsis amongst local clinicians;
- The proportion of our population who are benefitting from extended hours access to primary care;
- One year survival from all cancers;
- Evidence based interventions;
- Investment in mental health services.

Performance and quality dashboard

This dashboard provides an overview of our performance in 2019-20 against key national measures, including The NHS Constitution pledges to patients about their care. The CCG holds our providers to account on their delivery of these pledges and other quality standards, and we work with them to create remedial plans when there are shortfalls.

NHS Constitution Rights and Pledges overview for 2019/20	Did we meet the standard?	Commentary
Waiting times 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.	☒	Delivery of the A&E waiting time standard for adults (at STHFT) continues to be our most challenging issue requiring system wide co-operation and focussed action. The CCG works closely with the trusts, our practices and the ambulance service to take forward a range of actions to improve performance, which includes commissioning a range of services which provide alternatives to A&E, such as additional appointments in the primary care "hubs", pharmacy based minor ailments scheme and emergency care practitioners, who see and treat people in their own homes. Sheffield Children's NHS Foundation Trust delivered the four hour standard throughout 2019/20.
Waiting times for elective treatment • 92% of all patients should wait less than 18 weeks for their treatment to start. • No patients wait more than 52 weeks for treatment to start.	✓ ☒	Whilst there have been several challenges at Sheffield Children's NHSFT in meeting this target during the year, overall for Sheffield patients, over 92% received their treatment within 18 weeks, until March 2020 (see discussion re COVID-19 above) . A very small number of Sheffield patients (fewer than 5) waited longer than 52 weeks for their treatment; for some cases, the delay may have been partly due to patient choice and capacity issues.
Waiting times for diagnostic tests • 99% of patients should wait should six weeks or less for their test/s from the date they were referred.	✓	There have been several challenges in certain specialities, across the year over 99% of patients had their diagnostic test within 6 weeks, until March 2020 (see discussion above re COVID-19).
Waiting time for Cancer treatments and diagnostic tests • There are nine separate waiting time pledges for Cancer that address how long patients should wait for various parts of their treatment journey.	☒	The nine standards were not met consistently in 2019 - 20, with particular challenges around the 62 day wait from urgent GP referral to first treatment, and the 31 day wait for second/subsequent treatment, where the treatment is surgery or radiotherapy. We have been able to consistently deliver the two week wait from GP referral to first outpatient appointment.
Ambulance Response times • Length of time for an ambulance to respond to an emergency as determined by the categorisation of the call and how urgent and time critical it is deemed to be.	☒	Yorkshire Ambulance Service NHS Trust has not delivered these standards consistently across the year, although progress is being made month on month for some of the categories of calls. These standards are designed to provide an appropriate response to meet the clinical need, prioritising the most acute and time sensitive conditions, and ensuring that the vehicle and personnel who are despatched are the best fit for the patient's need.
Ambulance Handover and Crew Clear times • Reduce the length of time it takes for an ambulance to transfer an emergency patient to the care of A&E and also the time it takes for the ambulance to be ready for the next call.	☒	Yorkshire Ambulance Service NHS Trust has not delivered these standards across the year, although improvements are being made at Sheffield hospitals.

NHS Constitution Rights and Pledges overview for 2019/20	Did we meet the standard?	Commentary
Mental Health • 95% of patients discharged from psychiatric inpatient care followed up by Mental Health Services within 7 days.	✓	During the first 3 quarters of the year, (latest available information), over 95% of patients were followed up within a week of discharge.
• 50% of people referred to the Early Intervention in Psychosis Services should be seen within 2 weeks	✓	This target has been met consistently every month this year.
• The number of people accessing IAPT services (Improving Access to Psychological Therapies, i.e. talking treatments) as a proportion of estimated need.	☒	The CCG commissioned ten new IAPT services, designed to help people cope with the psychological aspects of living with long term physical conditions. Specialists are available to help people with conditions such as respiratory problems, ongoing pain, dermatological problems, and musculoskeletal conditions. Towards the end of the year, the CCG and Sheffield health and Social Care NHS FT agreed an improvement plan to deliver increased access and higher numbers of people assessed as in recovery from their mental ill health. The service adapted quickly to deliver on line services during the pandemic.
• 75% of people referred to IAPT should wait 6 weeks or less until their first appointment; 95% of people should be seen within 12 weeks.	✓	Our service consistently delivers on this standard.
• 50% of people who receive IAPT services are moving towards recovery from their mental health condition.	☒	Our service treats a higher than the 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. Our service was very close to the target but was unable to meet it consistently in the year.

There are three other constitutional standards which relate to patient experience:

- Mixed sex accommodation:
  There have been a small number of occasions (<5 breaches as at January 2020) where patients were cared for in a mixed sex environment; at times this was due to significant bed pressures associated with the peak winter period. Each case is investigated and a remedial plan required.
- Operation cancelled on or after the date of admission, for non-clinical reasons to be offered another date within 28 days:
  There were 24 cases (up to January 2020) where a patient's operation was cancelled and not rescheduled within the 4 week period. These are investigated and each case is reported on in our monthly Performance, Quality and Outcomes report.
- Urgent operations cancelled for the second time:
  There have been a small number of breaches of this standard (<5 as at January 2020) each case is reported on in our monthly performance, quality and outcomes report.

We do not have any data on these standards after January 2020, as NHS England temporarily paused the collection and reporting of some data for a short time, to free up capacity in the NHS to respond to COVID-19.

Sustainable Development

NHS organisations were required to contribute to meeting the national target of a 10% cut in NHS wide carbon emissions by 2015, with a 34% cut in overall national carbon footprint by 2020, the latter is set out within in the Climate Change Act 2008.

NHS Sheffield CCG is a socially and environmentally responsible organisation which embraces the challenge to meet these targets; supported by the Social Value Act 2012 which requires us to consider how to use our contracts to improve the economic, social and environmental well-being of our communities.

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

The majority of our carbon footprint derives from the health and care services we commission rather than the resources that we use as an organisation, therefore our priority will be to work with our providers to improve their performance and maximise the benefits that they deliver to the health and welling of the people of Sheffield. We have ensured that all procurements have clauses requiring sustainability actions and that our core providers have sustainability plans in place, including the economic, social and environmental wellbeing of our local communities.

We have a draft sustainable development strategy and action plan and have an identified an executive director lead for sustainability and remain committed to the NHS Carbon Reduction Scheme. There is an on-going focus to reduce our direct building related greenhouse gas emissions and we are working with our landlord and his managing agents to achieve this; we continue to review business travel and introducing ways of reducing this, together with reduction of waste going to landfill.

The CCG is committed to recycling within the organisation. Members of staff and visitors are encouraged to separate their rubbish into dedicated recycling containers which are located on both floors of 722 Prince of Wales Road. We have reduced printing costs by changing all default printer settings to monochrome which will help to reduce our carbon foot print, as well as replacing our printing paper with recycled paper which is from the Nationally Contracted Products list, also used by other NHS organisations.

During quarter four of 2019-2020, the CCG introduced a number of recycling schemes including recycling of batteries and pens, and in the short period that the scheme has been running, the CCG has redirected 4kg of batteries away from landfill to be recycled.

Facilities Management

NHS Property Services (NHSPS) are responsible for managing the lease for the building from which we operate, as well as monitoring utility costs. The following table indicates our utilisation for gas, electricity and water for 2019/20:

Consumption			Cost		
Electricity (kWh)	Gas (kWh)	Water (m^3)	Electricity (£)	Gas (£)	Water (£)
366,789	498,612	20,638	62,920	18,405	2,540.25

CO2 emissions to atmosphere

During 2019/2020, 289.2tns of CO2 to atmosphere was created by electrical and gas usage by the CCG, an increase of 95.1tns from the previous year.

We continually examine our internal processes to ensure we meet our obligations through initiatives such as the use of technology to further embed paperless working, and the publication of our sustainable development management strategy and action plan in line with national best practice.

Improving quality

In 2019/20, the CCG worked hard to improve the quality of services we commissioned for the people of Sheffield.

Primary Care

The CCG supports primary care quality in several ways. We organised and delivered two successful protected learning events in May, July, October 2019 and November 2019:

- For practice managers to raise awareness of the Care Quality Commissioning changes and how to prepare for visits.
- For the whole practice team on patient safety including safety culture and serious incidents.

Further human factors vaccines and immunisation training was also delivered for health care support workers (HCSW), and flu updates for the nursing and HCSW s.

General Practice Nurse Awards

To celebrate excellence in primary care nursing, in February we held an award ceremony for the second year running. The award ceremony was well received and awards included recognising leadership in primary care; support and mentorship; compassionate and caring practice team; commitment to general practice; nursing rising star; inspirational health care assistant practice nurses and rising star.

Primary Care Development Nurses (PCDNs)

Working closely with practices, the PCDNs have had a positive impact on patients with diabetes this year. They've supported primary care staff to review patients looking at

blood pressure readings, medication and blood results. This has led to a significant improvement in patients' blood pressure and improved the health of patients.

Quality Improvement in Care Homes Feb 2020

During the past 12 months the Quality in Care Home Team (QCHT) has delivered several innovation projects to implement the national Enhance Health in Care Homes Framework in Sheffield as follows:

- **Improving nutrition and hydration**
  A dietitian has been appointed who is providing support, advice and guidance to care home staff to improve the nutritional status of residents. This is being delivered through visits to the homes and also through a virtual classroom method.

- **Recognising and managing deteriorating residents**
  A clinical educator is teaching care home staff how to look for signs to help them recognise when a resident is unwell. She is also teaching staff to take observations and respond to the abnormal. A tool is being used to calculate risk and help staff to identify the most appropriate team to escalate to.

- **Reducing conveyance to hospital following a fall**
  There is a project, working with the Yorkshire Ambulance Service, which helps staff to enable residents to be lifted safely from the floor following a fall, using assessment and equipment. Ten care homes are participating in the trial between April 2019 and February 2020 and data shows that there has been an average of 7% reduction in calls to YAS for help following a fall.

- **Enrichment activities**
  With Sheffield College, we have linked students to care homes. This provides mutual benefit as the students can "test" their work in the home, whilst enriching the lives of the resident. For example -photography students take family portraits. This model will be spread across South Yorkshire.

- **NHS mail**
  All Care homes have now been given an NHS email address. This has improved communication processes between the care home and NHS organisations making sure that critical information is sent and received on time and facilitates the right care for the individual.

Safeguarding at the CCG

On 1 April 2019 local safeguarding boards were replaced by new partnership arrangements making the CCG an equal partner with Sheffield City Council and police.

We have chaired and been involved in many of the sub-groups of the partnerships which have included several reviews including domestic homicide reviews, safeguarding adult reviews, child death overview panels and child safeguarding practice reviews.

We have significantly increased the percentage of GP reports for child case conferences by developing a simpler pathway. There has been partnership development this year of a South Yorkshire and Bassetlaw ICS Safeguarding Group. We have also introduced a dedicated looked after children ICS group - which is improving the unwarranted variation for looked after children - and increased partnership working on parental mental health workstreams.

Engaging people and communities

Involving people in our decision making

The CCG values the involvement of the public in its local and collective decisions, and we utilise various involvement approaches to ensure an inclusive approach to involving the diversity of our citizens.

We involve members of the public at the earliest opportunity in our decision-making process. In addition to direct regular contact with our citizens through the Involve Me network and city-wide involvement meetings, we hear from harder to reach communities through tailored approaches and partnership working with Healthwatch Sheffield and the voluntary, community and faith sector in the city. We also identify opportunities for public representatives to be directly involved in our planning and decision making through participation in project meetings, partnership boards and procurement activities.

Many local people give their time and energy to engage with us on specific topics. Sharing the outcomes of our decision making with the public and highlighting where the public voice has impacted on our plans and decisions is vitally important to building trust with our communities and encouraging more involvement.

Two lay members have been identified with responsibility for public involvement. Between them they Chair the Strategic Patient Engagement, Experience and Equality and Quality Assurance Committees, as well as being voting members of the Governing Body; and Remuneration, Primary Care Commissioning and Audit and Integrated Governance Committees. This further ensures there is a voice for patients and the public throughout our decision making and governance.

We consult with relevant Overview and Scrutiny Committees:

- Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
- South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee

Strategic Patient Engagement, Experience and Equality Committee (SPEEEC)

Our involvement activity is overseen and assured by our Strategic Public Engagement, Equality and Experience Committee (known as SPEEEC) whose members include local

people, governing body lay members, local GPs, Healthwatch Sheffield, the council and Sheffield University.
The Committee has delegated responsibility from our Governing Body to:

- gain assurance that engagement, patient experience and equality and diversity activity is being carried out in line with statutory requirements and to a high standard by the CCG and by its providers
- gain assurance that information from this activity is used appropriately to influence commissioning
- oversee equalities, engagement, and experience activity
- assure work in these areas is effectively joined up with partners

Our communications and engagement strategy

Our draft communications and engagement strategy sets out the principles we follow when engaging with the public, and the key ways we involve local people in our decision making. We aim to deliver high quality engagement at all times. Our principles set out what this will look and feel like.

- We will engage people early on in our decision making processes
- Involve the public in the governance of the CCG
- Before starting engagement activity, we will review existing sources of insight about the patient and public views and experiences, and bridge any gaps
- Engagement will be an ongoing process, not a one-off exercise
- We will be clear and concise, and all engagement will have a purpose
- Engagement will be representative. We will take time to involve hard to reach groups and the most vulnerable people. We will use accessible formats and ensure equality of opportunity
- We will go out to external groups; we will not depend on them coming to us
- We will work with our partners to avoid duplication and overload for the public
- We will meet our responsibilities under the Equalities Act, 2010 and statutory responsibilities under section 14Z2 including Gunning principles
- Sheffield CCG will listen and hear, what people tell us and we will feedback – so people will understand the impact of their views
- Sheffield CCG will recognise and record people's contributions
- We will recognise the difference between individual and collective engagement.

You can find our Communications and Engagement Strategy here.

Supporting people to be involved

Appropriately supporting local people to have their say and genuinely influence our commissioning decisions is a priority for us.

We believe that our values and behaviours speak louder than words and have developed a volunteering policy to ensure our staff offer consistent and appropriate support to individuals who help our work. This includes reimbursement of out of pocket expenses

tailored to an individual's circumstances, but as standard for travel, caring responsibilities, and subsistence costs.

You can find our volunteering policy here.

We also involve volunteers who give their time to multiple organisations in the city as part of our partnership responsibilities. It is important to ensure that those people are appropriately trained, supported and reimbursed. Examples of these roles include our Autism Partnership Board (in conjunction with the local authority), our musculoskeletal patient ambassadors (in conjunction with Sheffield Teaching Hospitals), and Dance to Health volunteers (in conjunction with voluntary organisations).

If you are interested in volunteering with the CCG, please contact us on SHECCG.engagementactivity@nhs.net or 0114 305 4609 to find out more.

Understanding our communities

As well as evidence gathered through consultation and involvement activities, we use monitoring information to help us identify possible impacts and to help shape and inform the equality impact assessment process. We use quality and equality impact assessments to plan our involvement activity, so we can target those people who are likely to be impacted to ensure their voice is heard in our decision making and any impacts or risks can be managed.

Identifying potential impacts requires an understanding of how the city is made up and the issues that people face. To build this understanding we use a wide range of evidence including:

- Joint Strategic Needs Assessment
- State of Sheffield Reports
- Community Knowledge Profiles
- NHS England's Right Care pack for Sheffield
- South Yorkshire Community Foundation's Vital Signs reports
- People Who Use Commissioned Services 2017/18
- Nuffield Trust: Quality and Inequality - How have inequalities in the quality of care changed over the last 10 years?

Equality monitoring

All our involvement activity is monitored to make sure that we are reaching all our communities. This information is regularly reviewed so we can target communities who we are not hearing from. This helps us to provide the best services for **all** our communities and to make sure that we do not knowingly discriminate against any section of our community.

Supporting our staff to involve people

We invested in staff training to raise awareness of the organisation's legal duties around public involvement and equality. In 2019/20 we commissioned the Consultation Institute to provide equality and consultation masterclasses to our primary care commissioning committee, strategic public engagement experience and equality committee, GP practice managers and commissioning managers. This training has helped our organisation to be more aware of the requirements and benefits of involving people in our work.

We recently introduced a series of learning sessions for our staff based around the protected characteristics of the Equality Act 2010. Through these sessions, we invite a member of the public or staff member with a protected characteristic to discuss their experience of receiving services and the challenges and barriers they have faced. This is bringing great insight into the communities we serve and how we can work towards reducing the health inequalities that exist across Sheffield.

Continuously improving how we involve

Each year NHS England assesses how well each CCG has discharged its public involvement duty through the NHS Oversight Framework - Patient and Community Engagement Indicator. In 2017/18 we were rated as ‘Requires Improvement’. However, last year we submitted evidence of how we engage with and involve our local communities and we were rated as ‘Good’, only one mark away from ‘Outstanding’.

NHS England has since identified six pieces of the evidence we submitted for 2018/19 as examples of good practice that other CCGs across the country could learn from. The examples covered four out of the five domains that are assessed. Our work has subsequently been included in a Good Practice Inventory that has recently been shared nationally. The evidence included:

- Our governance arrangements for assuring involvement activity across the organisation, including how we involve people through the Strategic Patient Engagement Experience and Equality Committee.
- Creating an accessible and appealing annual report.
- Our transparent reporting and evaluation of the City-wide engagement around the Dementia Strategy.
- Making consultation and involvement materials available in accessible formats and community languages including summary versions, British Sign Language, and audio interpretation.
- Our flexible approach to the Dementia Strategy engagement that allowed us to identify gaps and react accordingly.
- How we understand our local population and the feedback they give us through demographic monitoring of the Hospital Services Review work.

We have already submitted our evidence to NHS England for 2019/20, and we are very hopeful that our rating will reflect our progressive approach to continuously improving our involvement work.

Making a difference

During the year, we have worked with people in Sheffield on a wide range of issues and service areas. Below is a quick overview to show the difference this is making and how local people are helping to shape the city's health services:

Area of work	Impact of involvement with local people
Urgent care campaign – engaging communities	Building on from previous involvement work on urgent care in Sheffield, we have been working with over 250 residents across Sheffield to develop a social marketing campaign to improve the awareness of how people access urgent care services in the city. To target those communities that we know are less aware of and more likely to use urgent care services, we asked local community groups to bid for a fund to deliver an intervention that will increase awareness and confidence to navigate the urgent care system in their communities. The community interventions were based on the following evidence based principles: • Peer to peer support for behaviour change • Delivered in local communities by local communities • Delivered face to face • Person centred approach • Consistent aims of delivery across the City but tailored to local demographics, culture and geography • Based on tried and tested methods from the Sheffield community • Appropriate support in place to enable people to participate (e.g. crèche, interpretation etc.) We will be evaluating the impact of this work and we hope to see real benefits for our communities and services.
Primary care network involvement	Two separate pieces of work were commissioned to gain insight from people living in each of the 15 Primary Care Networks across Sheffield. We funded community organisations in each of the 15 Primary Care Networks to undertake one to one interviews or focus groups. A telephone survey was also undertaken by SMSR Research.

	We gained insight from a combined total of 1,769 people across Sheffield which represented. This insight will be used in the development of all the Primary Care Networks.
Interpreting services using equality delivery system (EDS)	Access and delivery of interpretation and translation services were highlighted as an issue by our local communities as we engaged with them about our plans. We used the EDS framework to review interpretation and translation services in GP services to assess how well we are performing, look at best practice and identify areas to improve. The feedback we get will inform our recommissioning of the service.
Primary and community mental health transformation	Sheffield is one of twelve national early implementation sites selected by NHS England to test new models of care and services for delivering the Adult Community and Mental Health Framework 2019. We have been working in partnership with Co Create to involve people living with severe mental illness in the development of this new model.
SEND	Sheffield City Council, NHS Sheffield Clinical Commissioning Group and Sheffield's Parent Carer Forum have worked together to draft an inclusion strategy. It explains how we, as a city, improve in meeting the needs of our children and young people with special educational needs and/or disabilities (SEND). Developing this strategy involved: • co-production sessions in October (over 60 people attended) • the views of young people taking part in discussion groups • a survey • the Parent Carer Forum's State of Sheffield survey (over 700 responses) The strategy will run for five years and set the priorities for how Sheffield supports its children and young people with additional needs. We asked people to let us know what they thought of our draft strategy, the support that is currently

	available and how they think it could be improved. This feedback influenced the final strategy and an action plan for delivering the strategy across Sheffield.
Access to infertility treatment	We have been working with colleagues across Yorkshire and Humber to develop a shared Access to infertility treatment policy that will provide consistency to how we offer these services. The shared policy sets out who is eligible for specialist fertility services. We engaged with local LGBT+ and disability groups as they were identified as being specifically impacted by the changes to the policy which looked to broaden the access to these communities. The results from the involvement exercise were mainly positive and welcomed the changes.
GP Practices	We have supported our member GP practices to involve their patients in service changes including branch closures, mergers, opening times

Patient Participation Group (PPG) Network

The Sheffield Patient Participation Group Network allows PPG members from across Sheffield to come together to network with each other, share ideas on how they can develop their own PPGs, and find out about and contribute to projects happening across the City.

We held two Patient Participation Group Network meetings throughout 2019/20. Topics at the PPG Network meetings this year have included:

- Primary care networks
- Patient experience in GP practices

We invested in the development of PPGs and the PPG Network by commissioning Primary Care Sheffield to run development sessions. Throughout 2020/21, the focus will be on how PPGs can work with Primary Care Networks to make sure that patients are involved in their decisions.

Working with partners across the region

The CCG is a partner in the South Yorkshire and Bassetlaw Integrated Care System (ICS). The ICS is a group of partners involved in health and social care that have agreed to work in closer partnership to improve health and care. The ICS has made a commitment to involving patients and the public in health service developments.

With support from voluntary sector partners, the ICS has undertaken extensive involvement work with the public and patients to inform the work of the Hospital Services

Review (read our engagement reports from the HSR work here). Partners have also worked with the community, patient and voluntary groups as well as staff to inform work across a range of areas, including over the counter medicines, autism, emergency admissions from care homes, children's healthcare website, stoma care, and the development of the South Yorkshire and Bassetlaw 5 year plan.

To support the strategic work of the ICS the SYB ICS Guiding Coalition was established – a strategic advisory forum which includes voices from primary and secondary care clinicians, local authorities, voluntary sector and the public.

The Citizens' Panel has continued to develop, bringing together people from across the region to provide an independent view and critical friendship on matters relating to work at System level (find out more about the Citizens Panel here) and a Transport and Travel Panel (TTP) with patients and the public, also from across the region, to look at the potential impact changes to services would have. The TTP is currently not meeting as there are no significant changes in the pipeline but it will be reinstated should this change.

The 'Get Involved' page of the ICS website directs members of the public to opportunities to become involved in work being carried out by the organisation. Members of the public can keep abreast of ways in which they can contribute their thoughts, views and time via the ICS's social media channels as well as by signing up to an ICS mailing list.

Detail about feedback received and how we put it to use is available on our 'Using your feedback' page.

Hospital Services

In August 2017 the ICS started work looking at hospital services in the region. Patient, public, and clinical involvement was key to this work. Several methods were employed throughout the hospital services work, much of which was detailed in previous annual reports, and reports about this engagement can be found here: www.healthandcaretogethersyb.co.uk/get-involved/using-your-feedback

In August and September 2019 the South Yorkshire and Bassetlaw Integrated Care System's (ICS) Hospital Services Review Case for Change report were received by all of the ICS partners' clinical commissioning group governing bodies and the trust boards. The full report was published online on the 6 August.

We have taken the key recommendations from the report and sought opinions from parent/carers. This community was targeted as they are the community most likely to be affected by the recommendations in the report, which centres on maternity and paediatric services. It was also an opportunity for us to return to the parent/carer groups from whom we heard regularly in earlier Hospital Services Review engagement exercises to demonstrate how their input had helped shape the recommendations in this report.

The South Yorkshire Community Foundation carried out focus groups with parent/ carer groups in South Yorkshire, these included a group which supports young mothers and that are long-term unemployed, a centre that aims to help overcome the inequalities and lack of access to services that have a direct impact on those with low incomes, and a charity working to support the emotional wellbeing and mental health of mothers and their families during pregnancy, birth and afterwards; and the Bassetlaw Community and Voluntary Service conducted focus groups with parent/carer groups in Bassetlaw in children's centres in disadvantaged communities.

The full reports from these engagement activities can be found here.

Long Term Plan

The NHS Long Term Plan was published by NHS England in January 2019 and set out how the NHS will improve the quality of patient care and health outcomes. The South Yorkshire and Bassetlaw Integrated Care System (ICS), along with all other ICS/STPs in the country, was then tasked with working with their local partners to develop their local response and producing an ICS five-year strategic plan. As an essential part of this process wide engagement with health and care staff, patients, the public and other stakeholders across South Yorkshire and Bassetlaw has taken place.

The Barnsley, Doncaster, Nottinghamshire, Rotherham and Sheffield Healthwatches joined forces to co-ordinate conversations with more than 1500 members of the South Yorkshire and Bassetlaw public throughout the spring and summer 2019. They asked people, either by survey or in face to face group conversations about their views on the priority areas that had already been identified by the public in similar conversations in 2016.

SYB ICS also connected and had conversations with staff and stakeholders online and through partner organisations, our ICS Staff Side Forum, forums and at events.

Three reports are outlining the feedback and a summary of how the feedback has shaped the plan, available online here.

Reducing emergency admissions from care homes

The urgent care workstream wanted to look at how in SYB we might reduce the numbers of people who are taken to hospital when it isn't clinically appropriate. The ICS engagement team visited three care homes in June 2019 and spoke to staff and residents to gain some insight into why they typically call ambulances and whether the residents would prefer to have the support they need to stay where they are living or would prefer to go to a hospital or a hospice.

The findings from this insight gathering exercise were provided to the urgent care workstream for them to utilise and are available on our website here.

Children's healthcare website

The Care of the Acutely Ill Child Clinical (CAIC) work-stream and the SYB Local Maternity System (LMS) want to put in place a 'Healthier Together' website to provide health information and advice for pregnant women, children, young people, and their families across SYB. Based on the successful Healthier Together 0-18 Hampshire Website, the CAIC work-stream and SYB LMS wanted to replicate this website resource across SYB ICS to:

a) provide a clinically led website with simple health information that is easy to navigate for pregnant women, children, young people, and their families
b) support the consistency of information between SYB services, Trusts and between primary and secondary care on a range of conditions including the most common illnesses – to improve patient outcomes
c) promote and guide choice and personalisation in access to care
d) provide a facility for system wide patient engagement
e) reduce costs to services by providing health professionals with a free SMS facility to share patient information with pregnant women, children, and their families
f) Support reductions in child and adolescent GP attendances and hospital admissions as seen across Hampshire.

A survey was launched in October 2019, online and via partners' circulation to seek the views of pregnant women, children, young people and their families, and health professionals on the website and the concept. The survey closed in January 2020 having received just under 100 online responses. The responses were analysed and used to inform the business case. More information is available on our website here.

Autism

Autism is a key priority for the ICS across 'all-ages' and there is a clear commitment to becoming more autism friendly. To take this forward, and to ensure all stakeholders, including patients and their carers are involved in developing a workshop, co-produced by Speak Up, was held on the 10 October with representation from schools, health, voluntary sector organisations, social care, police, experts by experience, parents and carers. Patient stories, from people who weren't able to be at the workshop but wanted their story told, were gathered by the ICS engagement team and were heard at the workshop. Some of the outcomes from the workshop can be found on our website here.

During the workshop areas of focus for the SYB wide autism work were agreed and these are now being taken forward by Task and Finish Groups for each of the themes. The ICS engagement team continues to work on behalf of the workstream, and with Speak Up to ensure patients and their carers are allowed to share their views and help shape the direction of travel. This includes ensuring the voices of the seldom heard communities and those not directly involved with autism support services are heard.

Over the counter medicines

In late 2018, the South Yorkshire and Bassetlaw ICS undertook a public engagement campaign designed to raise awareness of planned changes to prescribing of over the counter (OTC) medicines for minor, common, short-term health concerns.

The campaign evaluation report told us:

- 82% of respondents said they would be happy to purchase their medicine OTC if told to do so by a GP
- People are reasonably confident to treat themselves where appropriate – either without further medical assistance or with advice from a pharmacist
- Knowledge of what prescriptions cost the NHS is relatively low

Phase two of the campaign builds on the success of the 569million reasons brand and voice. It is a digital campaign comprising of online and social media content to help drive engagement with the message across South Yorkshire and Bassetlaw. The narrative of phase two is strongly based on the findings from the engagement in phase one. A snapshot of viewpoints from small numbers of the public and clinicians was also used to pilot the phase two materials before they were launched in January 2020.

Stoma

The Medicines Optimisation workstream identified that across South Yorkshire and Bassetlaw, stoma services are provided in many ways. To help them understand this better they first held a focus group with stoma patients from across South Yorkshire and Bassetlaw. The focus group gave their views and also helped to develop a survey to be sent via GP practices to current and recent stoma patients to ask them about their experiences of the stoma products that they order and receive (to receive more quantitative data to support the qualitative insight gathered from the focus group). The survey ran for 4 weeks from January to February 2020.

The findings will inform the future development of stoma services across South Yorkshire and Bassetlaw. A summary of the findings is available on our website here.

Children's surgery and anaesthesia

In June 2017, the Joint Committee for Clinical Commissioning Groups (JCCCG) for South Yorkshire and Bassetlaw decided to change the way some children's surgery and anaesthesia services are provided in South and Mid Yorkshire, Bassetlaw and North Derbyshire.

At the time, the JCCCG agreed to clinical recommendations that children needing an emergency operation for a small number of conditions, at night or a weekend, would not be treated in hospitals in Barnsley, Chesterfield and Rotherham, and would instead have their surgery at Doncaster Royal Infirmary, Sheffield Children's Hospital or Pinderfield's General Hospital.

However, the change is yet to take effect, and since the decision:

- Strengthened partnerships across the region and even closer ways of working have been formed across the patch
- Closer joint working across the NHS Hospitals has strengthened ENT services and made them more stable and sustainable. This has reduced the need for children's surgery in the areas previously identified
- The more detailed investigation that happens before any proposed change takes place has shown reality to be more complex than the business case assumed
- There is evidence to suggest that appendectomies in children can be done with keyhole surgery (minimally invasive)
- There is evidence that the torsions pathways are appropriate and should be retained
- The introduction of Sustainability and Transformation Partnership/Integrated Care System footprints has changed previous joint working arrangements. In South Yorkshire and Bassetlaw this has impacted on working arrangements with Mid Yorkshire Hospitals.

These changes of circumstance led the Children's Surgery and Anaesthesia Managed Clinical Network to develop new recommendations, which meet the principles from the original workaround safety and care closest to home, but which do not support the three hubs geographical model proposed in 2017.

A new paper decided upon by the Joint Committee of Clinical Commissioning Groups (JCCCG) in March, instead recommended that clinical models should be different depending on the type of surgery.

The paper proposed that:

- The ENT models that are in place, through the close joint NHS hospitals work are appropriate and should stay as they are
- Torsions pathways are appropriate and should stay as they are
- Consideration should be taken as to whether Mid Yorkshire Hospitals (MYH) should remain as a part of this work. Changing MYH's involvement would have some small volume implications
- Abdomens are the most complex pathway and the recommendation is that a change should be made to the treatment of appendicitis in young children. The number of appendectomies undertaken in South Yorkshire and Bassetlaw each year on children under 8 is very small, less than 100. Children under 8 are not 'small adults' and if they need an appendectomy, it is better and safer for them to be seen by a surgeon who is trained to and regularly operates on children their size. Therefore, the proposal is for children aged under eight, and for children with complex needs, appendectomies should be conducted at Sheffield Children's Hospital.

An engagement exercise was undertaken in early 2020 with those most likely to be affected by this decision (parents/ carers and young people who may be parents in the future) to test their views on the proposal. The summary of this engagement can be found here.

Gluten free

In July 2019, the Joint Committee of Clinical Commissioning Groups was asked to consider whether the CCGs for Barnsley, Bassetlaw, Doncaster, Sheffield, and Rotherham should undertake a public engagement around changing the prescribing of gluten free products in some parts of the region so that it is all in line.

It was agreed that involvement activity should take place to allow potentially affected citizens and stakeholders the opportunity to share their views on the inconsistencies between each place and whether CCGs should consider aligning prescribing processes to make the access to prescriptions for gluten free products equitable across South Yorkshire and Bassetlaw. This involvement activity was a targeted exercise using face to face engagement with individuals and groups to ensure a cross-section of views are captured. Read the outcomes of this engagement exercise here**.**

Hip and Knee

The elective and diagnostics workstream wanted to get views from patients to a proposal that hip and knee follow up appointments would continue to be provided in each hospital, however where a patient agrees the final one year appointment would be virtual, meaning the patient doesn't need to attend a clinic and be seen in person.

The ICS engagement team visited hip and knee outpatient clinics in Bassetlaw, Mexborough and Doncaster hospitals in June 2019 and spoke to patients waiting for their appointment. The summary of this engagement can be found here.

Developing a Hyper Acute Stroke Unit (HASU) Aphasia friendly leaflet

Receiving specialist treatment in the first 72 hours after having a stroke is vital for patients to survive, and to survive well. The NHS across South Yorkshire and Bassetlaw are now better able to provide this specialist care. After significant work, clinical input and public consultation, changes to the way we deliver hyper acute stroke services came into place from 1 July 2019 for Rotherham patients and 1 October 2019 for Barnsley patients.

To support the changes work was undertaken with an aphasia stroke survivors group to help develop a leaflet about HASU that would be accessible for those who have aphasia, which is a language disorder that results from damage to portions of the brain that are responsible for language.

Echo

The elective and diagnostic workstream wanted to seek patient opinion on the idea of offering for patients' repeat echo scans to be undertaken locally. The ICS engagement team visited the Northern General in May 2019 and spoke to patients waiting to go into echo clinic. The summary of this engagement can be found here.

Innovation fund bid assessments

The urgent and emergency care workstream set up an urgent and emergency care innovation fund with just under £400,000 funding available for local place partnerships and

SYB organisations to bid for to help them develop innovative urgent and emergency care approaches, which if successful could be rolled out wider in SYB. A panel was established to assess the bids and the ICS engagement team facilitated the involvement of Healthwatch to sit on the panel to represent the patient voice in the decision making.

Suicide and the media

South Yorkshire and Bassetlaw (SYB) has a higher suicide rate than the England average. In May 2019 the SYB ICS held a workshop to discuss what can be done differently to better support those who are bereaved by suicide and to raise awareness to support other vulnerable people and prevent suicide in South Yorkshire and Bassetlaw. To help inform the workshop the ICS engagement team reached out to families bereaved by suicide to hear their stories. A short video with the experiences of the families was made and shared at the workshop and online here.

Involving through 2020/21

Over the next year, the CCG will be involving people in the following areas of work. There will also be lots of other opportunities that come up throughout the year.

- Impact covid is having on communities particularly those in protected groups and also around changing service models and deliveries.
- physical health for those living with mental health conditions, learning disabilities and autism
- Changes to Primary Care services including GP Practices
- Dementia action plan and delivery

If you would like to be involved in making sure we have the best services for people in Sheffield, please contact us on sheccg.engagementactivity@nhs.net or 0114 305 4609.

Reducing 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 often 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 one of the CCG's main priorities it's our first priority. 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.

Many of the major determinants of health and life expectancy are outside the direct influence of the health service (e.g. employment, lifestyle choices), but the CCG works with partners to inform and influence action in these areas. We also act to ensure equality

of access to quality healthcare, and work with healthcare providers, including GPs, to contribute to reducing inequalities.

Some of our key achievements in 2019/20 include:

- Supported and committed to, as part of the Sheffield City Partnership, taking forward the Partnership Framework for An Inclusive and Sustainable Economy
- Supported and contributed to the launch of the city's Health and Wellbeing Strategy
- Actively participated in partnership work with the police and other agencies on tackling knife and gun crime
- Worked with our Deep End Practices to continue our work in supporting people to access care in the more deprived communities
- Invested in the further development of all of our neighbourhoods. Invested in some of the more mature neighbourhoods to go further faster with their partners to provide targeted support that meets the needs of their local populations
- Continued to invest in social prescribing across the city to support wellbeing
- Continued investment in improving access to psychological therapies (known as IAPT)

Sheffield's joint health and wellbeing strategy

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 ambitions set out within the strategy do not represent all our commitment to health and wellbeing. There is much going on in Sheffield already that is essential for improving the health of our population. For example, in the last two years, Sheffield made major commitments to reducing smoking and improving access to healthy food. Existing work such as these are not formally part of this strategy but remain important and the Health and Wellbeing Board is clear that they and other strategic commitments continue to be delivered on as part of our overall approach.

Its goal is to close the gap in healthy life expectancy in Sheffield by improving the health and wellbeing of the poorest and most vulnerable the fastest. The strategy takes a life course approach to healthy lives as follows:

- Starting well – where we lay the foundations for a healthy life
- Living well – where we ensure people have the opportunity to live a healthy life
- Ageing well – where we consider the factors that help us age healthily throughout our lives

For each of these, we have identified three ambitions to focus on over the coming five years. These ambitions have been identified based on local evidence of what is most likely to improve life chances and reduce inequalities, focusing on factors that will support people to be healthy from the start, rather than on intervening once they are unwell.

The strategy and a summary overview are available at www.sheffield.gov.uk in the Health and Wellbeing Board section. At its meeting on 29 March 2019, the Health and Wellbeing Board approved the refreshed Health and Wellbeing Strategy, which Governing Body will formally approve at its May meeting.

Emergency Preparedness, Resilience and Response (EPRR)

The NHS needs to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004 (CCA 2004) and the NHS Act 2007 (as amended). The CCA 2004 specifies that responders will be either Category 1 (primary) or Category 2 responders (supporting agencies). NHS England, acute and ambulance service providers, Public Health England and Local Authorities are Category 1 responders and CCGs are Category 2 responders.

As a Category 2 responder, the CCG supports Category 1 responders and is part of a wider EPRR framework that includes local health providers, YAS, NHS England and Public Health which is called the Local Health Resilience Partnership. The CCG also works closely with other agencies and partners including the local authority, police and fire services through the Local Resilience Forum. To carry out its responsibilities, the CCG has relevant plans and a 24/7 on call structure in place. A self- assessment is carried out each year by the CCG (as with all NHS Category 1 and Category 2 responders) to assure compliance against core standards for EPRR. For 2019/20 the Level of Compliance for the CCG was ‘Substantially Compliant’.

In light of the Coronavirus pandemic, the CCG has mobilised it’s emergency response arrangements in line with our EPRR policy,

EU Brexit

During the year, the Governing Body has been updated on the national expectations on Commissioners related to the United Kingdom leaving the European Union. The CCG has complied with all relevant national requirements as per the EU Exit Operational Readiness Guidance (December 2018) and has actively complied with all planning requirements through the Local Resilience Forum.

The Governing Body has reviewed plans and the potential risks across the system and for the CCG about the seven areas of activity, and has concluded that this is not a significant strategic risk for the organisation given the matters being dealt with directly by NHS central bodies and HM Government.

ACCOUNTABILITY REPORT

Lesley Smith
Accountable Officer

18 June 2020

Corporate Governance Report

1 Members' Report

Sheffield CCG is a clinically led member organisation. This means that GPs and nurses, and managers, make decisions about local health services by using their local knowledge to improve services and focus resources where there is the greatest need. The CCG is made up of 79 GP practices and is responsible for a budget of £946 million. Together the GP practices have a registered population of 582,506 patients (October 2019). The membership is represented by a Governing Body of local GPs, a nurse representative, a secondary care doctor and lay members, supported by our executive team.

The Governing Body is chaired by Dr Terry Hudsen, a GP at Sheffield Hallam University Practice, Lesley Smith is the Accountable Officer. Our Governing Body members have specific areas of responsibility and sit on various committees of the Governing Body. The Members exercise their constitutional rights in respect of the CCG through the Members' Council for which each Member practice has a representative.

Our Governing Body meets in public every other month, and we encourage our community to join us to find out about the work we're doing. Details of public governing body meetings and meeting papers are published on the CCG's website.

1.2 Composition of Governing Body

Governing Body members (i.e. formal voting members) throughout 2019/20 comprise:

- Chair
- Accountable Officer
- Medical Director
- Director of Finance
- Chief Nurse
- Director of Commissioning and Performance
- Director of Delivery, Care Outside of Hospital
- Secondary Care Doctor
- Locality Nominated GPs x 4 (of which one currently is chair)
- Elected GPs x 4
- Lay Members x 4

1.3 Member profiles

During 2019/20, the following individuals served on our Governing Body and remained in post throughout the year *(except where indicated – no date indicates that the member was in post the full financial year)* and up to the signing of this annual report and accounts:

Dr Terry Hudsen – Chair and West Locality Nominated GP (wef 01.09.2019)

Dr Terry Hudsen graduated in 2006 and started his medical career in anaesthesia 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.

Terry 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's lives.

Lesley Smith – Interim Accountable Officer (wef 10.06.19)

Lesley brings to the CCG a breadth of leadership experience of commissioning, service transformation, and Organisational Development. Lesley combines her work in Sheffield with the role Accountable Officer at NHS Barnsley CCG, as well as Deputy Lead for the South Yorkshire and Bassetlaw Integrated Care System. She is a very experienced Chief Executive having spent over 12 years as a Chief Executive in the NHS, both in Yorkshire and in Scotland and with 15 years of board level experience, across provider and commissioning organisations.

Her experience has included leading strategic change in large and complex cities comparable to Sheffield and she has played a leading role in the development of the South Yorkshire and Bassetlaw Integrated Care System. She has been Accountable Officer at Barnsley CCG since 2015 and from June 2019 has combined her work in Barnsley with the role with of interim Accountable Officer at Sheffield CCG.
Lesley lives in Leeds and is married with a grown up son and daughter

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. He is passionate about the NHS, preserving and championing its founding principles, to deliver the best possible care for the people of his adopted city.

Brian Hughes - Director of Commissioning and Performance

Brian Hughes was appointed as Director of Commissioning and Performance in May 2017. He is responsible for the commissioning and contracting of services across the city, with lead responsibility for planned care, urgent care, and mental health, working in partnership with CCG's lead clinical directors. He also leads on Information, Performance and the Programme Management Office within the CCG.

Before joining the CCG he was employed within NHS England in the role of Locality Director for West Yorkshire. His career has focused on performance improvement and delivery, holding previous roles at Regional (Yorkshire and Humber) and sub-Regional (South Yorkshire and Bassetlaw) levels, including Director roles in Operations and Delivery, and Performance and Accountability. He also has experience in primary care commissioning as Director of Business Development and Innovation and has worked within an acute hospital environment on hospital-wide improvement programmes, and strategic development. A career in performance improvement was enhanced through working in the Audit Commission in the Value for Money arena. He studied in Sheffield, in a subject area that he has subsequently worked in for over 20 years

Nicki Doherty – Director of Delivery, Care Outside of Hospital

Nicki is responsible for the Transformation and Delivery Directorate. Her areas of responsibility include Primary Care; Active Support and Recovery; Active Ageing, Long Term Conditions, End of Life Care and Person Centred Care; Communications and Engagement; Equality and Diversity, Public Health, Partnerships, Estates and Capital, Health and Wellbeing Board and the Better Care Fund. Nicki has worked for the CCG since February 2015, before this she developed a broad range of operational and corporate experience in the acute hospital sector.

She is passionate about Sheffield, about the NHS and about designing care and support that work for both the people who need them as well as people who deliver them.

Jackie Mills – Interim Director of Finance (wef 1.06.19)

Jackie is a chartered public finance accountant with nearly 30 years of NHS experience and was appointed as interim Director of Finance at NHS Sheffield CCG in June 2019. She joined the NHS in 1990 as part of the Graduate Financial Management Training scheme. She went on to hold several senior NHS appointments, the majority of which have been in the Sheffield health community.
Jackie is our lead executive director for finance, governance, and corporate affairs

Alun Windle – Acting Chief Nurse (wef 13.01.20)

Alun undertook his training as registered adults' nurse at Teeside University and later completed a masters at York St John in leadership, innovation and change, with clinical experience in medical, surgical and trauma care, accident and emergency, gastroenterology, endocrinology and safeguarding before starting his career in clinical commissioning groups in 2013.

Alun's area of expertise is patient safety, quality assurance, safeguarding and patient experience, with a focus on seeking service assurance and improvement for the population of Sheffield.

Elected GP members

Dr Nikki Bates

Dr Nikki Bates has been a GP for 28 years. She is senior partner at Porter Brook Medical Centre and elected by Sheffield GPs as one of their representatives to the CCG Governing Body in 2014. Nikki has recently been re-elected for a further term of office with effect from 1 January 2020.
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 assists GPs to review their work, celebrate excellence and prepare for revalidation with the GMC.

Dr Marion Sloan

Dr Marion Sloan is a 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 the 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 gynaecology 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. Her current work includes working with CCG colleagues developing and embedding the green agenda. This

is looking for straightforward ways to promote practising in a sustainable way across the Sheffield health community. Marion has recently been re-elected for a further term of office with effect from 1 January 2020.

Dr Leigh Sorsbie (wef 1.11.19)

Dr Sorsbie qualified in 1990 and has worked as a GP at Firth Park Surgery from 1996, as a partner for 22 years and continued as a salaried GP in the same surgery for a further 2 years. She now divides her working hours between the CCG and GP locums, predominantly in North Locality.
Leigh was previously North Sheffield Locality GP Representative from 2013 to August 2019 and was then elected as citywide GP from November 2019.

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.

Dr Lisa Philip (wef 1.12.19)

Dr Lisa Philip is a partner at Chapelgreen Practice, covering a diverse patient population across the north of Sheffield.

Lisa was born and raised in Sheffield and went on to study medicine later in life with the full support of her husband and three daughters. On completion of the Sheffield GP vocational training scheme in 2016, she continued her career at Chapelgreen Practice, in addition to working as a locum GP across the neighbouring cities.
Working at multiple practices allowed her to gain an insight into a wide variety of services around the region and the differing needs of specific patient populations. Her regular involvement in the voluntary sector highlights the impact of social and economic factors on health, and the importance of health education.

Lisa is the wellbeing lead at her practice and has an interest in social prescribing and health promotion. She is passionate about tackling health inequalities and shaping a health service which will meet the needs of our ever-changing communities. Her work with the early years' medical students aims to inspire our next generation of doctors to have a holistic view of medicine.

Locality nominated GPs

Dr Amir Afzal (Central)

Dr Amir Afzal 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 a senior partner at the practice. 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.

Having served on the CCG from inception to October 2017, Amir was reappointed in November 2018. The year out has allowed Amir to reflect on the many changes occurring in Primary Care and the central role General Practice needs to play in ensuring the best possible outcomes for the population of Sheffield. In adopting the service to cater for larger populations and "care closer to home" Amir feels that the essence of individual needs should be paramount and co-ordinated in an effective manner.

Dr David Warwicker (North) (wef 01.09.19)

Dr David Warwicker is a GP Partner at Mill Road Surgery in Ecclesfield. He also works as a locum GP in different practices across North Sheffield. This gives him a broader understanding of the diverse and changing communities within the locality he represents, along with the challenges the CCG faces in commissioning services that meet the needs of these communities.

Alongside his work as a GP, David is a clinical assistant in dermatology at the Royal Hallamshire Hospital. He finds that this role complements his work as a GP and as a Governing Body member, providing valuable first-hand insight into secondary care services in Sheffield.

David was born and raised in Sheffield, going on to study medicine at the University of Sheffield, and later training as a GP in the city. He has engaged with NHS services in Sheffield his entire life – not just as a doctor, but also as a patient, parent and next-of-kin. He has a vested interest in improving the quality of healthcare in Sheffield, along with ensuring its equality and sustainability.

Dr Andrew McGinty (Hallam and South) (wef 01.08.19)

Andrew is a clinical director at Sheffield CCG where he is the clinical lead for active ageing, cancer, end of life care and long term conditions.

He is also a GP at Woodhouse Medical Centre where he has worked for over 20 years, having previously worked in anaesthetics.

Lay members

Amanda Forrest

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 that enables voluntary sector organisations to work collaboratively. Amanda is Chair of the Sheffield Carers Centre.

For the CCG, Amanda chairs the Quality Assurance Committee and is Vice Chair of the Audit and Integrated Governance Committee. She is also a member of the Remuneration Committee, the Primary Care Commissioning Committee and the Strategic Patient Engagement, Experience and Equality 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. Mandy was elected as the Deputy Chair of the CCG with effect from 1 April 2019.

Mark Gamsu

Mark is a professor at Leeds Beckett University. He believes that if people's health and wellbeing are 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.

Mark chairs the Strategic Public Engagement, Experience and Equalities Committee (SPEEEC) which supports the CCG improve the way it consults, collaborates and engages with people in Sheffield. He is also vice chair of the Primary Care Commissioning Committee. 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

Chris Nield

Chris is keen to help make a difference to the health and wellbeing of the Sheffield community, particularly in the areas of health inequalities and mental health. She recognises and values the skills and talents of local people in influencing the health of their communities.

Chris started her career teaching in Sheffield. She moved to public health working as a public health consultant in Nottingham and then Sheffield. Throughout her public health career, Chris has led public health work in communities, primary care and mental health and wellbeing. She is an associate lecturer at Hallam University and an honorary lecturer at Sheffield University. Chris is Chair of the Primary Care Commissioning Committee.

Anthea Morris (wef – 01.04.19)

Anthea is the CCG Lay Member for audit and governance as well as the conflicts of interest Guardian. She is Chair of the CCG's Audit and Integrated Governance Committee and a member of Governing Body and Remuneration Committee. Anthea believes that strong governance is at the heart of any successful organisation which wants to achieve its strategic aims and can help to further improve the health and well-being service in Sheffield.

Anthea has extensive experience over the last 20 years in the NHS, public, private and charitable sectors, including being: Audit Chair and Vice-Chair of the Governing Body at NHS Doncaster CCG, Co-Founder of Better2Know, Strategic Advisor for Nyangao Hospital in Tanzania, Treasurer for the FPA charity, Audit Committee Member for South Yorkshire Police and Crime Commissioner, Finance Director of the Centre of Excellence for Life Sciences and Financial Controller of Citizens Advice. Anthea has an MA in Management and is a Chartered Accountant and Chartered Member of the Chartered Institute of Personnel and Development.

Secondary Care Specialist Doctor

Following the resignation of Dr Chris Whale this role remains vacant

Profiles of members who ceased to be members of Governing Body during 2019-20

Dr Tim Moorhead - Chair and West Locality Nominated GP Representative – 1.4.13 to 30.08.19

Dr Tim Moorhead stood down as Chair, as well as nominated GP representative for West Locality, in August 2019, having undertaken these roles since the inception of the CCG in 2013.

Dr Tim Moorhead has been a GP for 24 years and is Senior Partner at Oughtibridge Surgery. In his role of Chair, Tim led and inspired the CCG to improve health services in the city and he was particularly committed to making sure we accelerate the improvement of health for those people who are most vulnerable or disadvantaged. Tim's GP experience enabled him to understand what patients want and need, and it is because of this that he always made sure patients were at the heart of our decisions. Tim had a national profile through his work with NHS Clinical Commissioners and was dedicated to influencing government around key issues and challenges facing health and social care and patients. He was also co-chair of the Sheffield Health and Wellbeing Board with the Local Authority.

Maddy Ruff - Accountable Officer – 01.09.15 to 09.06.19

Maddy Ruff resigned from the CCG in June 2019 to take up a new post with a neighbouring Integrated Care System, having served as Accountable Officer for almost 4 years. She had over 28 years' NHS experience, 17 years working in a variety of board-level positions. Maddy was committed to achieving organisational success and driving improvement through her passion and energy, engaging and inspiring others. Maddy was passionate about delivering high quality healthcare services to improve the health of everyone in the city.

Julia Newton - Director of Finance – 01.04.13 to 31.05.19

Julia retired in May 2019 after a long and successful career in NHS Finance. Julia was appointed as Director of Finance at NHS Sheffield CCG in July 2012, having previously served as Director of Finance for Sheffield PCT since October 2006. A Chartered Accountant, Julia held several senior finance posts since joining the NHS in 1992.

Mandy Philbin, Chief Nurse – 25.09.17 to 12.01.20

Mandy stood down from the CCG Governing Body in January 2020 to take up a secondment as quality lead within the South Yorkshire and Bassetlaw Integrated Care System. Mandy started her career as an auxiliary nurse in 1985. Her love for nursing subsequently saw her complete both enrolled and registered nurse training. By working in the health care setting for over 34 years, Mandy has gained experience working across hospital, community and hospice transformation programmes. She attained an MSc in Leadership in Health and Social Care from Bradford University and in 2016 completed the NHS Leadership Academy's Nye Bevan.

Chris Whale, Secondary Care Specialist Doctor - 01.07.17 to 31.08.19

Originating from South Yorkshire, Chris' role on the Governing Body as Secondary Care Doctor gave him the chance to help improve health outcomes in the main city of his home county. Chris' main clinical role is working as a Consultant Chest and General Physician at the University Hospitals of Derby and Burton, where he also has a leadership role as Divisional Medical Director. Chris lives on the edge of the Peak District with his wife and young family, trying to find time for his favourite pursuits of road cycling and cricket.

Dr Annie Majoka – 01.01.17 to 30.06.19

Dr Annie 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 passionate about the NHS, and is keen to be part of any changes to improve healthcare services in the region.

Dr Leigh Sorsbie - (North Locality GP Representative 01.04.13 – 31.08.19)

Dr Sorsbie resigned from her role as Locality Appointed GP for North Locality in August 2019. As noted above, she took up the role of GP Elected member from November 2019.

1.4 Appointments to Governing Body in Year

The following appointments were made to our Governing Body during 2019/20. Each of the appointments were made in accordance with the Standing Orders set out within the CCG's Constitution

- Dr Terry Hudsen was appointed as Chair and West Locality Appointed GP for a three year term with effect from 1 September 2019.
- Dr Marion Sloan – re-elected GP Elected member
- Dr Nikki Bates – re-elected GP Elected member
- Dr Leigh Sorsbie – GP Elected member
- Dr Lisa Philip – GP Elected member
- Dr David Warwicker – Locality Appointed GP
- Dr Andrew McGinty – Locality Appointed GP
- Anthea Morris – Lay Member
- Lesley Smith – Interim Accountable Officer
- Alun Windle – Acting Chief Nurse
- Jackie Mills – Interim Director of Finance

1.5 Member practices

The following is a list of all of NHS Sheffield CCG's 79 GP member practices listed by locality.

Central Locality (21)	Hallam and South Locality (22)
Abbey Lane Surgery	Birley Health Centre
Baslow Rd, Shoreham Street and York Road Surgeries	Carterknowle Surgery
Carrfield Medical Centre	Charnock Primary Care Centre
Clover City Practice	Crystal Peaks Medical Centre
Clover Group Practice	Falkland House Surgery
Darnall Health Centre (Mehrotra)	Greystones Medical Centre
Dovercourt Group Practice	Hackenthorpe Medical Centre
Duke Medical Centre	Jaunty Springs Health Centre
East Bank Medical Centre	Manchester Road Surgery
Gleadless Medical Centre	Meadowgreen Health Centre
Handsworth Medical Practice	Mosborough Health Centre
Heeley Green Surgery	Nethergreen Surgery
Manor Park Medical Centre	Owlthorpe Surgery
Norfolk Park Health Centre	Richmond Medical Centre
Sharrow Lane Medical Centre	Rustlings Road Medical Centre
The Sloan Medical Centre	Selbourne Road Medical Centre
The Matthews Practice	Sothall Medical Centre
The Medical Centre	Stonecroft Medical Centre
Veritas Health Centre	The Avenue Medical Centre
The White House Surgery	The Hollies Medical Centre
Woodseats Medical Centre	Totley Rise Medical Centre
	Woodhouse Health Centre
North Locality (20)	**West Locality (16)**
Barnsley Road Surgery	Broomhill and Lodge Moor Surgeries
Buchanan Road Surgery	Deepcar Medical Centre
Burngreave Surgery	Devonshire Green and Hanover Medical Centres
Chapelgreen Practice	Dykes Hall Medical Centre
Dunninc Road Surgery	Far Lane Medical Centre
Ecclesfield Group Practice	Harold Street Medical Centre
Elm Lane Surgery	Oughtibridge Surgery
Firth Park Surgery	Porterbrook Medical Centre
Forge Health Group	Stannington Medical Centre
Foxhill Medical Centre	The Crookes Practice
Grenoside Surgery	Dr Milner and Partners
Mill Road Surgery	Tramways Medical Centre (O'Connell)
Norwood Medical Centre	University Health Service Health Centre
Page Hall Medical Centre	Upperthorpe Medical Centre
Sheffield Medical Centre	Valley Medical Centre
Shiregreen Medical Centre	Walkley House Medical Centre
Southey Green Medical Centre	
The Healthcare Surgery	
Upwell Street Surgery	
Wincobank Medical Centre	

1.6 Committees, including Audit and Integrated Governance Committee

The Governing Body has five directly reporting committees as follows:

- Primary Care Commissioning Committee
- Audit and Integrated Governance Committee
- Quality Assurance Committee
- Remuneration Committee
- Strategic Patient Engagement, Experience and Equality Committee

Highlights from each of the committees are detailed in the Governance Statement on page 56 onwards.

1.7 Audit and Integrated Governance Committee

Core members of the Audit and Integrated Governance Committee throughout 2019/20 include:

- Anthea Morris, Lay Member (Chair and Conflicts of Interest Guardian)
- Chris Nield, Lay Member
- Amanda Forrest, Lay Member (Deputy Chair)
- Dr Andrew McGinty
- Dr Lisa Philips

The Committee includes the following regular attendees:

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

Further details of the work of the Audit and Integrated Governance Committee can be found on page 56 of the Governance Statement.

1.8 Register of Interests of Governing Body Members

The CCG maintains a number of Registers of Interests. 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 and Procedure which was reviewed and updated in September 2017 in line with NHS England's: Managing Conflicts of Interest Statutory Guidance for CCGs.

1.9 Personal data related incidents

There were no serious untoward incidents relating to data security breaches, including any that were reported to the Information Commissioner during 2019-20.

1.10 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 CCG'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.

1.11 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.

1.12 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 Lesley Smith to be the Accountable Officer of NHS Sheffield Clinical Commissioning Group.

The responsibilities of an accountable officer 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. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- 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 quality of services (in accordance with Section14R 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 a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts 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 income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual 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 Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that KPMG LLP (UK) auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Lesley Smith
Accountable Officer

18 June 2020

Governance Statement

1 Introduction

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

The CCGs 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 2019, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

2 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my CCG 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

The main function of the Governing Body is to ensure that the group 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 that are relevant to it.

3.1 The Clinical Commissioning Group Governance Framework

Our Constitution sets out arrangements for the exercise of our functions and governance arrangements, and that the CCG will, at all times, observe generally accepted principles of good governance which include:

- Strive towards the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business
- The Good Governance Standard for Public Services
- The Seven Key Principles of the NHS Constitution
- The standards of behaviour published by the Committee on Standards in Public Life (1995) known as the Nolan Principles
- The Equality Act
- Standards for Members of NHS Boards and Governing Bodies in England

NHS Sheffield is a clinically led, member organisation comprising 79 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. Each practice has a registered key representative who is appointed to vote on behalf of their practice. Each practice is aligned to one of four localities across the city. A full list of member practices is set out within the Accountability Report on page 39..

Organisational structure and accountabilities are clear and well defined. Where capacity and / or capability gaps have been identified, actions have been put into place with expected outcomes and timescales. Sheffield CCG clearly articulated its values to stakeholders through its Commissioning Intentions for 2019/2020.

In March 2019, the CCG received feedback from an independent 360 assessment that highlighted some work was needed to ensure we returned to being a great place to work and to become an outstanding CCG. Our staff were extensively involved in developing an improvement plan and a steering group was established to oversee the development of the plan which was chaired by a lay member. The improvement plan was agreed by our Governing Body on 4 July and supported by our partners including Healthwatch, our local Overview and Scrutiny Committee and NHS England / NHS Improvement.

The Governing Body takes overall responsibility for governance throughout the organisation but discharges some of its responsibilities to a number of committees. The following committees have been established by the Governing Body.

a) Audit and Integrated Governance Committee
b) Primary Care Commissioning Committee
c) Remuneration Committee
d) Quality Assurance Committee
e) Strategic Patient Engagement, Experience and Equality Committee
f) Governance Sub-committee

A full list of committees, including their responsibilities, membership and key highlights are set out at paragraph 3.3 of this Statement. In addition to governance, the Governing Body and its delegated committees place a clear focus on the services, performance and patient safety of its commissioned providers.

CCGs are statutory bodies established under the NHS Act 2006 (the 2006 Act) as amended by the Health and Social Care Act 2012. Legislation requires that each CCG maintains and publishes a Constitution which contains specific information.

The CCG has established a properly constituted Governing Body with the appropriate clinical, managerial and lay member skill mix, including: 4 locality nominated GPs, 4 elected GPs, a secondary care specialist doctor*, a registered nurse, four independent lay members, the Accountable Officer, Director of Finance, Director of Delivery, Care Outside of Hospital and the Director of Commissioning and Performance. Details of the membership and attendance of those members are set out on page 55.

3.2 NHS Sheffield CCG Constitution

Legislation requires that each CCG maintains and publishes a Constitution which contains specific information. NHS Sheffield CCG adopted the initial model Constitution as recommended by NHS England as part of its authorisation back in January 2013.

In September 2018, NHS England issued a suggested revised model Constitution which takes account of changes to legislation, CCG accountability frameworks and wider developments such as creation of Integrated Care Systems which have taken place over the last few years. The revised model also looks to the future in an attempt to facilitate a greater degree of flexibility for CCGs whilst maintaining high levels of transparency and accountability.

Following consideration and considerable debate, the Governing Body approved in principle at its meeting on 1 November 2018, to adopt the new model Constitution appending a full suite of Committee Terms of Reference together with the Scheme of Reservation and Delegation, Standing Orders, Prime Financial Policies and which now includes Standing Financial Instructions. The final draft Constitution and its attachments were approved by our Governing Body at its meeting on 2 May 2019, followed by agreement from our Member Practices. Approval to our Constitution was granted by NHS England / NHS Improvement in September 2019 and is accessible via the CCG webpage.

Our Constitution sets out the arrangements we have made to meet our responsibilities for commissioning care for the people for whom we are responsible. It describes the governing principals, rules and procedures that ensure probity and accountability in the day to day running of the CCG to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to our goals.

Our Constitution details:

- Membership and area covered
- Arrangements for the exercise of our functions including good governance
- Procedures for making decisions
- The Governing Body and its Committees
- Collaborative commissioning arrangements
- Provisions for conflict of interest management and standards of business conduct and managing conflicts of interest
- The CCG as an employer
- Transparency, ways of working and standing orders

The CCG's Scheme of Delegation defines those decisions that are reserved to the CCG Membership and which are delegated to the Governing Body, its committees and sub-committees and key officers of the CCG.

The CCG works in collaboration with a wide range of local NHS partners and clinical networks to commission service improvement priorities from a range of NHS, voluntary, private and independent sector service providers. In addition, a number of other partnership arrangements are in place, including the CCG's membership of the local Health and Wellbeing Board and collaborative commissioning network.

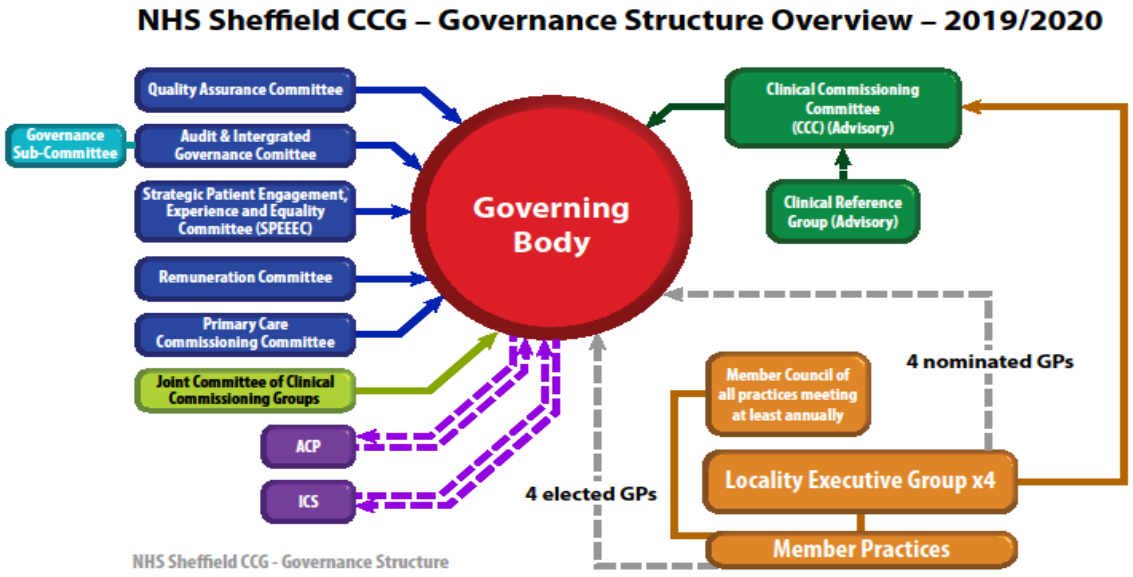
External to the management structure, Internal Audit has an important role in the risk assessment of the CCG by advising on the achievement of corporate governance requirements, providing independent assessment and opinion to the Audit and Integrated Governance Committee, Governing Body and individual managers. An annual work plan is agreed between the Head of Internal Audit and the Director of Finance and is approved by the Audit and Integrated Governance Committee. Progress reports are presented to each meeting of the Audit and Integrated Governance Committee, including an update on progress against agreed recommendations.

The CCG has maintained a comprehensive governance framework that adheres to recognised standards of best practice. It has established and maintained support structures which adopt an integrated governance approach to its risk and control framework. The Governing Body receive and discuss performance reports with regard to the high level risk management system and processes. Governing Body is subject to statutory/mandatory training. Training and development is provided through Organisation Development (OD) workshops and individual need as identified through appraisals.

3.3 Governing Body, Committees, Sub-committees and Joint Committees of the Governing Body

The governance or accountability structure (Fig 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.

Fig 1



NHS Sheffield CCG is a member of The Joint Committee of Clinical Commissioning Groups (JCCC), along with NHS Barnsley, NHS Bassetlaw, NHS Doncaster, and NHS Rotherham CCGs. The JCCC has delegated authority to make decisions only in relation to two specific service areas: hyper acute stroke services and some out of hours children's surgery and anaesthesia services.

3.3.1 Governing Body

The Governing Body has responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance. The Governing Body met 8 times in public during 2019-2020. The attendance of Governing Body members is shown in the table below.

Attendance at Governing Body Meetings

Membership	Role	Attendance	
		Actual	Poss
Dr Amir Afzal	GP Locality representative - Central	7	8
Dr Nikki Bates	GP Elected Citywide Representative	7	8
Nicki Doherty	Director of Delivery – Care Outside of Hospital	8	8
Amanda Forrest	Lay Member	8	8
Mark Gamsu	Lay Member	7	8
Dr Terry Hudsen (to 31.08.19)	Elected Citywide GP Representative	2	3
Dr Terry Hudsen (wef 01.09.19)	Locality representative (West) and CCG Chair	5	5
Brian Hughes	Director of Commissioning and Performance	7	8
Andrew McGinty (wef 01.08.19)	GP Locality Representative Hallam and South	5	5
Dr Annie Majoka (to 30.06.19)	Elected Citywide GP Representative	1	2
Jackie Mills (wef 01.06.19)	Director of Finance	6	6
Dr Zak McMurray	Medical Director	3	8
Dr Tim Moorhead (to 31.08.19)	Locality GP representative – West CCG Chair	2	3
Anthea Morris (wef 01.04.19)	Lay Member	8	8
Julia Newton (to 31.05.19)	Director of Finance	2	2
Chris Nield	Lay Member	8	8
Mandy Philbin (to 12.01.20)	Chief Nurse	4	6
Dr Lisa Philip (wef 01.12.19)	Elected Citywide GP Representative	3	3
Maddy Ruff (to 12.06.19)	Accountable Officer	0	2
Lesley Smith (wef 13.06.19)	Accountable Officer	6	6

Membership	Role	Attendance	
		Actual	Poss
Dr Marion Sloan	GP Elected Citywide Representative	8	8
Leigh Sorsbie (to 31.08.19)	Locality GP representative – North	3	3
Leigh Sorsbie (wef 01.11.19)	Elected Citywide GP Representative	3	4
Dr David Warwicker (wef 01.09.19)	Locality GP Representative, North	5	5
Dr Chris Whale (to 31.08.19)	Secondary Care Specialist Doctor	4	4
Alun Windle (from 13.01.20)	Acting Chief Nurse	1	2

3.3.2 Committees and their Remit

The remit of each committee, together with the key performance highlights for this year are summarised in the tables below:

AUDIT AND INTEGRATED GOVERNANCE COMMITTEE
Key Role and Responsibilities
The Committee is chaired by the Lay Member with responsibility for financial strategy and governance and is also the Conflicts of Interest Guardian. Membership of the audit committee has changed during the year with a new chair and two new GP members. In order for the induction of all members to be completed, the self-assessment for 2019-20 has been delayed until the summer of 2020 to enable a fair assessment to undertaken, the results of which will be used to determine future actions including any additional training for its members. Members of the committee agreed to move to the Internal Audit assessment tool when undertaking the 2020 review. 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 prior to 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 both the Governance Sub-committee and the Quality Assurance Committee and on-going dialogue with internal and external auditors. It has met on 4 occasions during the year, considering relevant issues in line with its annual work plan.
Key Performance Highlights
• Approval of the annual programme of work to be undertaken

- Receiving and reviewing updates from external audit, following approval of the annual plan for the March 2020 year end.
- Review of Internal Audit and Counter Fraud Services; approval of annual plans and in year monitoring of 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.
- Annual review of the CCG's Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies
- Approval of the CCG's Risk Management Strategy and Action Plan.
- Receiving and noting updates on guidance on conflicts of interest
- Review of Registers of Interests, procurement and gifts and hospitality and sponsorship
- 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 in May 2019

PRIMARY CARE COMMISSIONING COMMITTEE

Key Role and Responsibilities:

The CCG formally took over delegated Co-commissioning responsibility for primary care medical services with effect from 1 April 2016 following taking full delegated responsibility for the commissioning of Primary Care Medical Services. The Committee functions as a corporate decision making body for the management of the delegated functions and the exercise of delegated powers. The Committee has been established in accordance with statutory provisions to enable its members to make collective decisions on the review, planning and procurement of primary care services in Sheffield under delegated authority from NHS England.

Key Performance Highlights

During 2019/20 the Committee:

- Approved the establishment of 15 Primary Care Networks across Sheffield in response to the NHS Long Term Plan and GP Contract Reform
- Approved a number of practice mergers
- Governance Sub-committee approved plans and related spend in regard to Sheffield CCG GP Forward View (GPFV) strategy
- Considered regular reports on the practices within Sheffield and agreed appropriate actions to improve service quality and delivery where necessary.
- Monitored CCG progress to deliver primary care estates developments identified as part of the successful ICS Wave 4 Capital Bid
- Approved the Primary Care Annual and Financial Plan for 2020/21
- Approved the allocation of the CCG Primary Care Transformation Fund which was developed to support new ways of working across primary care

neighbourhoods

- Approved a local incentive scheme to ensure all Sheffield residents are able to access services offered by new Primary Care Networks
- Reviewed the future operation of the Committee in the context of the emerging SYB ICS and Sheffield ACS.
- Approved a number of practice mergers
- Reviewed progress against the Sheffield Primary Care Estates Strategy
- Considered the best use of void space in primary care buildings in the context of the Estates Strategy.
- Considered plans to increase practice resilience in Sheffield including workforce recruitment and retention.
- Approved plans and related spend in regard to Sheffield CCG GP Forward View (GPFV) strategy
- Monitored and approved actions related to the formal consultation on urgent primary care. Agreed a way forward plus move to ICS leadership and ownership.
- Made changes we have made to the way we work in PCCC, including includes how we manage the agenda so that we give priority to the issues which need decisions to make better use of the time at meetings, supporting governance and quality.
- Implemented PCCC development sessions alternating with formal meetings. Sessions this year included patient involvement, primary care contracting principles and decision making, GP Patient Survey Results for 2018/19.

REMUNERATION COMMITTEE

Key Role and Responsibilities

The Remuneration Committee is chaired by a Lay Member. The Committee has delegated authority to determine the remuneration and conditions of service for all Governing Body Members, taking into account any national Directions or guidance on these matters. The Committee has the delegated authority to consider the outcome of any performance review of the Accountable Officer and other senior CCG employees. 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 2019/20 key areas considered by the Committee included:

- Annual review of the Remuneration Committee Terms of Reference and recommendation to Governing Body for approval
- Review and approval of all proposed redundancy business cases
- Review of the remuneration of all Governing Body members and all other staff

in the CCG who are not on Agenda for Change terms and conditions

- Review of the performance of all Directors on Very Senior Manager contracts and determination of appropriate financial awards
- Oversight of the recruitment processes for all other Governing Body members
- Oversight of the exit arrangements for the Accountable Officer and oversight of the subsequent appointment of the Interim Accountable Officer

QUALITY ASSURANCE COMMITTEE

Key Role and Responsibilities

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 across Sheffield. The committee has continued its rolling programme of focussing on a specific provider at each meeting.

During 2019-20 the committee has continued to develop and deliver its responsibilities. Specifically, the committee has achieved good attendance from GP's, Internal Audit and Healthwatch. It has:

- Set out a programme of provider focused sessions at each meeting
- Continued to review the reporting format to streamline exception reporting and highlight provider concerns
- Systematically reviewed provider's performance in relation all areas of quality, including not for profit organisations, Primary Care providers and Sheffield In-area providers that are not directly commissioned by the CCG
- Reviewed feedback relating to providers from the Care Quality Commission (CQC) and other regulatory bodies and taken action with providers where appropriate
- Monitored patient safety issues, including Serious Incidents, 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 and monitored action plans linking with Quality Assurance and contracting process
- Extensively monitored patient experience feedback from providers including provider and public websites
- Reviewed and approved clinical policies and procedures
- Received reviews from Internal Audit that demonstrate effective internal functions of the CCG's Quality Assurance systems (Primary Care Quality Assurance internal Audit March 2019 reported 'significant assurance')
- Planning to undertake further provider Committee to Committee meetings
- Provided quarterly exception reports and recommendations to Governing Body

Strategic Patient Engagement, Experience and Equality Committee

Key Roles and Responsibilities

The Committee has delegated responsibility for approval of the arrangements for discharging the CCG's statutory duties relating to public engagement and consultation and equality. It is responsible for assuring that engagement, patient experience and equality and diversity activity is being carried out in line with statutory requirements and to a high standard and that information from these activities is used appropriately to influence commissioning.

Key Performance Highlights

SPEEEC became a formal governing body committee in November 2017. Since this time, key areas considered by the Committee included:

- Assurance that public and partner involvement influenced the review of challenges facing the urgent care system
- Assurance of the approach to public involvement on the long term plan and local implementation within primary care networks
- Oversight of the review of the Terms of Reference
- Training for members regarding statutory duties on public involvement and equality and assurance tool developed for SPEEEC members
- Assurance on implementation of revised Quality and Equality Impact Assessment process
- Assurance of process for delivery of Equality Delivery System 2
- Assurance of involvement process for Sheffield element of the regional revised IVF commissioning policy
- Assurance of partnership approach to engagement, alongside the local authority, on the SEND inclusion strategy consultation
- Assurance of the impact of public engagement as part of the wider CCG assurance process
- Assurance of the approach to Primary Community Mental Health Services public and partner involvement
- Oversight of proposals relating to Adult Short Breaks
- Oversight of the Communications and Engagement Strategy development
- Oversight of the implementation of the Volunteering Policy implementation

GOVERNANCE SUB-COMMITTEE

Key Roles and Responsibilities

The Governance Sub-committee is 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 providing the AIGC, and ultimately Governing Body, with assurance as both an employer and a statutory body.

It receives reports on high level risks, reviews risk registers and scrutinises any new

organisational risks and their associated risk scores. The Sub-committee also receives reports from a number of sub-groups including information governance and health and safety. Reports to the Sub-committee include quarterly updates in relation to workforce, Freedom of Information requests, 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 for approval of both corporate and HR policies.

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

Key Performance Highlights

- Review of policies throughout the year with significant assurance that the process for review and management of policies is well managed
- Management of Freedom of Information (FOI) requests during the year which has achieved 100% response to requests for information
- 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
- Requests for lessons learned to be included in all future incident reports to governance sub-committee.
- Investigations shared with staff where appropriate
- Assurances received with regard to Information Governance systems and processes, including Data Security and Protection Toolkit, Data Quality, Information Governance Incidents, Compliments and Complaints, Emergency Preparedness, Resilience and Response (EPRR) Framework and Business Continuity Planning, Research Governance
- Positive assurance received in support of health and safety initiatives, premises inspections, security and fire risk assessments
- Scrutinised all major risks from the Corporate Risk Register at every meeting with a particular focus on new risks, major risks and risks that had increased in score. This included reviews of the effectiveness and progress of mitigating actions.
- Robust and detailed workforce reports including sickness absence, statutory and mandatory training, equality and diversity information
- Terms of Reference reviewed and updated to incorporate the Sub-committee's role with regard to its overview of IT Services with effect from 2020
- Received the Annual Health and Safety Report and organisational risk assessment
- Provided assurance to AIGC of the sound systems of internal control, highlighting any areas where further scrutiny may be required

3.4 Committee Membership and Attendance

The table overleaf sets out details of membership and attendance at each of the CCG's committees during 2018/19. Each committee meets quarterly (unless stated otherwise) – all meetings were quorate throughout the year with the exception of SPEEEC which was not quorate on two occasions, however no decisions were made at these meetings.

Committee	Membership	Role	Attendance	
			Actual	Poss
Audit and Integrated Governance	Anthea Morris (From 01.04.19)	Lay Member and Chair	4	4
	Amanda Forrest	Lay Member	4	4
	Chris Nield	Lay Member and Vice Chair	4	4
	Dr Leigh Sorsbie (wef 01.11.19)	Locality Appointed GP Governing Body Member	1	1
	Dr Andrew McGinty (wef 01.08.19)	Locality Appointed GP Governing Body Member	2	3
	Dr David Warwicker (wef 01.09.19)	Locality Appointed GP Governing Body Member	1	1
	Dr Lisa Philip (wef 01.12.19)	GP Elected Member	1	2
Quality Assurance	Amanda Forrest	Lay Member and Chair	4	4
	Mandy Philbin (to 12.01.20)	Chief Nurse and Vice Chair	1	3
	Alun Windle (wef 13.01.20)	Acting Chief Nurse and Vice Chair	1	1
	Prof Mark Gamsu	Lay Member	1	4
	Jane Harriman (to 11.03.20)	Head of Quality	4	4
	Dr Marion Sloan (wef 01.10.19)	CCG GP Lead for Quality	4	4
	Dr Zak McMurray	Medical Director	1	2
	Dr Terry Hudsen (to 31.08.19)	GP Elected Member	2	2
	Dr Andrew McGinty (wef 01.08.19)	Locality Appointed GP Governing Body Member	0	2
	Dr Chris Whale (to 31.08.19)	Secondary Care Doctor	0	1
Primary Care Commissioning Committee (Whilst PCCC would normally meet *least six times per year, the Committee was cancelled in*	Chris Nield	Lay Member and Chair	6	7
	Nicki Doherty	Director of Delivery – Care Outside Hospital	6	7
	Amanda Forrest	Lay Member	5	7
	Prof Mark Gamsu	Lay Member and Deputy Chair	6	7

Committee	Membership	Role	Attendance	
			Actual	Poss
February and March 2020	Julia Newton (to 31.05.19)	Director of Finance	2	2
	Jackie Mills (wef 01.06.19)	Director of Finance	5	5
	Mandy Philbin (to 12.01.20)	Chief Nurse	2	6
	Alun Windle (wef 13.01.20)	Acting Chief Nurse	1	1
	Maddy Ruff (to 09.06.19)	Accountable Officer	0	2
	Lesley Smith (from 13.06.19)	Accountable Officer	1	4
Remuneration Committee	Amanda Forrest (Chair to 31.05.19)	Lay Member and Chair	7	7
	Prof Mark Gamsu (Chair wef 01.06.19)	Lay Member and Chair	7	7
	Dr Amir Afzal	CCG GP Governing Body Member	7	7
	Dr Nikki Bates	CCG GP Governing Body Member	7	7
	Anthea Morris (wef 01.04.19)	Lay Member	7	7
	Dr Annie Majoka (to 30.06.19)	CCG GP Governing Body Member	0	2
	Dr David Warwicker (wef 01.09.19)	CCG GP Governing Body Member	3	3
Strategic Patient Engagement, Experience and Equality Committee (SPEEEC) The March 2020 meeting was cancelled	Prof Mark Gamsu	Lay Member and Chair	5	7
	Parveen Ali	Senior Lecturer in Nursing and Midwifery, with responsibility for equality at SHU	4	7
	Mahara Haque (01.11.19)	Public Lay Member Representative	2	2
	Nicki Doherty	Director of Delivery – Care Outside of Hospital	6	7
	Lucy Ettridge	Deputy Director of Communications. Engagement and Equality	6	7
	Amanda Forrest	Lay Member and Deputy Chair	6	7
	Lea Lapautre (01.11.19)	Public Lay Member Representative	2	2
	Michelle Glossop (wef 01.01.19)	Sheffield City Council Representative	2	7
	Dr Leigh Sorsbie	CCG GP Governing Body	1	2

Committee	Membership	Role	Attendance	
			Actual	Poss
	(From 01.11.19)	Member		
	Dr Lisa Philip (From 01.12.19)	CCG GP Governing Body Member	2	2
	Lucy Davies (07.0719)	Healthwatch Sheffield Representative	3	7
	Richard Kennedy	Engagement, Communications and Equality Lead	6	7
	Helen Mulholland	Engagement Officer	5	7
	Alun Windle (from 13.01.20)	Acting Chief Nurse / Chief Nurse	1	1
	Sarah Neil	Patient Experience Manager	5	7
	Mandy Philbin (to 12.01.20)	Chief Nurse	2	6
	Dr Terry Hudsen	CCG GP Governing Body Member	3	4
	David Foster	Public Lay Member Representative	2	5
	Eleni Chambers	Public Lay Member Representative	4	5

3.5 Other Partnership Arrangements

Joint Committee of Clinical Commissioning Groups

In 2015, the CCG became a member of the Joint Committee of CCGs (JCCCG). Initially the Committee had delegated authority to only make decisions on two service areas (Hyper Acute Stroke Services and some out of hours Children's Surgery and Anaesthesia services). In June 2019, CCGs agreed revised delegated authority for decision making for a new set of priorities, which can be found here

These were accompanied by a revised Manual Agreement, Terms of Reference and Workplan for the JCCCG.

South Yorkshire and Bassetlaw Integrated Care System

The CCG is also a partner in the South Yorkshire and Bassetlaw Integrated Care System (ICS). ICSs are systems in which NHS commissioners and providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and health outcomes. They are expected to make faster progress than other health systems in transforming the way care is delivered, to the benefit of the population they serve.

The ICS does not replace any legal, or statutory, responsibilities of any of the partner organisations.

During 2019/20, the ICS evolved, with some existing groups continuing to meet, and other additional groups meeting:

i) The System Health Oversight Board

The System Health Oversight Board (HOB) is the primary governance group comprising Executive and Non-executive members from across SYB statutory bodies and the regional NHS Bodies. The HOB provides a joint forum between health providers, health commissioners, NHS England and NHS Improvement and other national arm's length bodies, to respond to the national policy direction for health and implementation of the NHS Long Term Plan. A key purpose of the HOB is to give assurance to partners and the regions on progress and delivery and to give strategic direction on healthcare issues. The HOB meets quarterly.

Membership of the HOB is drawn from the SYB health community, the regions and arm's length bodies and includes Chairs from the Mental Health Alliance, Joint Committee of CCGs x 2, Acute Providers Committees in Common, Health and Wellbeing Boards and Healthwatch as well as a lead for Primary Care Networks from each place and the Executive membership.

ii) Health and Care Partnership Board

The Health and Care Partnership Board (CPB) continues the work of the Collaborative Partnership Board, and as well as including the chief executives and accountable officers from acute and mental health hospitals, primary care, commissioning groups, umbrella Voluntary Action organisations, Healthwatch, NHS England and other arms-length bodies it is a key forum for engaging with the chief executives from the local authorities in South Yorkshire and Bassetlaw.

iii) The System Health Executive Group

The System Health Executive Group (HEG) is the primary executive group comprising chief executive and accountable officer members from each health statutory organisations across the ICS and other partner organisations across Yorkshire and the Humber, to plan and deliver strategic health priorities which require collaborative working across the SYB ICS footprint.

iv) The Integrated Assurance Committee

The Integrated Assurance Committee has non-executive and lay member representatives as well as executive membership. The purpose of the Integrated Assurance Committee is to provide assurance to the partners and to regulators on the performance, quality, and financial delivery of health and care services within the five places and across the system in South Yorkshire and Bassetlaw.

v) The ICS System Health and Care Management Team

The ICS System Health and Care Management Team includes accountable officers and chief executives, directors of strategy, transformation and delivery and directors of finance.

vi) Work stream Programme Boards

There is also a range of programme boards responsible for delivering the work streams. These are led by a chief executive and senior responsible officer (an Accountable officer from a clinical commissioning group) and supported by a director of finance and a project manager / workstream lead.

The ICS has evolved from the establishment of a Sustainability and Transformation Partnership in January 2016, an Accountable Care System in April 2017, to then becoming one of the first and most advanced ICS systems in England. A review of governance and ways of working led by an independent expert who engaged with system partners to develop the proposals for new partnership arrangements led to the revised governance that has been introduced in 2019.

Following the publication of the NHS Long Term Plan in January 2019, the ICS has been working with partners, staff, patients, public and stakeholders on the development of a South Yorkshire and Bassetlaw 5 Year Plan which was launched in January 2020.

3.6 Sheffield Accountable Care Partnership (ACP)

The ACP is a partnership comprising seven partners in the City (Sheffield City Council, NHS Sheffield CCG, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust, Primary Care Sheffield Ltd, Voluntary Action Sheffield (VAS)).

The ACP vision, agreed as part of our refreshed 'Shaping Sheffield' plan, outlining our ambitions for the 5 years from 2019-2024, is to develop **'***prevention, well-being and great care together'***.** The partnership works in the context of the general national move towards greater health and care integration set out in the NHS 5 Year Forward View and consolidated by the Long Term Plan; this refresh of 'Shaping Sheffield' largely reaffirmed the direction of travel for the ACP. It built on and refreshed the original Shaping Sheffield strategy developed through city wide events held in 2015 and 2016. The 2015/16 vision was based on key principles of prevention, early help and working together differently. The 2019 plan can be downloaded in full, or in summary form from the ACP website, here: https://www.sheffieldacp.org.uk/about/shaping-sheffield/

The 2019 Shaping Sheffield Plan identifies the following five priorities:

- Starting well
- All age mental health
- Neighbourhood development
- Ageing well
- Promoting prevention (with a focus on reducing smoking prevalence)

Further, in August 2019, the ACP partners' chief executives agreed that their own particular focus as a group (without necessarily narrowing the scope of the broader ACP) would be on developing an integrated and neighbourhood based model of care, particularly for people at risk of needing urgent care; workforce; and prevention – particularly preventing, and mitigating the impact of adverse childhood experiences.

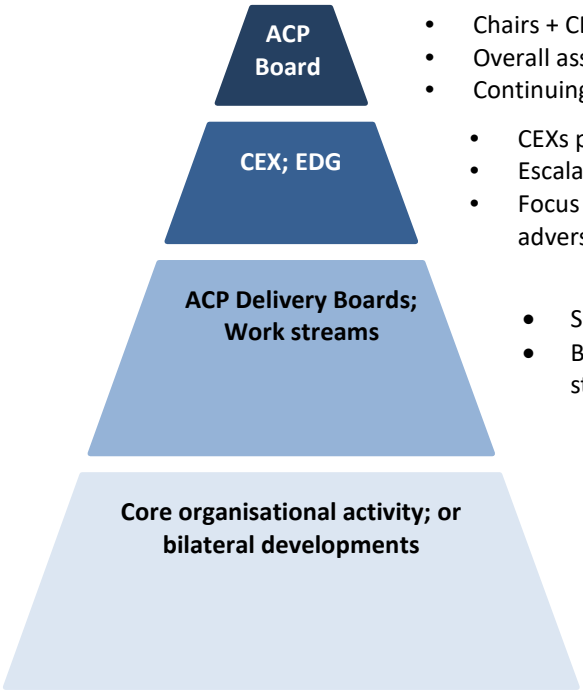
Healthwatch has been appointed as the ACP voluntary sector partner on public and service user voice and is funded to support the ACP on this work, whilst retaining that important independent focus. This arrangement commenced from November 2018, and is currently being reviewed and developed for 2020/21 onwards. This relationship has

provided a great opportunity to build the public and service user voice to the strategic and operational development of the ACP, alongside focusing on agreed priorities, such as older people's experience.

The CCG plays a crucial role throughout all core and enabling workstreams of the ACP, summarised in the diagram below.

Transformation Approach within the ACP

The ACP's transformation structure is as follows:



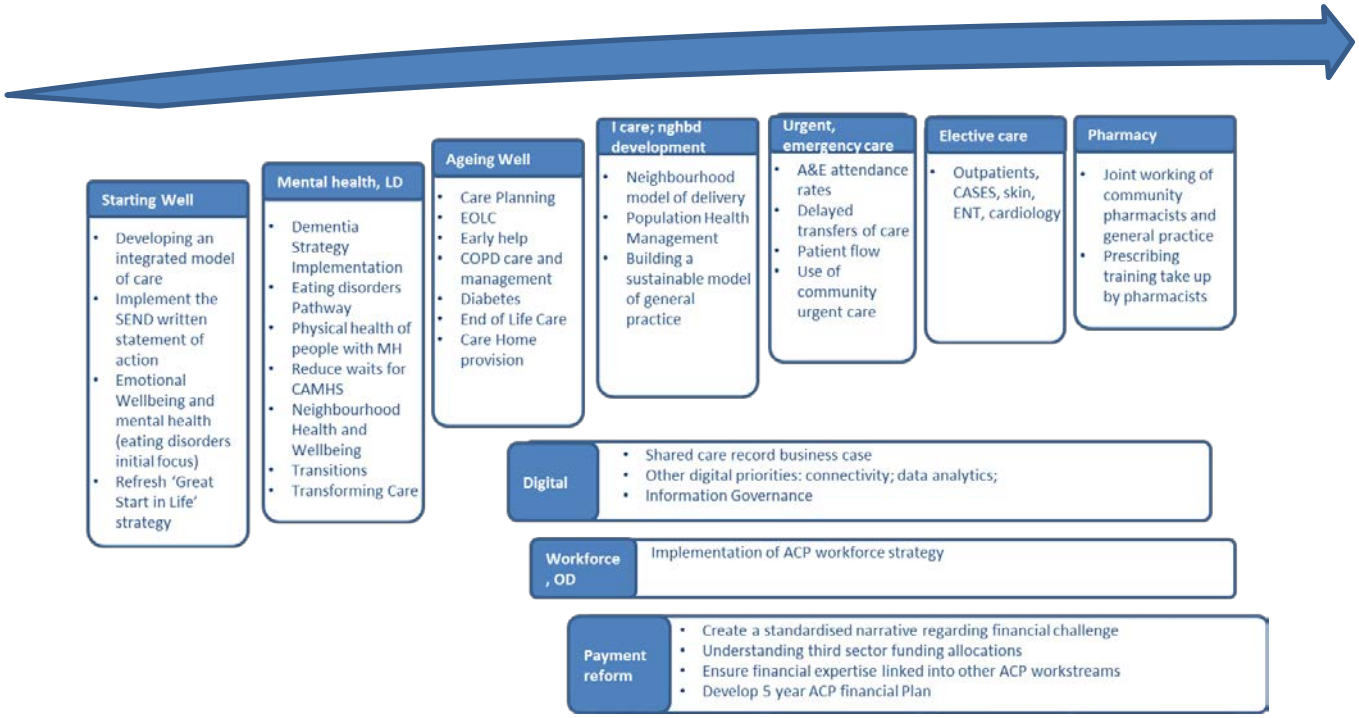
- Chairs + CEXs of ACP partner organisations
- Overall assurance of the work of the ACP;
- Continuing to work through the decision-making structures of partner organisations

- CEXs plus selected other senior officers and clinicians
- Escalation and resolution for work streams
- Focus on three particular areas: integrated model of care; prevention and adverse childhood experiences; workforce

- See below for the set of work streams
- Broad partnership involvement in each work stream

- The ACP ***can*** serve as a helpful way of raising awareness and broadening input to key pieces CEXs plus selected other senior officers and clinicians
- Escalation and resolution for work streams
- Focus on three particular areas: integrated model of

Selected priorities for different delivery boards



The ACP has coordinated the system wide response to the CQC Local System Review which reviewed care for Older People in the city in March 2018. Since then, and through 2019/20, the ACP has provided and published regular reports for the ACP Board.

The city has demonstrated significant outcomes through an ACP way of working across the city, which has been developing for a number of years. There are a number of excellent **models of commissioning and provision** which illustrate excellent partnership working, a population focus and more innovative payment and contracting models, underpinned by strong public and patient co-design and an outcomes focus. Examples and outcomes can be provided on request.

4 UK corporate governance code

NHS bodies are not required to comply with the UK Code of Corporate Governance, however, compliance with relevant principles of the Code is considered appropriate and good practice. This Annual Governance Statement is intended to demonstrate how the CCG has due regard to the principles set out in the Code and which are considered appropriate for CCGs. For the financial year ended 31 March 2020, and up to the date of signing this statement, we had regard to the provisions set out in the code, and applied the principles of the code.

5 Discharge of statutory functions

Arrangements put in place by the CCG and explained within the Constitution, have been developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for the Membership and Governing Body decision and the scheme of delegation.
The Constitution has been extensively reviewed during 2019/20 in line with the new Model Constitution with appropriate legal advice and approval by NHS England and NHS Improvement and which reflects changes to organisation's responsibilities.

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 legislation and regulations. As a result, I can confirm that the CCG 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.

6 Risk management arrangements and effectiveness

6.1 Risk Management Arrangements

A fundamental element of good governance is ensuring a clear and integrated approach to risk management. Leadership of the risk management process is given a high profile within the CCG. As such the CCG's Risk Management Strategy is reviewed annually and

sets out the roles of key personnel in handling and reporting risks. Risk management is built into the strategic planning process and managed operationally with the governance of decision making set out in the organisation's Scheme of Reservation and Delegation (SoRD).

We have a clear and integrated approach to risk management, combined with defined ownership of risk at all levels within the organisation. Identifying and assessing risks at both strategic and organisational levels is a well-embedded process within the CCG. Our Strategy describes how strategic and organisational risks will be identified, managed and monitored in a consistent, systematic and co-ordinated manner.

Organisational risks arising from day-to-day activities are monitored through the Corporate Risk Register and strategic risks are monitored through our Governing Body Assurance Framework (GBAF).

Good risk management is not just about being risk averse, it is also about recognising the potential for events and outcomes to result in opportunities for improvement, as well as threats to success. A 'risk aware' organisation encourages innovation in order to achieve its objectives and exploit opportunities and can do so in confidence that risks are being identified and controlled by senior managers.

Staff are required to bring to the attention of the Senior Management Team (SMT), via their line manager, issues of identified risk and where existing control measures may be considered inadequate. Managers are responsible for supporting and encouraging staff to report adverse incidents and near misses. All staff are responsible for the effective identification, reporting and management of risks within their area of responsibility.

The GBAF is considered by SMT, AIGC and Governing Body on a quarterly basis, providing the Governing Body with a comprehensive method for the effective and focused management of those identified principal risks that arise in meeting our strategic objectives and that risks are being monitored and mitigated, highlighting any exceptions and that action plans are developed and prioritised.

6.2 Capacity to handle risk

The CCG ensures its ongoing capacity to handle risk in a number of ways. The Risk Management Strategy and Action Plan are owned by the AIGC and its members providing leadership to the risk management function. However, risk is considered to be the business of all staff, and managers are expected to lead by example by ensuring that risk management is acknowledged and embedded throughout the organisation as a fundamental part of our approach to good integrated governance.

Risk awareness is a key element of the organisation's approach to risk management, ensuring that all staff understand and are able to discharge their roles and responsibilities in relation to risk. This approach is led by the Corporate Services Risk and Governance

Manager and includes highlighting the need for risk assessments and explanation of, and subsequent support through, the risk management process.

The Governing Body is responsible for ensuring that the CCG consistently follows the principles of good governance applicable to NHS organisations through its Assurance Framework (AF) and other processes including the development of systems and processes for financial and organisational control, clinical governance and risk management. The Director of Finance is designated as the executive director lead for implementing the system of internal control, including the risk management process. All members of SMT are accountable for the effective management of risk within their areas of responsibility. This includes ensuring that appropriate controls are in place and that risk identification and mitigating actions are progressed and monitored.

Risk Management is a key function of the AIGC which meets quarterly and chaired by a Lay Member of the Governing Body. The Committee receives detailed reports on the GBAF as well as the Corporate Risk Register through Governance Sub-committee reports. Prior to review and challenge by the AIGC, SMT meet quarterly to review all high level risks on the GBAF. Additionally, the Governance Sub-committee receives reports on the Corporate Risk Register where all new risks are reviewed and risk scores discussed and confirmed. All high level risks scoring 15 and above are individually reviewed and risks which have remained static for two or more review cycles are also noted.

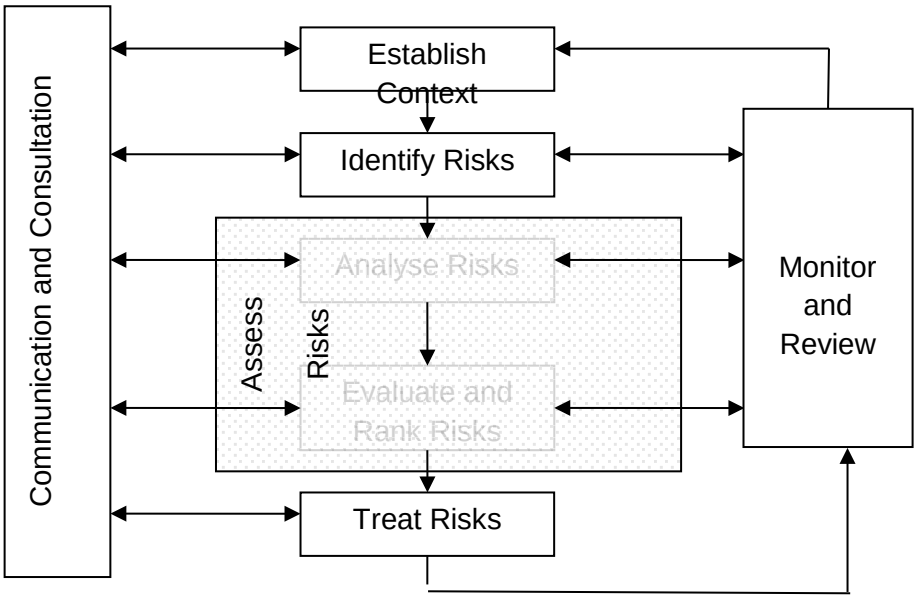
Deputy Directors meet monthly where risk management is a standing item for the agenda. Deputies offer leadership and guidance on mitigating the level of risk and ensuring that risks are appropriately managed. Deputy Directors will also consider potential escalation from team risk logs to the Corporate Risk Register where this is appropriate.

6.2.1 Risk Management Training

Staff are required to attend mandatory risk management training as part of their responsibilities in relation to the Risk Management Strategy and Action Plan. They receive training in relation to identifying, reporting, recording and managing risks, risk assessment and incident reporting. This ensures that risk is seen as the responsibility of all members of staff not only senior managers.

6.3 Risk Assessment

The Risk Management and assessment of risks is governed by the Risk Management Strategy which outlines how all risks are identified, assessed against impact and likelihood and managed through either the Governing Body Assurance Framework (GBAF), the Corporate Risk Register or directorate / team risk logs. A five stage process that can be illustrated as follows is in operation:



The risk assessment will reflect both the likelihood and any consequences of the risk and its potential to:

- Cause death, injury or ill health to individuals or groups
- Result in civil claims/litigation against the CCG, a Governing Body member, or member of staff
- Result in enforcement action to the CCG
- Cause damage to the environment
- Cause property damage / loss
- Impact on the day to day operational issues of the CCG or
- Result in reputational damage to the organisation

The level of risk is assessed using the CCG's 5 x 5 risk matrix by assessing the *likelihood* of the residual risk occurring and *consequences* for the CCG should the event occur. This assessment results in an overall score ranging from 1 to 25 and a risk level of low, medium, high, very high or critical as summarised in the table below.

Risk Stratification 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

All risks included on the GBAF and Corporate Risk Register have three scores:

Initial Risk Score:

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 risk and is used as a benchmark against which the effect of risk management will be measured.

Current Risk Score:

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 risk 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.

6.3.1 Governing Body Assurance Framework (GBAF)

The GBAF is designed to meet the requirements of the 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 achievement of the organisation's objectives. Our GBAF is built around the CCG's 5 strategic objectives and principal risks aligned to the risk register. It is a dynamic tool that maps key controls, highlighting any gaps in control and assurance to mitigate the risks identified, providing a mechanism to assure Governing Body of its effectiveness of these controls.

During 2019/2020, an additional feature was incorporated into the GBAF which sets out the actions identified in order to mitigate the level of risk and monitors achievement of these actions by target date. The Framework 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 Governing Body with confidence that systems and processes are operating in a way that is safe and effective.

Executive directors meet annually with internal audit colleagues to discuss the high level of risk facing delivery of the organisations objectives. Meetings are followed by a 'Confirm and Challenge' session where review and challenge risk scores of all principal risks highlighted on the refreshed framework takes place. The Governing Body was provided with details of the refreshed GBAF at its meeting in March 2019 which included details of the changes to be taken forward to 2019/2020.

Management of the GBAF is the responsibility of the Corporate Services Risk and Governance Manager and is formally received by each executive director risk lead on a quarterly basis. The GBAF is reviewed by the Senior Management Team prior to quarterly presentation to AIGC and Governing Body providing assurance that risks are being monitored and mitigated whilst highlighting any exceptions.

AIGC also reviews any identified gaps in control and / or assurance ensuring these are closed wherever possible. This approach ensures that principal risks are managed effectively towards achieving the target risk score. As the CCG focuses on its role as a commissioner of safe and high quality services, it seeks to embed the principles and practice of risk management into its commissioning function. As a commissioner, the CCG seeks to ensure that all services commissioned meet nationally identified standards which are managed through the contracting process.

At the start of the 2019/20, 18 risks were identified on the GBAF, at the end of the monitoring period 2 risks were closed and no new risks added. 16 risks remained at the end of the monitoring period. The level of risk is set out below.

Review period	Critical	Very High	High	Medium	Low	Risks Closed
Up to and including 16 March 2020	0	2	6	10	0	2
Up to and including 26 November 2019	0	6	6	6	0	0
Up to and including 22 August 2019	0	7	6	5	0	0
Up to and including 14 May 2019	0	7	8	3	0	0

Following review and consideration by SMT 4 strategic risks reduced in score between November 2019 and March 2020 (Quarter 4) – see below for details of these risks and the rational for risk scores:

Risk Ref	Principal Risk	Q3 Risk Score	Q4 Risk Score	Rationale
4.1	Financial plan with insufficient flexibility and resilience to meet investment requirements and in year pressures	16	9	Stress testing of plan in different scenarios and identifying further mitigations to risk should give us the confidence that we can deliver as a minimum our statutory duty of breakeven.
4.2	Joint commissioning arrangements do not progress sufficiently to allow the release of savings across the system to support the transfer of funding to ensure sustainable social and community care.	16	12	SCC and CCG have ambitious integrated commissioning programme, but major changes in services, areas of investment such as prevention and savings in acute services will take time to implement. It will also take time to embed formal joint commissioning arrangements and any extension of risk share arrangements with key providers. This important Place work needs to happen within a changing national and ICS regulatory framework.
4.3	Unable to deliver the QIPP savings plan due to lack of internal capacity and lack of engagement by key partners.	16	6	The financial plan for 2019/20 has a QIPP plan of £15.24m, for which a full programme plan has been developed to achieve the total amount. Whilst some programmes have not delivered the expected efficiency savings, whereas others are forecasting to over deliver. Overall at M10 we are forecasting to deliver £13.6m savings (93% of the planned savings), with sufficient flexibility in the financial plan to manage the shortfall.
5.2	Unable to secure timely and effective shared services in light of required running cost reduction, to enable us to adequately respond and secure delivery to existing and new emerging requirements.	12	6	Current commissioning support arrangements with IT provider will terminate March 2020 and therefore options appraisal process underway in order to define requirements post 2020. Business continuity plans are in place in the event of the contract terminating prior to 31.03.20.

At 31 March 2020, the GBAF identified the following outstanding gaps in control and assurance each of which have robust action plans and have been built into the 2020/2021 Framework

Risk Ref	Principal Risk	Identified Gap in Control / Assurance
2.3	That the CCG commissioning activities fails to impact on the health inequalities and reduced life expectancy of its citizens who experience mental health conditions, as it is unable to influence the societal attitudes that prevail and lead to disparity of investment in mental health services when compared with physical health services. (Parity of Esteem)	This agenda is long term, and reflects the national health inequalities faced by the population with MH conditions. It will not be mitigated within year
5.5	Insufficient internal workforce, talent management and succession planning could lead to inability to monitor and evaluate services while delivering organisational objectives and priorities during transformational changes (Control and Assurance).	Refresh of OD Strategy not yet completed

6.3.2 Corporate Risk Register

The CCG maintains a Corporate Risk Register through a web-based reporting system, which is accessible to all staff via the issue of a login and password and is reviewed on a 13 week cycle. All risks are reviewed by risk owners, senior managers and final reviewers (Directors). Risks are systematically reviewed by the Governance Sub-committee which includes a review of risks identified as 'serious' with a score of 15+ and each new risk added. Assurance is provided to the AIGC and ultimately Governing Body on a quarterly basis that there are systems and processes in place for the effective management of operational risks.

The Corporate Risk Register assesses the original and mitigated risks for their impact and likelihood and tracks the progress of individual risks over time through the standard 5 x 5 risk matrix. Risks which increase in score are subject to additional scrutiny and review. A protocol in support of the risk register is in place and sets out the requirements of risk owners, together with details of reporting arrangements.

The table below identifies the level of risk by risk category at each quarter during 2019/2020.

Quarter	Critical	Very High	High	Medium	Low	Total
4	1	5	17	10	2	35
3	0	4	18	10	5	37
2	0	7	15	10	5	37
1	1	0	19	7	4	31

The following risks were classified as 'critical or 'very high' at the end of Quarter 4:

Risk Type	Risk Rating	Principal Risk
Governance	20	There is a risk that the CCG is unable to deliver its core functions and priorities due to Covid-19 pandemic
QIPP	16	Given the low prescribing outturn in 17/18 and the combination of modest uplift and substantial QIPP targets deducted, the 18/19 prescribing budget has significant risk of overspend. The CCG now has the lowest average cost per item since 2012 and a risk of increased cost pressures in prescribing from category M, no cheaper stock obtainable (NCSO) and transfer of prescribing into primary care remains. The enhanced clinical engagement of prescribers following introduction of the PQIS has shown considerable benefit in counteracting cost pressures, but this support could also be lost if the prescribing budget is set at an unrealistically low level.
Medicines Management	16	In the event of a 'no-deal' Brexit, the government has said there could be six months of delays for medicines to enter the country. As the medicines supply chain operates on a just in time basis, there is a risk that patients will be unable to obtain prescribed medicines. Furthermore, as supplies become limited there will be an increase in the cost of generics, reflected in the Concessionary Price List. This will ultimately have an impact on prescribing costs and make financial predictions difficult
Commissioning	16	Inability of the Sheffield system to meet NHS Constitution pledge on A and E waits leading to potential reputational risks for the CCG and the wider city along. Failing to meet the pledge will also impact on the system's ability to qualify for STF payments.

Commissioning	16	The N3 network is currently end of life the all N3 organisations need to migrate to the new Health and Social Care Network (HSCN) by August 2020. There are financial implications if the CCG does not move to HSCN before this date this at a worst case could be £360k per month.
Commissioning	16	There is a high risk that a current provider of Intermediate Care beds will be unable to continue to provide the current service due to significant financial difficulties.

6.3.3 Impact of COVID-19 virus

In the last month of 2019/2020, the CCG has seen the significant impact of Covid-19 and in response, we have established local system arrangements ensuring business critical functions are able to remain operational. We have supported our staff to enable effective remote working and to maximise their availability, focussing on key priorities in line with national directions and building on and accelerating existing system plans. We have established a Gold, Silver and Bronze command structure reporting through the South Yorkshire and Bassetlaw Local Resilience Forum with focussed cell reporting to Gold Cell on system response. We have maintained a log of information received, issues and risks arising, decisions and actions taken. All risks and issues relating to Covid-19 pandemic are managed through this structure.

7 Other sources of assurance

7.1 Internal Control Framework

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 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.

Staff are involved in risk management, both through the incident reporting process and the proactive management of risk which includes risk management issues identified on agendas, reports and the cover sheets that are presented to the respective Committees. The CCG risk and control framework is based on the methodology and principles outlined in the following publications:

- Integrated Governance Handbook 2006
- A risk matrix for risk managers – NPSA January 2008
- The Intelligent Board 2010
- Good Governance Institute – Good Governance Outcomes for CCGs toolkit 2015
- The Audit Committee Handbook

The following CCG procedural documents support the risk management and assurance processes:

- Risk Management Strategy and Action Plan
- Serious Incidents Policy
- Standards of Business Conduct and Managing Conflicts of Interest Policy and Procedure
- Incident Reporting Policy
- Emergency Preparedness, Resilience and Response Policy
- Business Continuity Policy and Plan
- CCG Constitution incorporating the Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions and Prime Financial Policies
- Health and Safety Policy
- Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy

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. NHS Sheffield CCG has undertaken the annual audit of conflicts of interests and has been assessed as having **Significant Assurance.** The following low level / advisory recommendations were made:

Action / Recommendation	Risk and Score	Actions taken
Liaise with Committee Chairs and Business Managers to remind them what information needs to be recorded in minutes when any conflicts of interest are declared during a meeting	2 x 2 (Low)	Completed
Update the Standards of Business Conduct and Conflicts of Interest Policy to reflect the process for obtaining declarations from suppliers involved in Single Tender Waivers	Advisory	Completed
Consider requesting bidders to submit declarations of interests for all procurement decisions	2 x 2 (Low)	Completed

7.3 Data Quality

All reports received by Governing Body provide information on how they link to the GBAF. The Governing Body receives a monthly Performance, Quality and Outcomes 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. (by local agreement local data is always noted as such to aid transparency). 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. Any queries or feedback are sent back to the Information Team to investigate and the responsible Director (Director of Commissioning and Performance) presents back the answers and additional information. Periodic review of the contents / format helps ensure that processes reflect national changes in focus or monitoring. Joint working across the health economy and across South Yorkshire and Bassetlaw also exposes processes to review.

The Director of Commissioning and Performance is responsible for the use of high quality data throughout the organisation. The Information Governance Team is responsible for the management and monitoring of data quality and provides assurance to the Governance Sub-committee on the data quality processes that are in place. The Sub-committee is responsible for overseeing Data Quality within the CCG and as such:

- Receives such reports to ensure that high quality data is collated and appropriately used throughout the organisation, that data is of a high standard and complies with the Data Protection Act 2018 and General Data Protection Regulation 2018.
- Receives such reports to ensure that the CCG's data is fit for purpose and supports the commissioning of high quality health care and decision making.
- Reviews the associated risks that have been identified through the CCG's Risk Register on the consequences of working with poor quality data.

Regular reviews and audits are completed on our internal data quality checks, processes and reporting frameworks to ensure we consistently quality check the data that is used throughout the organisation.

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 the Data Security and Protection Toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

As an organisation we ensure we always have good practice at all levels of the organisation and strive to be beacons of good practice within the health economy. Staff are encouraged to report all IG breaches when confidential information comes into our organisation to help ensure that the culture of a 'clean' organisation is upheld and that those breaches can be fed back to the responsible provider organisation.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed and implemented information governance processes and procedures in line with the Data Security and Protection Toolkit. We have ensured all staff undertake annual information

governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents (SIs) which are reported and discussed at the Information Governance Group meeting which is chaired by either the Caldicott Guardian or Senior Information Risk Owner (SIRO) for the organisation and feeds into the Governance Sub-committee.

General Data Protection Regulations (GDPR) 2018 and the Data Protection Act 2018 were implemented throughout the CCG in 2018 which included various changes with regards to how the organisation handled confidential information. The changes were successfully communicated to all members of staff and incorporated within our routine practices. The CCG was audited on pre implementation of GDPR which resulted in an outcome of Significant Assurance. Due to the COVID-19 response advising that the organisation's deadline for submitting the toolkit was now extended until September 2020, Sheffield CCG will be reviewing all evidence to ensure everything is fully up to date prior to submission.

The level of compliance demonstrated by completion of the 2018/19 Information Governance (IG) Toolkit is 66% with all standards at a score of at least two, which is deemed by NHS Digital to be satisfactory. Our IG Toolkit is also reviewed by our Internal Auditors and this audit resulted in an outcome of Significant Assurance. 2019/20 is the first year of the new Data Security and Protection Toolkit (known as DSPt). The CCG would have submitted in late March 2020 the 2019/20 version of the DSPt, but the deadlines were nationally extended due to the revised business operations due to COVID19 response.

7.5 Business Critical Models

An appropriate framework and environment is in place via our Business Continuity Policy and 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

NHS Sheffield CCG relies on a number of third party providers for the delivery of key systems.

Service Organisations 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.

For a number of key services, NHS England manages the contracts on behalf of all CCGs. Service Auditor reports have been received by NHS England and shared with CCGs in respect of the following services:

- NHS Shared Business Services for the provision of financial accounting Services
- NHS Business Service Authority regarding Prescription Payment Processes
- NHS Digital regarding the processing of NHS payments and deductions to providers of general practice ("GP") services

At the point of approval of this annual report by Governing Body, the Service Auditor report in respect of services provided by Capita for Primary Care Support Services has not yet been received, although it is currently expected after 19 June. KPMG have noted that 'we substantively test primary care transactions so any control observations are unlikely to impact our audit of the CCG's financial statements'.

In addition to the above Service Auditor Reports, the CCG takes additional assurance from its own internal control procedures. For example, GP Co-commissioning expenditure is monitored against budgets on a monthly basis and is reported to the Primary Care Commissioning Committee.

Up to 31 March 2020, the CCG held a contract for third party support with eMBED Health Consortium in relation to IT services for both corporate and GP IT. Assurance was received through the contract service delivery meetings and contract meetings which are held between the CCG and eMBED. This contract expired on 31 March 2020, and following confirmation from the contract holder that they did not want to exercise the option to extend the current contract, the decision was taken, jointly with Barnsley and Bassetlaw CCGs, to take this service in house, hosted by Sheffield CCG, from 1 April 2020.

North East Commissioning Services (NECS) provides support 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.

Certain support services are shared with local CCGs in South Yorkshire and 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 highlighted, and advises

the Audit and Integrated Governance Committee accordingly. Reports are presented quarterly to the AIGC of all high and medium level risks.

Furthermore the CCG receives independent external assurance from regulatory bodies with which service providers are registered, namely the Care Quality Commission and NHS Improvement.

8 Control issues

The CCG has implemented governance, risk management, and internal control processes and subjected these to both internal scrutiny through the various committees of the Governing Body as well as a comprehensive internal audit programme. There were no control issues identified within the Month 9 Governance Statement return and no issues have arisen subsequently that require reporting in this Governance Statement.

9 Review of economy, efficiency and effectiveness of the use of resources

The Governing Body has oversight of the appropriateness of the organisation's arrangements to exercise its functions effectively, efficiently and economically and as Accountable Officer I have overall executive responsibility for the use of resources.

The following key processes and review and assurance mechanisms have been established in order to ensure proper stewardship of public money and assets:

- Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies are set out within our Constitution to ensure proper stewardship of public money and assets. Clear policies in relation to Standards of Business Conduct are also in place.
- The Procurement Strategy sets out the CCG's approach for establishing contracts that provide value for money in line with the principles of good procurement practice. The Strategy requires the CCG to ensure delivery of improved efficiency and effectiveness in the provision of healthcare and non-healthcare services. The AIGC scrutinises all instances where requirements for formal competitive tendering or quotations have been waived
- The CCG has developed and continues to refine systems and processes to effectively manage financial risks and to secure a stable financial position. The CCG's financial plan was developed for 2019/2020, and budgets set within this plan, and signed off by Governing Body prior to the start of the financial year. These budgets were subsequently communicated to managers and budget holders within the organisation. The Director of Finance and management accountants have worked closely with managers to ensure robust annual budgets were prepared and delivered.
- The CCG had clear internal audit, external audit and counter fraud arrangements which provide independent assurance to the organisation on a range of systems and processes that are designed to deliver economy, efficiency, effectiveness including the Annual Accounts and reporting processes. The Annual Accounts are reviewed

by the Audit and Integrated Governance Committee prior to formal approval by the Governing Body

- A Remuneration and Terms of Service Committee is in place with responsibility for reviewing the remuneration and terms of service for key senior leaders within the CCG. Arrangements are in place to ensure that no member of the Committee is involved in discussions and decisions about their own remuneration
- Robust processes have been implemented to control the development, implementation and monitoring of the CCG's Quality, Innovation, Productivity and Prevention (QIPP) programme. Work is ongoing to develop schemes to achieve the QIPP targets and savings from whole system transformation which form part of future financial plans. A clear process has been developed to ensure monitoring and oversight of these schemes including the establishment of the Integrated QIPP Working Group.

10 Delegation of functions

We have collaborative commissioning arrangements for 999 and Integrated Urgent Care (IUC) services provided by YAS across CCGs in the Yorkshire and Humber region. Assurance is provided via a Memorandum of Understanding and local representation at the Yorkshire and Humber Joint Strategic Partnership Board. Limited delegation in respect of quality and performance matters is in place to the Coordinating commissioner for YAS 999 (Wakefield CCG) services and the IUC service provided by YAS (Greater Huddersfield CCG) through the Memorandum of Understanding.

11 Counter fraud arrangements

The Director of Finance is responsible for ensuring compliance with the NHS Counter Fraud Authority strategy for countering fraud, bribery and corruption and the application of the related NHS Counter Fraud Authority Standards for Commissioners. The CCG undertakes comprehensive risk assessments to identify and manage its fraud, bribery and corruption risks, ensuring that counter fraud activities are prioritised and focussed towards areas of greatest risk.

Our Counter Fraud Service is provided by 360 Assurance and the Local Counter Fraud Specialist attends meetings of the Audit and Integrated Governance Committee to provide updates on progress against the annual work plan and compliance with Standards for Commissioners in the following areas:

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

All concerns of fraud, bribery and corruption at the CCG are referred to the Local Counter Fraud Specialist and addressed in accordance with the CCG's Fraud, Bribery and Corruption Policy. The Local Counter Fraud Specialist reports annually on all work undertaken, including the outcome of investigations.

12 Whistleblowing

The CCG has introduced a policy to enable staff to raise concerns or suspicions about any issues of malpractice at an early stage and in the right way. The policy applies to all employees and any agency or contract staff whilst they are working at the CCG, and is in accordance with the CCG's Equality and Diversity policy. We know from experience that to be successful we must all try to deal with issues on their merits. The CCG welcomes genuine concerns and is committed to dealing responsibly, openly and professionally with them and in this respect we have identified 'Freedom to Speak Up Guardians' who have been trained in receiving concerns and will provide information about where staff can go for more support.

13 Head of internal audit opinion

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

I am providing an Opinion of Significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

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

Area of Audit	Level of Assurance
Governance and Risk Management	Significant
Conflicts of Interest	Significant
Integrity of the General Ledger, Financial Reporting and Key Financial Systems	Significant
Delegated Primary Medical Care Functions	Substantial (NHSE opinion level)
Contract Management Framework	Significant
Data Security and Protection Toolkit	Significant

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
- The Audit and Integrated Governance Committee
- The Governance Sub-committee
- The Quality Assurance Committee
- Internal audit
- The Joint Commissioning Committee
- Other explicit review/assurance mechanisms

Previous sections of this Governance Statement set out our approach to reviewing the ongoing effectiveness of the system of internal control, particularly in relation to the Governing Body and its Committees and Sub-committees. During the year, the Governing Body and AIGC have kept under regular review the application of the system of internal control. With the support of Internal Audit where areas for improvement had been identified, appropriate actions have been taken and changes made to ensure that the systems in place remain robust and effective.

I have also been informed by the broad range of internal and external assurances received by the CCG during the year as set out within the Governing Body Assurance Framework.

All CCGs are held to account by our regulatory body, NHS England / Information (NHSE/I). The former Improvement and Assessment Framework (IAF) which was used to assess CCG performance has been replaced by the National Oversight Framework (NOF). This framework contains the same indicators as the IAF, as well as some new ones. At present, we do not know when the NOF results for 2019-20 will be published; we expect that this will be delayed due to the need for NHSE/I to prioritise the co-ordination of commissioners' response to the COVID-19 pandemic.

One of the indicators in the former IAF which also features the new NOF focusses on Quality of Leadership in CCGs. The most recent assessment available to the CCG was in February 2020, and this showed that we were rated as Amber for this element.

The results of the IAF were previously published on a website called "MyNHS", which has been discontinued due to low usage. The outcome of the National Oversight Framework is expected to be made public on the NHS England website, when the results are announced later in the year. Our results will also be presented to our Governing Body in public when they are available."

14 Conclusion

My review confirms that NHS Sheffield CCG 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.

Lesley Smith
Accountable Officer
18 June 2020

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 65). Governing Body delegates responsibility to the Remuneration Committee, as required as part of the CCG's Constitution, to make decisions or recommendations regarding the appointment, remuneration and conditions of service for employees of the CCG and people who provide services to the CCG

This Committee only determines the reward package of directors and senior managers on locally-determined pay. The vast majority of staff remuneration is determined in accordance with the national NHS pay framework, Agenda for Change.

2. Policy on the remuneration of senior managers

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 the Governing Body as set out in the CCG's Constitution.

Under GDPR rules all named individuals are required to give their consent to disclosure of information within the Remuneration Report. All such disclosures in the Remuneration Report will be consistent with identifiable information of those individuals in the Financial Statements.

Senior Managers remuneration for 2019/20 was determined by the Remuneration Committee, taking account of national guidance, the prevailing economic climate, local market conditions and the requirement to obtain best value for money. The costs of all posts are met from within the notified CCG Running Cost Allowance.

The Committee seeks to apply best practice in the decision making processes when considering individual remuneration. The table below sets out what constitutes the senior managers' remuneration policy:

ELEMENT	POLICY
Base pay	The Remuneration Committee ensure senior managers pay complies with current disclosure requirements for remuneration, on occasion seeking independent advice. The committee ensure that decisions are based on clear and transparent criteria determined by using benchmarked data in order to attract and reward the right calibre of leaders.
Pension	Senior managers are able to join the NHS pension scheme that is available to all staff.
On call payment	Senior managers receive on call payments in line with on call responsibilities.
Benefits	The CCG operates a salary sacrifice schemes including childcare vouchers; these are open to all members of staff.
Travel expenses	Appropriate travel expenses are paid for business mileage.

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.
- 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.

Senior managers' performance is subject to evaluation in the same way as the main staffing body in line with the CCG's 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 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 CCG's strategic and operational plans. 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, and the financial circumstances of the organisation plus any national guidance.

The Accountable Officer, Director of Finance and the Director of Commissioning and Performance are entitled to performance related payments. However the Remuneration Committee agreed that due to the financial pressures faced by the CCG, performance related payments would not be made in relation to 2018/19.

3. Remuneration of Very Senior Managers

There were three Senior Managers on the Governing Body whose salary exceeded £150,000 per annum when adjusted to reflect a full time annualised equivalent post. These posts (CCG Chair and Medical Director) were/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.

Table 1 below details members of the Governing Body and the dates of their contract commencement and expiry.

4. Salary 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 2018/19 within Appendix Bii.

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

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

6. 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.

7. Pension Benefits (subject to audit)

The table at Appendix Biii 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 2019/20.

Table 1: Membership of the Governing Body with dates of contract commencement and expiry

Name	Title	Contract Commencement*	Contract Expiration
Dr Tim Moorhead	Chair Locality Appointed GP	01-Nov-18 01-Nov-14	31-Aug-19 31-Aug-19
Dr Terry Hudsen	Chair GP Elected Member Locality Appointed GP	01-Sep-19 01-Jan-17 01-Sep-19	31-Aug-22 31-Aug-19 31-Aug-22
Mrs Madeline Ruff	Accountable Officer	01-Sep-15	12-Jun-19
Mrs Lesley Smith	Interim Accountable Officer	13-Jun-19	11-Aug-21
Mrs Mandy Philbin	Chief Nurse	25-Sep-17	12-Jan-20
Mr Alun Windle	Acting Chief Nurse	13-Jan-20	12-Jan-21
Miss Julia Newton	Director of Finance	01-Apr-13	31-May-19
Mrs Jackie Mills	Interim Director of Finance	01-Jun-19	30-Sep-20
Ms Nicola Doherty	Director of Delivery - Care Outside of Hospital	03-Nov-17	Substantive Post
Mr Brian Hughes	Director of Commissioning and Performance	29-May-17	Substantive Post
Dr Zak McMurray	Medical Director	01-Apr-13	Substantive Post
Dr Nikki Bates	GP Elected Member	01-Jan-17	31-Dec-22
Dr Marion Sloan	GP Elected Member	01-Oct-13	30-Sep-22
Dr Annie Majoka	GP Elected Member	01-Jan-17	30-Jun-19
Dr Lisa Philip	GP Elected Member	01-Dec-19	30-Nov-22
Dr Leigh Sorsbie	GP Elected Member	01-Nov-19	31-Oct-22
Dr Andrew McGinty	Locality Appointed GP	01-Aug-19	31-Jul-22
Dr Leigh Sorsbie	Locality Appointed GP	01-Nov-14	31-Aug-19
Dr David Warwicker	Locality Appointed GP	01-Sep-19	31-Aug-22
Dr Amir Afzal	Locality Appointed GP	01-Nov-18	31-Oct-21
Ms Chris Nield	Lay Member	01-Jul-18	30-Jun-21
Ms Amanda Forrest	Lay Member and Deputy Chair	01-Jul-13	30-Jun-20
Miss Anthea Morris	Lay Member	01-Apr-19	31-Mar-22
Prof Mark Gamsu	Lay Member	01-Jul-13	30-Jun-20
Dr Christopher Whale	Secondary Care Doctor	01-Jul-17	31-Aug-19

* Contract commencement relates to the date the individual became a voting member of the Governing Body not necessarily the total appointment date.

8. Fair Pay disclosure (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director or 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 CCG is required to include temporary and agency staff in the calculation. 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 director or member of NHS Sheffield Clinical Commissioning Group in the financial year 2019/20 was £146,103 (£144,228 in 2018/19). This was 3.8 (3.9 times in 2019/20) times the median remuneration of the workforce which was £38,168 (£36,903 in 2018/19). The year-on year change to the highest paid member is due to a pay inflation increase.

There has been a minimal 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 2019/20 decreased from 472 employees in 2018/19 to 458 employees. The primary reason for the decrease was a slightly lower turnover of staff throughout the year.

There was a minimum 1.1% pay increase for all staff on Agenda for Change terms and conditions in 2019/20 which the majority of staff received. A higher % pay increase was applied to some staff depending on their pay band increment point with a maximum increase of 13.09%

In 2019/20 there are no employees of the CCG who received remuneration in excess of the highest paid director or member of the CCG's Governing Body (none in 2018/19) reflecting national guidance on the treatment of shared posts. Remuneration for CCG employees ranged from £13,705 to £146,103 where the salary is calculated on an annualised, full-time equivalent basis.

The South Yorkshire and Bassetlaw Integrated Care System (SYandBL ICS) as stated above, is not a statutory body in its own right and therefore is not required to produce a set of accounts or annual report. Sheffield CCG hosts the SYandBL ICS and accounts for national funding received from NHS England specifically for the ICS, some of which is used to fund members of the ICS leadership and staff team. In 2019/20 there was one individual who received remuneration in excess of the highest paid member of the CCG's Governing Body when calculated on an annualised, full-time equivalent basis and excluding shared posts. The remuneration relating to the post was £252,985.

Staff Report

1. Senior Managers

The number of senior managers on Governing Body as at 31st March 2020 is summarised below:

Pay Band	No. of Employees
Senior Managers	6
Of which; Very Senior Managers (VSM)	3

N.B. The figure above excludes the GPs and lay members who are voting members on the Governing Body

2. Staff numbers and costs (subject to audit)

The table below summarises the average number of people employed by Sheffield CCG in 2019/20, 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 (WTE)	327.7	283.9	43.8
Net employee benefit costs in £'000s	19,491	15,392	4,099

Employee benefit costs are shown in more detail in Note 4.1 of the Annual Accounts

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 2020.

	Female	Male
All Employees	260	73
Of which; Very Senior Managers (VSM)	2	1
Of which; Voting Members of the Governing Body	10	8

4. Sickness absence data

Sickness absence is managed in accordance with agreed policies and procedures which include employee wellbeing services of Occupational Health, Counselling, 24/7 Employee Assistance Programme and Physiotherapy.

The Department of Health and Social Care has taken the decision to not commission the sickness absence data production exercise for NHS bodies for 2019/20 data and that each organisation should instead provide a link to the NHS Digital publication series.

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

5. Staff Policies and actions applied during the financial year

We follow a clear governance structure for the approval and ratification of policies for matters relating to current and prospective staff members. Policies are reviewed on a regular basis. 10 policies were reviewed within 2019/20 including the introduction of two new policies – Smoke Free Policy and the Use of E-Cigarettes and Vaping Policy.

Equality impact assessments are completed for all relevant policies and we continue to monitor the impact of the implementation of our workforce policies on all our employees to ensure that we are proactively identifying and addressing any potential inequalities.

Our staff policies capture aspects from the commencement of employment, identifying relevant statutory and mandatory training and ensuring development to support career progressions. Our policies establish minimum expectations in relation to conduct, behaviour and performance as well as supportive approaches to allow staff members to raise matters of concern in a safe and protected way.

We recognise that in order to remove the barriers experienced by individuals with a disability, we need to make reasonable adjustments. We do this on a case by case basis and involve Occupational Health services as appropriate. The principle of reasonable adjustments is embedded throughout all of our staff policies

We are committed to equality of opportunity for all employees and potential employees and we continue to operate fair recruitment practices. We have been re-awarded the 'Disability Confident Employer' status which we use on our recruitment material to encourage applications from applicants with disabilities. As an employer this means we are committed to the following:

- Ensure recruitment processes are inclusive and accessible
- 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 recruitment 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. Facilities time publication

The Trade Union (Facility Time Publication Requirements) regulations 2017 require relevant public sector organisations to report on trade union facility time in their organisations. Facility time is paid time off for union representatives to carry out trade union activities.

Relevant Union Officials: The total number of employees who were relevant union officials during 1 April 2019 to 31 March 2020 was as follows:

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent number*
4	2.5

Percentage of time spent on facility time: The percentage of time spent on facility time during 2019/20 was as follows:

Percentage of time	Number of employees
0%	0
1%-50%	3
51%-99%	0
100%	1

Percentage of pay bill spent on facility time: The percentage of the total pay bill spent on paying employees who were relevant union officials for facility time during 2019/20 was as follows:

Total cost of facility time £	**£6,852**
Total pay bill - £000	**£12,589**
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) × 100	**0.05%**

Paid Trade Union activities: The Time spent on paid trade union activities as a percentage of total paid facility time was as follows:

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: *(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) × 100*	**14.54%**

7. Other Employee Matters

Joint Staff Consultative Forum (JSCF)

The JSCF helps to advise and support the organisation by jointly recognising the maintenance of effective employee relations, employee engagement and employment practice through partnership working with employees and Trade Unions.

The purpose of the JSCF is to:

- Recognise, develop and maintain the efficiency and success of the organisation in commissioning healthcare services on behalf of, and to the benefit of, the local population.
- Ensure that the organisation has effective partnership working arrangements in place in order to consult and negotiate with the workforce and their Trade Unions.
- Promote and maintain mutual trust, respect and co-operation between the organisation, its workforce and their Trade Unions.

Staff Forum

The Staff Forum acts as a bridge between staff and senior management as well as a sounding board for ideas and developments. It's an integral part of our culture and values to encourage two-way communication and employee involvement to provide an interactive opportunity for staff engagement in relation to development and improvement of within NHS Sheffield CCG.

The aims of the group are to:

- Feedback on experiences of what has worked well/less well and what we can learn
- Share ideas of best working practice
- Bring colleagues together to gather views and suggestions across the organisation
- Take ideas forward to create a happy working atmosphere where staff feel valued as a team member

Staff Survey 2020

During March 2020, a staff survey invitation was sent via email to all directly employed staff of the organisation.

This new survey was developed by staff, for staff and gave an opportunity for staff to have their say on what it's like working at Sheffield CCG in a more detailed way than the National NHS Staff Survey does.

The survey is designed to provide insight into opinion on many aspects of staff experience and engagement. The results of which will inform an action plan that is formulated with staff engagement and input.

Health and Safety

We recognise the importance of ensuring the health and safety of our employees as enshrined within the NHS constitution. We strive to provide colleagues with a healthy and safe working environment.

We also take an active interest in the health and wellbeing of our employees. A number of initiatives have taken place throughout the year such as promotion of our trained Mental Health First Aiders, Bullying and Harassment Prevention Training and promotion of our Employee Assistance Programme.

8. Expenditure on consultancy

NHS Sheffield Clinical Commissioning Group spent £714K in total on consultancy services in 2019/20. Of this, £543k related to consultancy services commissioned by the South Yorkshire and Bassetlaw Integrated Care System (ICS), which the CCG hosts, mainly in relation to the Hospital Services Review and transformation projects.

9. 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 £245 per day and that last longer than six months. Payments to GP Practices for the services of employees and GPs are deemed to be 'off-payroll' engagements and are therefore subject to these disclosure requirements.

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.

Table 1: Off-payroll engagements longer than 6 months

The off-payroll engagements as of 31 March 2020 for more than £245 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2020	8
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	6

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.

Table 2: New off-payroll engagements

New off-payroll engagements or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than 6 months are as follows:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	11
Of which:	
Number assessed as falling within the scope of IR35	4
Number assessed as not falling within the scope of IR35	7
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	7
Number of engagements reassessed for consistency / assurance purposes during the year	11
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements / senior official engagements

Table 3 provides information on any off-payroll engagements of Governing Body members and/or senior officials with significant financial responsibility between 01 April 2019 and 31 March 2020.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll of Governing Body members during the financial year (this figure includes both on payroll and off payroll engagements).	24

10. Exit Packages (subject to audit)

The table below details the number and value of the exit packages agreed in 2019/20 (2018/19 £24k).

Table 1: Exit Packages

Exit package cost band (incl. 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	2	12,101			2	12,101		
£10,000 - £25,000								
£25,001 - £50,000								
£50,001- £100,000								
£100,001-£150,000								
£150,001 –£200,000								
>£200,000								
TOTALS	**2**	**12,101**	**0**	**0**	**2**	**12,101**	**0**	**0**

Redundancy costs have been paid in accordance with the provisions of the NHS Pension Scheme.

The exit packages detailed in Table 1 relate to compulsory redundancies for fixed term contracts that ended in 2019/20, one for a Programme manager of the CCG and the other a Communications and Engagement Associate both of whom are not Governing Body members.

Analysis of Other Departures
There were no other departures in 2019/20.

Lesley Smith
Accountable Officer

18 June 2020

Appendix A – Register of Interests, Governing Body 2019/20

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

Remuneration Report: Senior Managers: Salaries and Allowances 2019/20

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

	2019-20					
Name and Title	**Salary** (bands of £5k) £000	**Expense Payments (taxable)** (rounded to the nearest £100) £00	**Performance pay and bonuses** (bands of £5k) £000	**Long term Performance pay and bonuses** (bands of £5k) £000	**All Pension Related Benefits** (bands of £2.5k) £000	**TOTAL** (bands of £5k) £000
T Moorhead Chair of the Governing Body (up to 31 August 2019)	40 - 45	0	0	0	0	40 - 45
T Hudsen Chair of the Governing Body and Locality Appointed GP (from 1 September 2019)	60 - 65	0	0	0	72.5 - 75.0	130 - 135
*M Ruff Accountable Officer (up to 12 June 2019)	30 - 35	0	0	0	2.5 - 5	30 - 35
*L Smith Accountable Officer 0.6 wte (from 13 June 2019)	65 - 70	1	0	0	0	65 - 70
N Doherty Director of Delivery - Care Outside of Hospital	95 - 100	0	0	0	30.0 - 32.5	125 - 130
B Hughes Director of Commissioning and Performance	115 - 120	2	0	0	45.0 - 47.5	160 - 165
Z McMurray Medical Director	110 - 115	0	0	0	0	110 - 115
J Newton Director of Finance (up to 31 May 2019)	20 - 25	0	0	0	0	20 - 25
Jackie Mills Director of Finance (from 1 June 2019)	85 - 90	1	0	0	145.0 - 147.5	230 - 235
M Philbin Chief Nurse (up to 12 January 2020)	70 - 75	1	0	0	47.5 - 50.0	115 - 120
A Windle Chief Nurse (from 13 January 2020)	15 - 20	0	0	0	62.5 - 65.0	80 - 85
N Bates GP Elected Member	10 - 15	0	0	0	0	10 - 15
T Hudsen GP Elected Member (up to 31 August 2019)	5 - 10	0	0	0	Benefit shown in role above	5 - 10
A Majoka GP Elected Member (up to 30 June 2019)	0 - 5	0	0	0	0	0 - 5
L Philip GP Elected Member (from 1 December 2019)	0 - 5	0	0	0	87.5 - 90.0	90 - 95
M Sloan GP Elected Member	10 - 15	0	0	0	0	10 - 15
L Sorsbie GP Elected Member (from 1 November 2019)	5 - 10	0	0	0	5.0 - 7.5	10 - 15
A Afzal Locality Appointed GP	15 - 20	0	0	0	0	15 -20
Dr A McGinty Locality appointed GP (from 1 August 2019)	5 - 10	0	0	0	0	5 - 10
L Sorsbie Locality appointed GP (up to 31 August 2019)	5 - 10	0	0	0	Benefit shown in role above	5 - 10
D Warwicker Locality appointed GP (from 1 September 2019)	5 - 10	0	0	0	17.5 - 20.0	25 - 30
C Whale Secondary Care Doctor (up to 31 August 2019)	0 - 5	0	0	0	0	0 - 5
**A Forrest Lay Member	25 - 30	1	0	0	0	25 - 30
**M Gamsu Lay Member	15 - 20	0	0	0	0	15 - 20
**A Morris Lay Member	10 - 15	0	0	0	0	10 - 15
**C Nield Lay Member	15 - 20	0	0	0	0	15 - 20

Notes

*The Accountable Officer (up to June 2019) M Ruff was employed by Sheffield CCG and as part of this role worked within the South Yorkshire & Bassetlaw Integrated Care System (SY&B ICS) on a 0.4 whole time equivalent basis. As Sheffield CCG hosts the SY&B ICS and accounts for its funding from NHS England, a 100% of M Ruff's costs are shown.

*The Accountable Officer (from June 2019) L Smith is employed by Barnsley CCG and works across both CCGs as Accountable Officer. In line with the guidance on shared posts we are required to show Sheffield CCG's share of the total salary in the table above. As part of these roles she is also Deputy Lead of the South Yorkshire & Bassetlaw Integrated Care System. Her 100% salary across the 3 roles is £152,647.

** Lay member salaries are based on the number of sessions worked, hence the difference to total salary.

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, Director of Finance and Director of Commissioning and Performance are on such a contract, the Remuneration Committee agreed that due to the financial pressures faced by the CCG, performance related payments, payable in 2019/20, would not be made to any staff on Very Senior Manager contracts in relation to 2018/19.

Remuneration Report: Senior Managers: Salaries and Allowances 2018/19

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

	2018-19					
Name and Title	**Salary (bands of £5k) £000**	**Expense Payments (taxable) (rounded to the nearest £100) £00**	**Performance pay and bonuses (bands of £5k) £000**	**Long term Performance pay and bonuses (bands of £5k) £000**	**All Pension Related Benefits (bands of £2.5k) £000**	**TOTAL (bands of £5k) £000**
T Moorhead Chair of the Governing Body	100 - 105	0	0	0	0	100 - 105
**M Ruff Accountable Officer	140 - 145	21	0	0	15.0 - 17.5	160 - 165
N Doherty Director of Delivery - Care Outside of Hospital	90 - 95	1	0	0	42.5 - 45.0	130 - 135
B Hughes Director of Commissioning and Performance	110 - 115	2	0	0	57.5 - 60.0	170 - 175
Z McMurray Medical Director	110 - 115	0	0	0	0	110 - 115
J Newton Director of Finance	115 - 120	1	0	0	7.5 - 10.0	120 - 125
M Philbin Chief Nurse	80 - 85	1	0	0	67.5 - 70.0	150 - 155
N Bates GP Elected Member	10 - 15	0	0	0	10.0 - 12.5	20 - 25
T Hudsen GP Elected Member	10 - 15	0	0	0	225.0 - 227.5	235 - 240
A Majoka GP Elected Member	10 - 15	0	0	0	7.5 - 10.0	20 - 25
M Sloan GP Elected Member	10 - 15	0	0	0	0	10 - 15
A Afzal Locality Appointed GP (from 1 November 2018)	5 - 10	0	0	0	0	5 - 10
N Anumba Locality appointed GP (to 13 May 2018)	0 - 5	0	0	0	0	0 - 5
G Chetty Locality Appointed GP (to 31 July 2018)	0 - 5	0	0	0	0	0 - 5
K Gilgrass Locality Appointed GP (from 14 May 2018 to 31 January 2019)	5 - 10	0	0	0	30.0 - 32.5	40 - 45
J Joyce Locality Appointed GP (voting rights ceased 1 November 2018)	5 - 10	0	0	0	200.0 - 202.5	205 - 210
*L Sorsbie Locality appointed GP (voting rights re-commenced 2 November 2018)	5 - 10	0	0	0	7.5 - 10.0	15 - 20
C Whale Secondary Care Doctor	5 - 10	0	0	0	0	5 - 10
A Forrest Lay Member	15 - 20	6	0	0	0	15 - 20
M Gamsu Lay Member	10 - 15	0	0	0	0	10 - 15
C Nield Lay Member (from 1 July 2018)	10 - 15	0	0	0	0	10 - 15
P Taylor Lay Member and Deputy Chair	10 - 15	0	0	0	0	10 - 15

Notes

*Dr Sorsbie was remunerated whilst on sabbatical for the period up to 2 November 2018, her total salary remuneration was £10k - £15k.

**The Accountable Officer M Ruff is employed by Sheffield CCG and as part of this role works within the South Yorkshire & Bassetlaw Integrated Care System (SY&B ICS) on a 0.4 whole time equivale basis. As Sheffield CCG hosts the SY&B ICS and accounts for its funding from NHS England, a 100% of M Ruff's costs are shown.

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, Director of Finance and Director of Commissioning and Performance are on such a contract, the Remuneration Committee agreed that due to the financial pressures faced by the CCG, performance related payments, payable in 2018/19, would not be made to any staff on Very Senior Manager contracts in relation to 2017/18.

Pension Benefits - 2019-20

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

Name and Title	Real increase in pension age at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020	Employer's Contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
*T Moorhead Chair of the Governing Body (up to 31 August 2019)	0	0	0	0	0	0	0	0
T Hudsen Chair of the Governing Body and Locality Appointed GP (from 1 September 2019)	2.5 - 5.0	7.5 - 10.0	15 - 20	45 - 50	197	45	255	0
M Ruff Accountable Officer (up to 12 June 2019)	0 - 2.5	(0 - 2.5)	50 - 55	150 - 155	1,137	0	1190	0
***L Smith Accountable Officer (from 13 June 2019)	0	0	0	0	0	0	0	0
N Doherty Director of Delivery - Care Outside of Hospital	0 - 2.5	0 - 2.5	15 - 20	30 - 35	233	15	266	0
B Hughes Director of Commissioning and Performance	2.5 - 5.0	0 - 2.5	35 - 40	75 - 80	552	38	618	0
*Z McMurray Medical Director	0	0	0	0	0	0	0	0
***J Newton Director of Finance (up to 31 May 2019)	0	0	0	0	0	0	0	0
J Mills Director of Finance (from 1 June 2019)	5.0 - 7.5	12.5 - 15.0	40 - 45	95 - 100	601	107	759	0
M Philbin Chief Nurse (up to 12 January 2020)	0 - 2.5	0 - 2.5	35 - 40	90 - 95	641	36	715	0
A Windle Chief Nurse (from to 13 January 2020)	0 - 2.5	0 - 2.5	15 - 20	35 - 40	249	10	311	0
*N Bates GP Elected Member	0	0	0	0	0	0	0	0
T Hudsen - GP Elected Member (up to 31 August 2019)	Pension figures shown in Chair role above							
A Majoka GP Elected Member (up to 30 June 2019)	(0 - 2.5)	(0 - 2.5)	10 - 15	25 - 30	178	0	184	0
L Philip GP Elected Member (from 1 December 2019)	0 - 2.5	2.5 - 5.0	5 - 10	20 - 25	70	23	143	0
*M Sloan GP Elected Member	0	0	0	0	0	0	0	0
L Sorsbie GP Elected Member (from 1 November 2019)	0 - 2.5	(0 - 2.5)	10 - 15	30 - 35	255	6	271	0
*A Afzal Locality Appointed GP	0	0	0	0	0	0	0	0
*Dr A McGinty Locality appointed GP (from 1 August 2019)	0	0	0	0	0	0	0	0
L Sorsbie Locality appointed GP (up to 31 August 2019)	Pension figures shown in GP Elected member role above							
****D Warwicker Locality appointed GP (from 1 September 2019)	0 - 2.5	0	5 - 10	0	82	4	95	0
**C Whale Secondary Care Doctor (up to 31 August 2019)	0	0	0	0	0	0	0	0

* Dr McMurray, Dr Moorhead, Dr Sloan, Dr Afzal, Dr Bates & Dr McGinty do not make contributions to the NHS Pension Scheme and hence no information is available to the CCG.
**Dr Whale makes contributions to the NHS Pension Scheme in his full time substantive clinical post and hence this is a nil return.
*** Lesley Smith and Julia Newton do not make contributions to the NHS Pension and hence no information is available to the CCG.
****Dr Warwicker - a lump sum is not automatically payable as contributions are made under the 2008 section of the existing scheme.
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

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. Where the member is in post for part of the year than the Real Increase values are calculated pro rata.

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.

The values in the table are calculated by comparing the accrued pension/lump sum as at 31 March 20 against the accrued pension/lump sum at 31 March 19 which is then adjusted by a factor of 2.4% to account for inflation (2.4% is a figure quoted in the Business Services Authority guidance on the Remuneration Report and is based on the Consumer Price Index). Where the result is a decrease in the pension or lump sum this reflects the fact that the previous years nominally inflated pension/lump sum is higher than the pension/lump sum value as at March 2019 and/or that the remuneration of the individual has decreased in the current financial year compared to the previous financial year.

Parliamentary Accountability and Audit Report

NHS Sheffield Clinical Commissioning Group is not required to produce a Parliamentary Accountability and Audit Report. There are no applicable disclosures about remote contingent liabilities, losses and special payments, gifts, and fees and charges. An audit certificate and report is also included in this annual report.

ANNUAL ACCOUNTS

Lesley Smith

Accountable Officer

18 June 2020

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS SHEFFIELD CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Sheffield Clinical Commissioning Group ("the CCG") for the year ended 31 March 2020 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2020 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2019/20.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Accountable Officer's conclusions we considered the inherent risks to the CCG's operations and analysed how these risks might affect the CCG's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the CCG will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work

we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 51, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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

Report on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the CCG has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 51, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in December 2019 and updated in April 2020 as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Sheffield CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Sheffield CCG for the year ended 31 March 2020 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Clare Partridge
for and on behalf of KPMG LLP
Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA

24 June 2020

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Annual Accounts for the Period

1st April 2019

to 31st March 2020

FOREWORD TO THE ACCOUNTS

NHS SHEFFIELD CLINICAL COMMISSIONING GROUP

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

These accounts for the year ended 31 March 2020 have been prepared by NHS Sheffield Clinical Commissioning Group under section 17 of schedule 1A of the National Health Service Act 2006 (as amended by the Health & Social Care Act 2012) in the form which the Secretary of State has, with the approval of the Treasury, directed.

The National Health Service Act 2006 (as amended by the Health & Social Care Act 2012) requires Clinical Commissioning Groups to prepare their Annual Accounts in accordance with directions issued by NHS England with the approval of the Secretary of State.

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Income from sale of goods and services	2	(4,344)	(2,659)
Other operating income	2	(323)	(463)
Total operating income		**(4,667)**	**(3,122)**
Staff costs	4	19,491	17,213
Purchase of goods and services	5	908,399	862,066
Depreciation and impairment charges	5	87	59
Provision expense	5	-	(5)
Other Operating Expenditure	5	809	718
Total operating expenditure		**928,786**	**880,051**
Net Operating Expenditure		**924,119**	**876,929**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**924,119**	**876,929**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**924,119**	**876,929**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**924,119**	**876,929**

The notes on pages 5 to 26 form part of this statement.

Statement of Financial Position as at 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Non-current assets:			
Property, plant and equipment	8	308	321
Total non-current assets		**308**	**321**
Current assets:			
Trade and other receivables	9	9,849	11,432
Cash and cash equivalents	10	324	139
Total current assets		**10,173**	**11,571**
Total assets		**10,481**	**11,892**
Current liabilities			
Trade and other payables	11	(54,501)	(48,875)
Total current liabilities		**(54,501)**	**(48,875)**
Assets less Liabilities		**(44,020)**	**(36,983)**
Financed by Taxpayers' Equity			
General fund		(44,020)	(36,983)
Total taxpayers' equity:		**(44,020)**	**(36,983)**

The notes on pages 5 to 26 form part of this statement.

The financial statements on pages 1 to 4 were approved by the Governing Body on 18 June 2020 and signed on its behalf by:

Chief Accountable Officer
Lesley Smith

Statement of Changes In Taxpayers Equity for the year ended 31 March 2020

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20				
Balance at 01 April 2019	(36,983)	0	0	**(36,983)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(36,983)**	**0**	**0**	**(36,983)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating expenditure for the financial year	(924,119)			**(924,119)**
Net gain/(loss) on revaluation of property, plant and equipment		0		**0**
Net gain/(loss) on revaluation of intangible assets		0		**0**
Net gain/(loss) on revaluation of financial assets		0		**0**
Total revaluations against revaluation reserve		**0**		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(924,119)**	**0**	**0**	**(924,119)**
Net funding	917,082	0	0	**917,082**
Balance at 31 March 2020	**(44,020)**	**0**	**0**	**(44,020)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(36,411)	0	0	**(36,411)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Impact of applying IFRS 9 to Opening Balances	(2)			(2)
Impact of applying IFRS 15 to Opening Balances	0			0
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(36,413)**	**0**	**0**	**(36,413)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating costs for the financial year	(876,929)			(876,929)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve		0		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(876,929)**	**0**	**0**	**(876,929)**
Net funding	876,359	0	0	876,359
Balance at 31 March 2019	**(36,983)**	**0**	**0**	**(36,983)**

The notes on pages 5 to 26 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(924,119)	(876,929)
Depreciation and amortisation	5	87	59
Impairments and reversals		0	0
Non-cash movements arising on application of new accounting standards		0	(2)
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	9	1,583	(5,777)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	5,646	6,348
Increase/(decrease) in other current liabilities		0	0
Provisions utilised		0	0
Increase/(decrease) in provisions		0	(5)
Net Cash Inflow (Outflow) from Operating Activities		**(916,803)**	(876,306)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(94)	(94)
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**(94)**	(94)
Net Cash Inflow (Outflow) before Financing		**(916,897)**	(876,400)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		917,082	876,359
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**917,082**	876,359
Net Increase (Decrease) in Cash & Cash Equivalents	10	**185**	(41)
Cash & Cash Equivalents at the Beginning of the Financial Year	10	**139**	180
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	10	**324**	**139**

The notes on pages 5 to 26 form part of this statement.

Notes to the Financial Statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2019-20 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

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

1.3 Pooled Budgets

The clinical commissioning group has entered into a pooled budget arrangement with Sheffield City Council [in accordance with section 75 of the NHS Act 2006]. Under the arrangement, funds are pooled for healthcare activities and a note to the accounts provides details of the income and expenditure.

The clinical commissioning group accounts for its share of the income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.4 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.5 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

NHS Sheffield Clinical Commissioning Group are the host for several admin and clinical service functions including Procurement, HR, Individual Funding Requests and Working Together. The provision of these services to other local clinical commissioning groups is the main source of income for NHS Sheffield Clinical Commissioning Group.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

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

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

1.6.2 Retirement Benefit Costs

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

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Notes to the Financial Statements

1 Accounting Policies

1.7 Other Expenses

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

1.8 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.9 Property, Plant & Equipment

1.9.1 Recognition

Property, plant and equipment is capitalised if:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 Measurement

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

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 Subsequent Expenditure

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

1.10 Depreciation, Amortisation & Impairments

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

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

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

1.11 Leases

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

Notes to the Financial Statements

1 Accounting Policies

1.11.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.12 Cash & Cash Equivalents

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

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

1.13 Provisions

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.50% (2018-19: positive 0.29%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 0.51% (2018-19: 0.76%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 0.55% (2018-19:1.14%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.14 Clinical Negligence Costs

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

1.15 Non-clinical Risk Pooling

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

1.16 Contingent liabilities and contingent assets

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

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

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.17 Financial Assets

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

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

Notes to the Financial Statements

1 Accounting Policies

1.17.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.17.2 Financial assets at fair value through other comprehensive income

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.17.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.17.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.18 Financial Liabilities

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

1.18.1 Financial Guarantee Contract Liabilities

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

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

1.18.2 Financial Liabilities at Fair Value Through Profit and Loss

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

1.18.3 Other Financial Liabilities

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

1.19 Value Added Tax

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

1.20 Foreign Currencies

The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.21 Losses & Special Payments

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

Notes to the Financial Statements

1 **Accounting Policies**

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

1.22 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.22.1 **Critical accounting judgements in applying accounting policies**

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

• Operating lease commitments - NHS Sheffield Clinical Commissioning Group has in substance a property lease arrangement with NHS Property Services Ltd relating to the headquarters site. As it has been determined that NHS Sheffield Clinical Commissioning Group has not obtained substantially all the risks and rewards of ownership of this property, the lease has been classified as an operating lease and accounted for accordingly.

1.22.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

• Basis of estimation of key accruals - NHS Sheffield Clinical Commissioning Group has included certain accruals within the financial statements which are estimates. The basis of the estimation of key accruals have been approved by the Director of Finance and reported to the Audit and Integrated Governance Committee. The key areas requiring estimation were healthcare contracts and prescribing expenditure.

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2019-20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2021-22, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – The Standard is effective 1 April 2020 as adapted and interpreted by the FReM.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

The CCG has commenced the assessment of the application of IFRS 16 to its financial statements. This commenced with work to identify leases which are currently operating leases and should be reclassified as finance leases as well as a broader review of recurring expenditure streams where right to use assets may be embedded in contracting arrangements. The work has progressed to March 2020, when the CCG revised it operational priorities and working patterns to deal with the COVID19 pandemic and combined with the decision to defer the implementation of IFRS16 in the NHS to 1 April 2021 means that it has not been practical to complete this work or present it for audit. The work to identify the impact of this standard is expected to recommence in Autumn 2020.

2 Other Operating Revenue

	2019-20 Total £'000	2018-19 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**548**	329
Non-patient care services to other bodies	**2,037**	1,265
Other Contract income	**1,759**	1,025
Recoveries in respect of employee benefits	**0**	40
Total Income from sale of goods and services	**4,344**	**2,659**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	**310**	448
Non cash apprenticeship training grants revenue	**13**	15
Total Other operating income	**323**	**463**
Total Operating Income	**4,667**	**3,122**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the clinical commissioning group and credited to the general fund.

For 2019/20, revenue shown under 'Other Contract income' includes £332k for Accountable Care Partnership services, £196k in relation to the provision of healthcare to refugees, £172k for Better Care Fund services, £160k in relation to Primary Care IT projects, £41k for services provided by development nurses and £29k income for facilities services. Also included is £805k for South Yorkshire & Bassetlaw Integrated Care System (ICS) which the CCG hosts.

For 2018/19, revenue shown under 'Other Contract income' includes £260k for Accountable Care Partnership services, £213k in relation to the provision of healthcare to refugees, £154k for Better Care Fund services, £150k for learning disability transforming care programme, £130k in relation to the transformation of estates and technology, £58k for procurement and contract management and £35k income for facilities services.

2.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000
Source of Revenue			
NHS	-	1,977	1029
Non NHS	548	60	730
Total	**548**	**2,037**	**1,759**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000
Timing of Revenue			
Point in time	-	5	50
Over time	548	2,032	1709
Total	**548**	**2,037**	**1,759**

3 Contract income recognition

No contract income has been recognised in the reporting period that was included within the opening balance of contract liabilities or that is from performance obligations satisfied in a previous reporting period.

All performance obligations in relation to contract income were completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits — Total — 2019-20

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	11,804	3,379	15,183
Social security costs	1,243	362	1,605
Employer Contributions to NHS Pension scheme	2,280	358	2,638
Other pension costs	5	-	5
Apprenticeship Levy	48	-	48
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	12	-	12
Gross employee benefits expenditure	**15,392**	**4,099**	**19,491**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Total - Net admin employee benefits including capitalised costs	**15,392**	**4,099**	**19,491**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**15,392**	**4,099**	**19,491**

4.1.1 Employee benefits — Total — 2018-19

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	11,418	2,570	13,988
Social security costs	1,197	217	1,414
Employer Contributions to NHS Pension scheme	1,538	201	1,739
Other pension costs	3	-	3
Apprenticeship Levy	45	-	45
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	24	-	24
Gross employee benefits expenditure	**14,225**	**2,988**	**17,213**
Less recoveries in respect of employee benefits (note 4.1.2)	(40)	-	(40)
Total - Net admin employee benefits including capitalised costs	**14,185**	**2,988**	**17,173**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**14,185**	**2,988**	**17,173**

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2019-20 Total £'000	2018-19 Total £'000
Employee Benefits - Revenue				
Salaries and wages	(0)	-	(0)	(32)
Social security costs	-	-	-	(4)
Employer contributions to the NHS Pension Scheme	-	-	-	(4)
Other pension costs	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Total recoveries in respect of employee benefits	**(0)**	**-**	**(0)**	**(40)**

4.2 Average number of people employed

	2019-20			2018-19		
	Permanently employed Number	**Other Number**	**Total Number**	**Permanently employed Number**	**Other Number**	**Total Number**
Total	**283.93**	**43.74**	**327.67**	**284.44**	**34.56**	**319.00**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

	2019-20 Compulsory redundancies		**2019-20 Other agreed departures**		**2019-20 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	2	12,102	-	-	2	12,102
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**12,102**	**-**	**-**	**2**	**12,102**

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	1	23,699	-	-	1	23,699
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**23,699**	**-**	**-**	**1**	**23,699**

	2019-20 Departures where special payments have been made		2018-19 Departures where special payments have been made	
	Number	**£**	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous

Redundancy and other departure costs have been paid in accordance with the provisions of the agenda for change terms and conditions and NHS Sheffield Clinical Commission Group's management of organisational change, redundancy and pay protection policy.

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

There have been no non-contractual payments made to individuals where the payment value was more than 12 months' of their annual salary.

Where entities have agreed early retirements, the additional costs are met by the entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that report where applicable.

4.4 Pension costs

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

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

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

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

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

5. Operating expenses

	2019-20 Total £'000	2018-19 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	446	463
Services from foundation trusts	589,105	556,400
Services from other NHS trusts	29,762	28,308
Purchase of healthcare from non-NHS bodies	69,066	63,473
Purchase of social care	21,346	22,085
Prescribing costs	93,215	88,806
Pharmaceutical services	304	308
General Ophthalmic services	351	320
GPMS/APMS and PCTMS	94,993	91,647
Supplies and services – general	3,245	3,030
Consultancy services	714	1,626
Establishment	1,311	1,070
Transport	41	65
Premises	3,800	3,554
Audit fees	48	47
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	7	10
Other professional fees	170	204
Legal fees	158	433
Education, training and conferences	304	202
Non cash apprenticeship training grants	13	15
Total Purchase of goods and services	**908,399**	**862,066**
Depreciation and impairment charges		
Depreciation	87	59
Total Depreciation and impairment charges	**87**	**59**
Provision expense		
Provisions	-	(5)
Total Provision expense	**-**	**(5)**
Other Operating Expenditure		
Chair and Non Executive Members	310	294
Research and development (excluding staff costs)	446	381
Expected credit loss on receivables	(2)	2
Other expenditure	55	41
Total Other Operating Expenditure	**809**	**718**
Total operating expenditure	**909,295**	**862,838**

Auditor Liability - The total aggregate liability of KMPG LLP is limited per the contract to £2 million for all defaults, claims, losses or damages where arising from breach of contract , misrepresentation, tort, breach of statutory duty or otherwise.

NHS Sheffield Clinical Commissioning Group spent £714k in total on consultancy services in 2019/20. Of this, £543k related to consultancy services commissioned by the South Yorkshire & Bassetlaw Integrated Care System (ICS) which the CCG hosts, mainly in relation to the Hospital Services Review and transformation projects.

6.1 Better Payment Practice Code

Measure of compliance	**2019-20 Number**	**2019-20 £'000**	2018-19 **Number**	2018-19 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	16,637	204,796	17,016	200,008
Total Non-NHS Trade Invoices paid within target	16,394	203,790	16,818	199,588
Percentage of Non-NHS Trade invoices paid within target	**98.54%**	**99.51%**	**98.84%**	**99.79%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,083	642,030	4,141	634,773
Total NHS Trade Invoices Paid within target	4,049	640,275	4,083	634,260
Percentage of NHS Trade Invoices paid within target	**99.17%**	**99.73%**	**98.60%**	**99.92%**

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense				**2019-20**				2018-19
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	**Land £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense								
Minimum lease payments	-	442	11	**453**	-	2,865	9	**2,874**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**442**	**11**	**453**	**-**	**2,865**	**9**	**2,874**

Whilst NHS Sheffield Clinical Commissioning Group has an arrangement with NHS Property Services Limited which falls within the definition of operating leases, rental charges for future years have not yet been agreed. Consequently this note does not include future minimum lease payments for the arrangement. The financial value included in the Statement of Comprehensive Net Expenditure for 2019-20 is £442k (2018-19 £1,107k).

7.1.2 Future minimum lease payments				**2019-20**				2018-19
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	**Land £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payable:								
No later than one year	-	-	9	**9**	-	-	35	**35**
Between one and five years	-	-	-	**-**	-	-	9	**9**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**9**	**9**	**-**	**-**	**44**	**44**

8 Property, plant and equipment

2019-20	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2019	415	205	620
Addition of assets under construction and payments on account	-	-	-
Additions purchased	74	-	74
Additions donated	-	-	-
Additions government granted	-	-	-
Additions leased	-	-	-
Reclassifications	-	-	-
Reclassified as held for sale and reversals	-	-	-
Disposals other than by sale	-	-	-
Upward revaluation gains	-	-	-
Impairments charged	-	-	-
Reversal of impairments	-	-	-
Transfer (to)/from other public sector body	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-
Cost/Valuation at 31 March 2020	**489**	**205**	**694**
Depreciation at 01 April 2019	94	205	299
Reclassifications	-	-	-
Reclassified as held for sale and reversals	-	-	-
Disposals other than by sale	-	-	-
Upward revaluation gains	-	-	-
Impairments charged	-	-	-
Reversal of impairments	-	-	-
Charged during the year	87	-	87
Transfer (to)/from other public sector body	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-
Depreciation at 31 March 2020	**181**	**205**	**386**
Net Book Value at 31 March 2020	**308**	**-**	**308**
Purchased	308	-	308
Donated	-	-	-
Government Granted	-	-	-
Total at 31 March 2020	**308**	**-**	**308**
Asset financing:			
Owned	308	-	308
Held on finance lease	-	-	-
On-SOFP Lift contracts	-	-	-
PFI residual: interests	-	-	-
Total at 31 March 2020	**308**	**-**	**308**

Revaluation Reserve Balance for Property, Plant & Equipment

	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2019	-	-	-
Revaluation gains	-	-	-
Impairments	-	-	-
Release to general fund	-	-	-
Other movements	-	-	-
Balance at 31 March 2020	**-**	**-**	**-**

8 Property, plant and equipment cont'd

8.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2019-20 £'000	2018-19 £'000
Land	-	-
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	-	-
Transport equipment	-	-
Information technology	-	-
Furniture & fittings	205	205
Total	**205**	**205**

8.2 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	2	5
Furniture & fittings	0	0

9.1 Trade and other receivables

	Current 2019-20 £'000	Current 2018-19 £'000
NHS receivables: Revenue	1,316	139
NHS prepayments	3,649	3,350
NHS accrued income	866	4,185
NHS Contract Receivable not yet invoiced/non-invoice	800	-
NHS Non Contract trade receivable (i.e. pass through funding)	312	1,196
Non-NHS and Other WGA receivables: Revenue	66	161
Non-NHS and Other WGA prepayments	95	109
Non-NHS and Other WGA accrued income	672	495
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	354	403
Non-NHS and Other WGA Non Contract trade receivable (i.e. pass through funding)	1,602	1,229
Expected credit loss allowance-receivables	(2)	(4)
VAT	76	111
Other receivables and accruals	43	58
Total Trade & other receivables	**9,849**	**11,432**
Included above:		
Prepaid pensions contributions	-	-

9.2 Receivables past their due date but not impaired

	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000
By up to three months	141	-	402	-
By three to six months	12	-	-	-
By more than six months	53	-	-	-
Total	**206**	**-**	**402**	**-**

NHS Sheffield Clinical Commissioning Group did not hold any collateral against receivables outstanding as at 31 March 2020.

9.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April 2019	(4)
Lifetime expected credit losses on trade and other receivables-Stage 2	2
Total	**(2)**

9.4 Provision Matrix on lifetime credit loss

	31-Mar-20 % Lifetime expected credit loss rate	31-Mar-20 £'000 Gross Carrying Amount	31-Mar-20 £'000 Lifetime expected credit loss rate	31-Mar-19 £'000 Gross Carrying Amount
Non NHS Debt				
Current	0.1	1,664	2	1
1 - 30 days	1.0	-	-	-
31 - 60 days	2.0	1	-	`
61 - 90 days	5.0	-	-	2
Greater than 90 days	10.0	2	-	1
Total expected credit loss		1,667	2	4

10 Cash and cash equivalents

	2019-20 £'000	2018-19 £'000
Balance at 01 April 2019	139	180
Net change in year	185	(41)
Balance at 31 March 2020	**324**	**139**
Made up of:		
Cash with the Government Banking Service	324	139
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**324**	**139**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2020	**324**	**139**

11 Trade and other payables	**Current 2019-20 £'000**	Current 2018-19 £'000
NHS payables: Revenue	6,661	11,740
NHS accruals	7,878	2,911
Non-NHS and Other WGA payables: Revenue	7,569	3,804
Non-NHS and Other WGA payables: Capital	37	57
Non-NHS and Other WGA accruals	31,139	29,202
Social security costs	197	191
Tax	150	173
Other payables and accruals	870	797
Total Trade & Other Payables	**54,501**	**48,875**

Non-NHS and Other WGA accruals includes £16.3m Prescribing accrual, £5.8m in relation to Primary Care, £6.9m Continuing Healthcare accruals and £1.1m in relation to Non-NHS contracts (31 March 2019: £15.1m Prescribing accrual, £5.6m in relation to Primary Care, £5.2m Continuing Healthcare accruals and £1.2m in relation to Non-NHS contracts).

Other payables include £254k outstanding pension contributions at 31 March 2020 (31 March 2019: £238k).

12 Provisions

NHS Sheffield Clinical Commissioning Group had no provisions as at 31 March 2020 (as at 31 March 2019 nil).

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the NHS Sheffield Clinical Commissioning Group. The value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2020 is £84k (31 March 2019: £100k).

13 Commitments

13.1 Other financial commitments

The NHS clinical commissioning group has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2019-20	2018-19
	£'000	£'000
In not more than one year	292	1,266
In more than one year but not more than five years	152	-
In more than five years	-	-
Total	**444**	**1,266**

14 Financial instruments

14.1 Financial risk management

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

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

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

14.1.1 Currency risk

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

14.1.2 Interest rate risk

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

14.1.3 Credit risk

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

14.1.4 Liquidity risk

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

14.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

14 Financial instruments cont'd

14.2 Financial assets

	Financial Assets measured at amortised cost 2019-20 £'000	Financial Assets measured at amortised cost 2018-19 £'000
Trade and other receivables with NHSE bodies	2,444	1,467
Trade and other receivables with other DHSC group bodies	850	4,053
Trade and other receivables with external bodies	2,737	2,288
Other financial assets	-	58
Cash and cash equivalents	324	139
Total at 31 March 2020	**6,355**	**8,005**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2019-20 £'000	Financial Liabilities measured at amortised cost 2018-19 £'000
Trade and other payables with NHSE bodies	500	456
Trade and other payables with other DHSC group bodies	14,362	14,189
Trade and other payables with external bodies	39,292	33,069
Other financial liabilities	-	797
Total at 31 March 2020	**54,154**	**48,511**

15 Operating segments

NHS Sheffield Clinical Commissioning Group considers that there is only one operating segment: Commissioning of Healthcare Services.

	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Commissioning of Healthcare	928,786	(4,667)	**924,119**	10,481	(54,501)	**(44,020)**

During the year NHS Sheffield Clinical Commissioning Group paid £445,029k, approx. 48% of total expenditure, (2018-19: £416,052k approx. 47%) to Sheffield Teaching Hospitals NHS Foundation Trust for the purchase of healthcare and other services provided.

16 Pooled budgets

Section 75 of the National Health Services Act 2006 allows partnership arrangements between NHS bodies, Local Authorities and other agencies in order to improve and co-ordinate services. Generally each partner makes a contribution to a pooled budget, with the aim of focussing services and activities for a client group. Funds contributed are those normally used for the services represented in the pooled budget and allow the organisations involved to act in a more cohesive way.

The Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems. The Sheffield Better Care Fund pool was constructed around seven themes focussed around the different areas of integration.

NHS Sheffield Clinical Commissioning Group and Sheffield City Council entered into a Section 75 agreement covering the Better Care Fund with effect from 1st April 2015. This pool is hosted by Sheffield City Council.

With effect from the 1st April 2017 a new theme for mental health was added to the Better Care Fund. NHS Sheffield Clinical Commissioning Group and Sheffield City Council agreed to pool their mental health resources through joint commissioning of Mental Health Activity. Since 2018-19 a Memorandum of Agreement has been in place to enter into a tripartite risk share including Sheffield Health and Social Care NHS Foundation Trust.

The following table summarises the contributions made by Sheffield City Council and the NHS Sheffield Clinical Commissioning Group into pooled budget arrangements, along with details of previous year's comparatives:

	2019-20			2018-19		
	NHS Sheffield CCG £'000	**Sheffield City Council £'000**	**Total £'000**	**NHS Sheffield CCG £'000**	**Sheffield City Council £'000**	**Total £'000**
The Better Care Fund	269,863	183,472	**453,335**	266,273	181,890	**448,163**

The CCG net contribution to the Better Care Fund for 2019/20 shown above is included within the expenditure recorded in note 5 to these accounts (Services from foundation trusts £191,988k; Purchase of healthcare from non-NHS bodies £57,594k; GPMS/APMS and PCTMS £753k; and Purchase of Social Care £19,528k).

The memorandum account for the pooled budget is:

The Better Care Fund	**2019-20**	**2018-19**
Gross Income	**£'000**	**£'000**
NHS Sheffield Clinical Commissioning Group	269,863	266,273
Sheffield City Council	183,472	181,890
	453,335	**448,163**
Allocation of expenditure		
Theme 1 - People Keeping Well in their Local Community	(14,039)	(11,283)
Theme 2 - Active Support and Recovery	(57,993)	(58,548)
Theme 3 - Independent Living Solutions	(8,520)	(8,249)
Theme 4 - Ongoing Care	(184,564)	(186,738)
Theme 5 - Adult inpatient Medical Emergency Admissions	(68,622)	(69,307)
Theme 6 - Mental Health	(115,755)	(110,497)
Theme 7 - Capital Grants	(3,842)	(3,542)
	(453,335)	**(448,163)**

17 Related party transactions

Details of related party transactions with individuals are as follows:

Name & Role of Individual	Related Parties for which transactions made & Role of Individual	Purpose of Payment/Receipt	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
			£000	£000	£000	£000
A Afzal, Locality Appointed GP	Duke Medical Centre - GP Principal	GP Practice payments	865	(0)	155	0
	Primary Care Sheffield - Practice is a shareholder in PCS	Contract payments	6,567	(52)	992	(84)
	Astra Zeneca - Chair of Medical Education meeting	Prescribing	0	(10)	0	(3)
N Bates, GP Elected Member	Porterbrook Medical Centre - GP Partner	GP Practice payments	2,212	0	258	0
	Primary Care Sheffield - Practice is a shareholder in PCS	Contract payments	6,567	(52)	992	(84)
	Sheffield Hallam University - Practice is a provider of Occupational Health Services	Course Fees, Research	0	(2)	0	0
M Gamsu, Lay Member	Darnall Wellbeing - Committee Member	CHP Charges/Voluntary Sector Grant	151	0	0	0
	Sheffield Citizens Advice - Chair	Contract Payments	227	0	0	0
	Voluntary Action Sheffield - Trustee	Voluntary Organisation contract, Health and Wellbeing Board funding	130	0	0	0
T Hudsen, Chair of the Governing Body (from 1 September 2019); GP Elected member (to 31 August); Locality Appointed GP (from 1 September 2019)	University of Sheffield Health Service - GP Principal	GP Practice payments	2,681	0	152	0
	Primary Care Sheffield - Practice is a shareholder in PCS	Contract payments	6,567	(52)	992	(84)
A Majoka, GP Elected Member (up to 30 June 2019)	Abbey Lane Surgery - GP Principal	GP Practice payments	359	(0)	66	0
	Totley Rise Medical Centre - GP Principal	GP Practice payments	342	0	58	0
	Primary Care Sheffield - Practice is a shareholder in PCS	Contract payments	6,567	(52)	992	(84)
A McGinty, Locality appointed GP (from 1 August 2019)	Woodhouse Health Centre - GP Partner	GP Practice payments	1,594	(0)	321	(3)
	Woodhouse Healthcare Services - Director	Pharmacy LES	3	0	0	(3)
	Primary Care Sheffield - Practice is a shareholder in PCS	Contract payments	6,567	(52)	992	(84)
Z McMurray, Medical Director	Woodhouse Healthcare Services - Shareholder	Pharmacy LES	3	0	0	(3)
T Moorhead, Chair of the Governing Body (up to 31 August 2019)	Oughtibridge Surgery - Senior Partner	GP Practice payments	767	0	131	0
	Baslow Road Surgery - Sibling is a GP Partner	GP Practice payments	1,318	(0)	292	0
	Primary Care Sheffield - Practice is a shareholder in PCS	Contract payments	6,567	(52)	992	(84)
	Sheffield Local Medical Committee - Executive Member	Statutory and Voluntary Levy	239	(15)	0	0
C Nield, Lay Member	Sheffield Hallam University - Associate Lecturer	Course Fees, Research	0	(2)	0	0
L Philip, GP Elected Member (from 1 December 2019)	Burncross Surgery - GP Partner	GP Practice payments	2,034	(1)	391	0
	Primary Care Sheffield - Practice is a shareholder in PCS	Contract payments	6,567	(52)	992	(84)
M Ruff, Accountable Officer (up to 9 June 2019)	Worklife Company - OD Services	OD Services	30	0	0	0
M Sloan, GP Elected Member	Sloan Practice - GP Partner	GP Practice payments	1,449	0	263	0
	Primary Care Sheffield - Works as a CASES GP and practice is a shareholder in PCS	Contract payments	6,567	(52)	992	(84)
L Sorsbie, Locality appointed GP (up to 1 September 2019) GP Elected Member (from 1 November 2019)	Firth Park Surgery - Salaried GP	GP Practice payments	950	(0)	238	0
D Warwicker, Locality appointed GP (from 1 September 2019)	Mill Road Surgery - GP Partner	GP Practice payments	722	(1)	128	0
	Primary Care Sheffield - Practice is a shareholder in PCS	Contract payments	6,567	(52)	992	(84)

The values shown for related party transactions are for the full financial year including when the relevant individual has a part year interest in the organisation.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the
• NHS England;
• NHS Foundation Trusts;
• NHS Trusts;
• NHS Litigation Authority; and,
• NHS Business Services Authority.
In addition, NHS Sheffield Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of

17 Related party transactions cont'd

Prior Year Comparator 2018-19:

Name & Role of Individual	Related Parties for which transactions made & Role of Individual	Purpose of Payment/Receipt	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
A Afzal, Locality Appointed GP (from 01 November 2018)	Duke Medical Centre - GP Principal	GP Practice payments	912	(0)	132	0
	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	4,608	(7)	214	0
	Astra-Zeneca - Chair of Medical Education Meeting	Prescribing	0	(91)	0	0
N Anumba, Locality Appointed GP (to 13 May 2018)	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	4,608	(7)	214	0
	Woodhouse Health Centre - GP Partner	GP Practice payments	1,839	(1)	364	0
	Woodhouse Healthcare Services Ltd - Director	Contract Payments	3	0	0	0
N Bates, GP Elected Member	Porterbrook Medical Centre - GP Partner	GP Practice payments	2,227	(0)	277	0
	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	4,608	(7)	214	0
	Rivelin Healthcare Ltd - Minority Stakeholder	Contract Payments	49	0	10	0
	Sheffield Hallam University - Practice is the provider of Occupational Health Services	Mentorship/Scoping Work/Contract Payment	49	(10)	43	0
G Chetty, Locality Appointed GP (to 31 July 2018)	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	4,608	(7)	214	0
	The Mathews Practice - GP Partner & provides Minor Surgery for Sheffield surgeries	GP Practice payments	1,127	(0)	194	0
A Forrest, Lay Member	Sheffield Carers Centre - Chair	Contract Payment	0	0	45	0
M Gamsu, Lay Member	Darnall Wellbeing - Committee Member	CHP Charges/Voluntary Sector Grant	137	0	1	0
	Leeds Beckett University - Professor, Institute for Health Development	Tuition fees for member of staff	6	0	3	0
	Sheffield Citizens Advice - Chair	Contract Payments	202	0	0	0
K Gillgrass, Locality Appointed GP (from 14 May to 31 January 2019)	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	4,608	(7)	214	0
	University of Sheffield - Senior Clinical Teacher	Research/Eating Disorders	298	(0)	74	0
	The Medical Centre, Crystal Peaks - GP Partner	GP Practice payments	666	0	167	0
T Hudsen, GP Elected Member	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	4,608	(7)	214	0
	University Health Service - GP Principal	GP Practice payments	2,459	0	131	0
J Joyce, Locality Appointed GP (to 1 November 2018)	Foundry Medical Group - Board & Executive Member	Core Contract/Transformational funding	608	(0)	0	0
	Pitsmoor Surgery - GP Partner	GP Practice payments	1,496	0	195	0
	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	4,608	(7)	214	0
A Majoka, GP Elected Member	Abbey Lane Surgery - GP Principal	GP Practice payments	335	(0)	69	0
	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	4,608	(7)	214	0
	Totley Rise Medical Centre - GP Principal	GP Practice payments	355	0	61	0
Z McMurray, Medical Director	Woodhouse Healthcare Services Ltd - Shareholder	Contract Payments	3	0	0	0
T Moorhead, Chair of the Governing Body	Baslow Road Surgery - Sibling is GP Partner	GP Practice payments	1,513	0	270	0
	Oughtibridge Surgery - Senior Partner	GP Practice payments	842	0	120	0
	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	4,608	(7)	214	0
	Rivelin Healthcare Ltd - Minority Shareholder	Contract Payments	49	0	10	0
	Sheffield Local Medical Committee - Executive Member	Statutory & Voluntary Levy	306	(12)	0	0
C Nield, Lay Member	Sheffield Hallam University - Associate Lecturer & Honorary Lecturer	Mentorship/Scoping Work/Contract Payment	49	(10)	43	0
M Ruff, Accountable Officer	Worklife Company - Occasionally see Director	OD Services	18	0	0	0
M Sloan, GP Elected Member	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	4,608	(7)	214	0
	Sloan Medical Centre - GP Principal and Lead GP Gastroenterology Community Service	GP Practice payments	1,541	(1)	289	0
L Sorsbie, Locality Appointed GP (voting rights re-commenced 2 November 2018)	Firth Park Surgery - Salaried GP	GP Practice payments	1,104	(0)	184	0
P Taylor, Lay Member and Deputy Chair (to 31 March 2019)	HFMA - Honorary Fellow and Non Executive Director and Lay Member FacultyChair	HFMA Conference Fees	4	0	0	0

18 Losses and special payments

Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2019-20 Number	**Total Value of Cases 2019-20 £'000**	Total Number of Cases 2018-19 Number	Total Value of Cases 2018-19 £'000
Administrative write-offs	-	-	-	-
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**-**	**-**	**-**	**-**

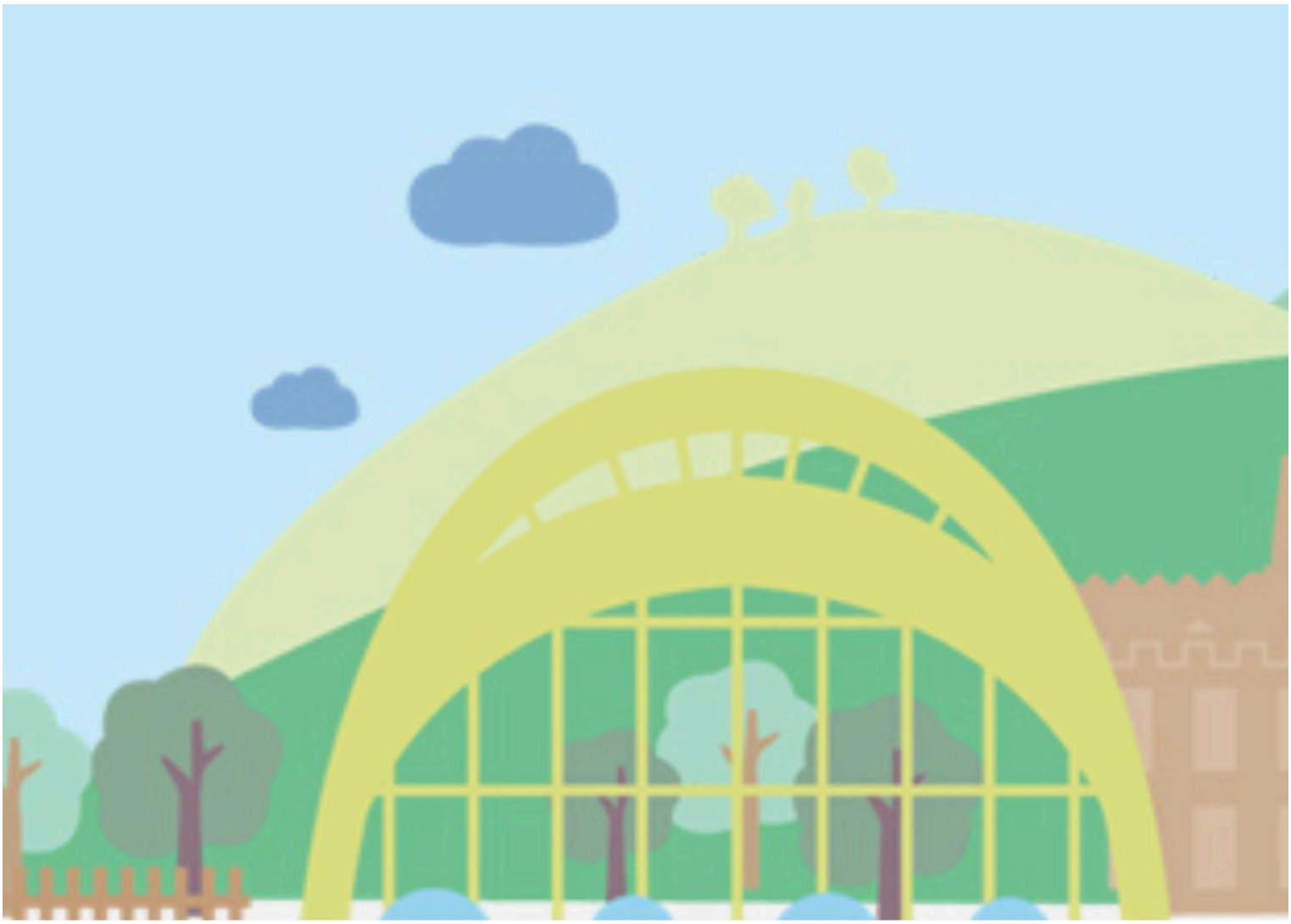
Special payments

	Total Number of Cases 2019-20 Number	**Total Value of Cases 2019-20 £'000**	Total Number of Cases 2018-19 Number	Total Value of Cases 2018-19 £'000
Compensation payments	-	-	-	-
Compensation payments Treasury Approved	-	-	-	-
Extra Contractual Payments	-	-	-	-
Extra Contractual Payments Treasury Approved	-	-	-	-
Ex Gratia Payments	1	3	2	1
Ex Gratia Payments Treasury Approved	-	-	-	-
Extra Statutory Extra Regulatory Payments	-	-	-	-
Extra Statutory Extra Regulatory Payments Treasury Approved	-	-	-	-
Special Severance Payments Treasury Approved	-	-	-	-
Total	**1**	**3**	**2**	**1**

19 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2019-20 Target	**2019-20 Performance**	2018-19 Target	2018-19 Performance
Expenditure not to exceed income	932,701	928,861	880,187	880,171
Capital resource use does not exceed the amount specified in Directions	74	74	120	120
Revenue resource use does not exceed the amount specified in Directions	927,959	924,119	876,945	876,929
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	13,366	11,141	12,778	10,011



https://www.sheffieldccg.nhs.uk

2019-20