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Interview with Maddy Ruff

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Interview with Kevin Clifford

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Annual Governance Report
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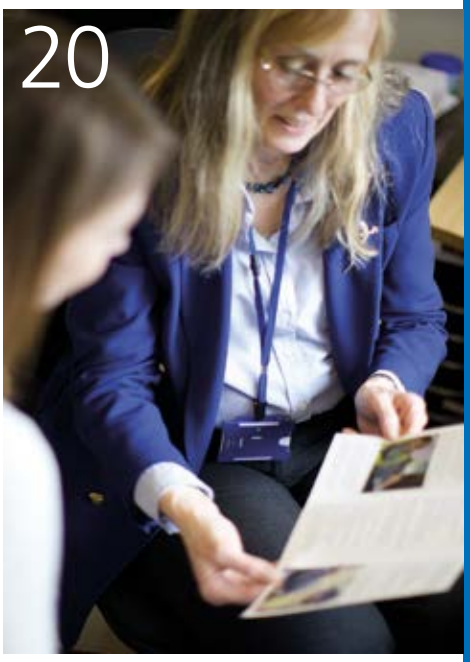
Annual Report 2015/16



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PERFORMANCE REPORT

ACCOUNTABILITY REPORT

FINANCIAL STATEMENTS

Do you want to know more about health in Sheffield?

We're really proud of the health services in Sheffield and I'm delighted to be bringing you this annual report so you can find out more.

It has been another exciting year for NHS Sheffield Clinical Commissioning Group (CCG) as well as for me personally. Having only joined the organisation in September 2015 I have welcomed the opportunity to reflect on what we have achieved as an organisation over the past 12 months – as well as think more about where we need to focus our efforts 2016/7 and beyond.

I hope you share with me a sense of real achievement in progress on our organisational priorities, particularly in areas such as mental health, children's services and in our joint working initiatives with the city council to keep people well within their own communities. However, throughout this annual report you can read about many more. 2015/6 has clearly been a year in which colleagues have worked hard to make health services better for you – the people of Sheffield and our patients - and I hope you join me in thanking them for their ongoing commitment.

You can find out more about me, my perspective on what we do, and what brought me to Sheffield in my interview on page 8. Our CHIEF NURSE KEVIN CLIFFORD talks about how he ensures our health services are always high quality on page 22; whilst our CHAIR, DR TIM MOORHEAD, gives a clear sense of where we are heading as an organisation and how, despite current challenges, we continue to have an ambitious transformation agenda to meet the future health and care needs of Sheffield (p24).

On page 14 you can read all about the many changes we've implemented over the past year that are contributing to making your experience of health and social care services as good as it can possibly be. You might even find out things about our city that you didn't know in our Welcome to Sheffield section on page 6 and if you like figures there's lots in here about how we manage the finances too!

I really hope you find this an interesting read, and learn something you didn't know about who we are or what we do, or how we've improved services over the past year. I also hope it inspires you to join with us in making a difference for our community – with further contact details provided on page 20 of how to join our active public and patient engagement network. If you have any ideas about how we can further improve services, want to ask a question or provide feedback on this report, we're very eager to hear your views (simply email us at sheccg.comms@nhs.net).

If there is one key message I'd like to leave with you its that we can all do so much more for ourselves to improve our own health. By eating more healthily, doing more physical activity, or even just finding more time for ourselves to improve our mental wellbeing we can lead healthier lives for longer. I challenge you to make that difference for yourself today!

Happy reading!

Maddy Ruff
Accountable Officer
(26 May 2016)

> *If you have any ideas about how we can further improve services, want to ask a question or provide feedback on this report, we're very eager to hear your views*
>
> Maddy Ruff

Want to help shape future services and have your say?

Join our 'involve me' network visit **www.sheffieldccg.nhs.uk** and go to the 'involve me' tab. If you can't get online call **0114 305 4609**

NHS Sheffield Clinical Commissioning Group:

Who Are We?

We are an NHS organisation made up of the 87 local Sheffield GP practices and we are passionate about helping the people of Sheffield live healthier lives.

Our purpose is to ensure high quality, efficient and cost effective healthcare services for people across the city. We are responsible for buying and contracting (otherwise known as commissioning) many of Sheffield's healthcare services. This includes hospital care as well as services people receive within a community setting (for example community and district nurses).

We have a Chairman (Dr Tim Moorhead) who provides overall clinical leadership. Our Accountable Officer (Maddy Ruff) has overall responsibility for managing the work of the CCG and its 256 commissioning staff. The work of the CCG is overseen by a Governing Body comprising other local GPs, a public health consultant, a secondary care consultant and Directors of the CCG. The Governing Body also includes members of the public (called lay representatives) who ensure the views of local citizens and patients are fully considered in all Governing Body decisions. Through this strong leadership and governance framework we work hard to ensure the health needs of the people of Sheffield are met.

Working on behalf of the people of Sheffield

As a GP-led organisation we have first-hand experience of what the

Our vision for the future!

NHS Sheffield CCG is working hard to make a difference to the way that patients use and access services to support them to stay well and healthy.

We believe that

By working together with patients, public and partners, we will improve and transform the health and wellbeing of our citizens and communities across Sheffield. Transformation of local services will be something that will continue to evolve, but we have some clear priorities that we think will make the greatest impact for our patients, their families and carers.

health problems are within our local communities and across Sheffield. We have five highly experienced GP Clinical Directors who have specialist expertise in key areas of health such as mental health, management of long term conditions (such as diabetes, respiratory and circulatory problems), childrens' services, end of life care, urgent and emergency care as well as planned care provided within a hospital. These clinical leads work closely with the wider commissioning team as well as other GP and hospital to drive improvements in the quality of services to patients. It is important that we also work in partnership with providers of health and care services, redesigning services and patient pathways of care in order to achieve the best possible outcomes with the resources we have.

Our membership practices naturally play a key role in CCG decisions about how we commission services. Practices regularly come together in four groupings known as 'localities' across the city to share views and steer commissioning in the best interests of patients, their families and carers. These localities are North, West, Central and Hallam & South.

Our Priorities

In April 2014 we published our 'Commissioning Intentions' for 2014/19. This document included both a two year Operational Plan and a five year Strategic Plan. These Plans set out our ambitions to improve the health and wellbeing of people in the city. It included a clear commitment to promoting fairness in the way that services are provided and working harder to progress improvements in the health of people in the poorest health.

We believe that unfairness in access to, and use of, health and care services is leading to some members of our community not always receiving the care they need when they need it. This unfairness is leading to 'health inequalities' which can result in the overall health of our city being affected. (see more about our health inequalities on page 7).

Further information about our Commissioning Intentions for 2014/19 can be found on our website: **www.sheffieldccg.nhs.uk/ourinformation/commissioning-intentions.htm.**

In this document we have also clearly stated those key areas of work that we think will help reduce inequalities in health and promote higher quality services.

OUR AMBITIONS ARE:

- All those who are identified to have an emerging risk of hospital admission are given the opportunity to have a care plan uniquely designed with them to support their individual health needs.
- To have closer working between GPs, practice teams and community based health and social care services. We will focus on helping people with long-term conditions to better manage their condition and live independently at home.
- Bring more services into local communities where it is safe and in the best interests of patients that have previously only been provided at the hospital
- We want to reduce the number of early deaths in adults that could have been avoided, especially for people with serious mental illness. We expect to achieve similar improvements in life expectancy for people with learning disabilities.
- We intend to ensure that services are in place to help all children have the best possible start in life because we know how important this is for a healthier life after childhood.

Further information about our ambitions for 2016/17 can be found on the website here: **www.sheffieldccg.nhs.uk**

How we work with others

We are proud of the way that we work in partnership across our diverse community in order to achieve our aims and priorities for the people of Sheffield. In developing these relationships we have core values that we work by. These values have been created by our staff and are shared across our wider membership organisations.

Our Values

Empowering
– Actively engaging staff, our population and partner organisations in improving the health and wellbeing of Sheffield people

Progressive
– Adopting a learning approach, encouraging innovation and continuous improvement

Fair, Honest and Accountable
– In how we make and implement decisions

Compassionate and Caring
– Focussing on the needs of our population and creating a positive working environment

Welcome to Sheffield

We live in a vibrant and energetic city with a population of over 560,000 people

We have a thriving student population (over 1 in every 10 Sheffield residents is a student) and increasing numbers of people with a diverse range of ethnic, religious and faith backgrounds. All this against a backdrop of the amazing Peak District National Park!

Other interesting facts about Sheffield

Over a quarter (25.2%) of the resident population in Sheffield is employed in professional occupations (compared to 17% in Yorkshire & the Humber and 19.7% in Great Britain).

Over the last 10 years there have been increases in the number of younger and older people, and it is more diverse in its ethnic groups and communities. Sheffield's ethnic minority population is now 19%.

The average gross weekly take home pay for full time workers in Sheffield is £477 (the average for Britain is £521).

Sheffield has remained a 'city at work' despite the recession. 76% of Sheffield citizens of working age are actively in work or seeking work. However there does appear to be an emerging increase in the unemployment rate of women and youth unemployment generally remained above the national average at 24.3% in June 2015.

Promoting fairness in health and care service

NHS Sheffield CCG is working closely with Sheffield City Council to make sure that we improve the health of everyone in the city but accelerate improvement for those people who are most vulnerable or disadvantaged. Improvements in life expectancy for both men and women has continued year-on-year since 2000/02 with an improvement of 3.5 years for men to 78.8 years and just over 2 years for women to 82.4 years in 2012/14.

However, remaining inequalities in our city continue to affect the health and wellbeing of our citizens such as:

- In Sheffield the gap in life expectancy between the least and most deprived women is 6.9 years; men 9.8 years. This has remained largely unchanged over the last 10 years. Consequently, people in Dore and Millhouses can expect to live 7 to 10 years longer than people in Burngreave or Firth Park.
- Referrals to Child & Adolescent Mental Health Services increased by over 30% 2012/13-2013/14.
- People with serious mental illness and learning disabilities are dying 20 years younger from preventable conditions than the rest of the population.
- Trends in healthy life expectancy are improving but men will live on average 18 years in poor health, women 23 years.
- Overall almost half of all premature deaths in Sheffield are identified as preventable. Main causes are cancer, heart and lung problems.
- One of our ongoing priorities is therefore to reduce unfairness and health inequalities across our city.

The Sheffield Health and Wellbeing Board has also identified tackling health inequalities as one of its priorities in the Joint Health and Wellbeing Strategy.
www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-theboard-does/joint-health-and-wellbeing-strategy.html

Further information about Sheffield can be found in our 'The State of Sheffield' Report (February 2016).

www.sheffieldfirst.com/key-documents/state-of-sheffield.html

This is an exciting time in the evolution of Sheffield. A key development for the city in 2015 has been the announcement that Sheffield is set to get £900m over the next 30 years as part of the Sheffield City Region Devolution Agreement. It is planned that from 2017 the region will vote for a directly-elected Mayor who will oversee a range of powers including transport budgets and planning. It will also see the emergence of a combined authority with enhanced power. Whilst health and social care is not part of current devolution plans it remains an important element in the overall development of the city.

Interview with Maddy Ruff,

NHS SHEFFIELD CCG'S ACCOUNTABLE OFFICER

Maddy Ruff was appointed as Accountable Officer for NHS Sheffield CCG in September 2015, taking the reins from Interim Accountable Officer Idris Griffiths. We (the Editorial team!) thought learning about NHS Sheffield CCG from Maddy's view point would give us real insight into the organisation as we exit 2015/16…

What brought you to NHS Sheffield Clinical Commissioning Group?

I have worked in the NHS for more than 25 years. The reason I joined the NHS initially was to make a difference for patients and that passion still drives me now. When I met the GPs working with the CCG I could see we were driven by the same values, they were very ambitious and committed about the changes they wanted to see which would lead to improved services for their patients. I really wanted to join their team!

So how have you found your first seven months at the CCG?

It's been very busy! We are looking at a period of unprecedented change in the NHS, with next year looking to be the first year where true transformation of health and social care services really takes shape, and we've spent a good deal of time over the past year planning for these big changes.

Getting to know the city and the organisation has been great. Sheffield NHS CCG is a fantastic organisation, with dedicated staff, an engaged GP Membership, and big ambitions. This makes it a really exciting place to work! We have real opportunities in Sheffield. We have a fantastic relationship with Sheffield City Council, and continue to have one of the biggest pooled integrated commissioning budgets in the country. This means we can bring management of health and care services closer together on the ground, avoiding duplication and combining skills and talents of our teams of staff to make the biggest impact for patients, their carers and families.

What have you been most proud of at the CCG this year?

I am really proud of a lot of what we've done already this year to improve services for patients, and really excited that this journey is just beginning and we are planning so much more!

I'm proud of our joint work with Sheffield City Council, particularly our projects that are bringing services closer to people's homes and helping them stay in control over their own health and wellbeing. For example, in the last year over 5000 people in Sheffield have developed an individualised care plan supported by a health care professional. These plans enable each person to be involved in decision-making about their own care and supports them to self-manage their condition.

We are involved with the Sheffield Big Lottery funded Age Better programme which is working hard to reduce social isolation and loneliness in older people. Social isolation can be as bad for a person's overall health as smoking! In the first nine months an impressive 456 people have taken part in the projects across the programme. You can read what people have said about the scheme on page 14.

Patients attending hospital for treatment primarily for physical health problems, or for symptoms of physical health conditions, can also access psychiatric treatment every day up to midnight in A&E at Sheffield Teaching Hospitals now thanks to increasing the Mental Health Liaison service, in some cases this means we are able to support people so they don't have to be admitted to hospital.

Another achievement I am proud of is that from April 2016 patients across Sheffield will have the choice to book their GP practice appointments online with all our practices offering their patients online services. This includes practice appointment booking, ordering of repeat prescriptions, and access to summary information from your GP records

In addition, the CCG, practices and Sheffield Teaching Hospitals have worked closely together over the last year to implement a system where patients can book their hospital appointment online at the GP surgery, or via phone using the national Appointment Line. Patients are able to choose a date and time for their appointment that is convenient for them. We know that patients are seen quicker as a result of these improved processes. Around 60-70% of GP referrals are now made being made to Sheffield Teaching Hospitals electronically and this rate continues to increase.

I am delighted at the aspiration of our local transformation plan to improve Emotional Wellbeing and Mental Health Services for

I am really proud of a lot of what we've done already this year to improve services for patients, and really excited that this journey is just beginning

Children and Young people. Lots of achievements have been made including a reduction in waiting times to access mental health treatment for Children; more support within communities and schools for Children and Young people with Eating Disorders, including a school based 'body project' aimed at young people. We are one of a few national sites providing mental health services into schools, this means that children's mental health needs can be identified and supported at an earlier stage and hopefully will change the way children's mental health is provided in the future.

We have also started this year to give personal health budgets to a number of families with children with complex health needs, which will enable families to have more control over the care they need in place.

It's been great to see the CCG's very active role in the Move More initiative, and development of the National Centre for Sports Exercise Medicine (NCSEM), and supporting our citizens to increase their physical activity levels. To be a partner in the UK-first NCSEM really demonstrates our commitment to supporting people to help themselves. The Centre opened at Concord in September designed to bring together clinical services, sport and exercise specialists and health professionals to make it easier for physical activity to become

Chair Dr Tim Moorhead, Lay Member Phil Taylor and Accountable Officer Maddy Ruff

"I'm proud of the efforts we make to look after each other at the CCG – leading the way, showing that we mean what we say about people looking after themselves…"

part of a patient's treatment.

I can also look back on this year and celebrate the fact that many of the large scale transformation plans that take time to plan and have taken a lot of hard work and commitment over the past year are now coming to fruition. We are looking forward to publishing both our Primary Care and Urgent Care Strategies in early summer 2016, a lot of clinician and public engagement has taken place in 2015/16 to get us to this position. Alongside the Active Support and Recovery approach, these strategies sit under our Care Outside of Hospital (COOH) Strategy, which has also been developed this year and will form a key component of our transformational plans in the coming year. Whilst strategies can seem uninteresting to members of the public, they really set out where we want to go and what we want to achieve for people in the city. We will put together some summary versions that are easy to read and I hope people will be interested in what we are planning.

As an employer I'm proud of the efforts we make to look after each other at the CCG – leading the way, showing that we mean what we say about people looking after themselves and their health by supporting our staff to do just that. We held a really successful Health & Wellbeing Week in September, inviting a whole host of external partners to join us in promoting wellbeing to our staff. Everyone who works for the CCG cares so passionately about improving services for our patients that it's really easy to fall into a trap of working long hours and not looking after ourselves, and I know that can be said about people in jobs across Sheffield. We want other employers in the city to look at what we do and realise that supporting staff to look after themselves has economic as well as health benefits.

It was great that some of our staff were chosen to talk at a national event about how we listen to what patients tell us and then use that information to change services. This is really important to me. People are dying prematurely in Sheffield as a result of respiratory conditions – we see this as a big priority. This year we asked people who use our respiratory services how we could improve them and they told us that they would have liked more support when they were first diagnosed so we have planned to have more self-care and educational sessions available for patients who are newly diagnosed.

We also asked patients who use physiotherapy, rheumatology and pain services what changes they would like to see and they told us they wanted more input from local people into how the system is run. Because of this feedback we have now set up a 'patient ambassadors' network so that patients are present when decisions are made.

We also don't shy away from difficult conversations and met with more than 80 interested citizens to discuss prescribing changes we were proposing such as reducing the amount of gluten free products prescribed and stopping the prescribing of paracetamol for short-term needs.

Find out more about our engagement with citizens and how you can get involved later in this annual report (p20).

My final 'proud of' is the great people who work for this CCG – to give an example, one of our Clinical Directors Dr Charles Heatley picked up an MBE this year for his fantastic services to the NHS and health services abroad. I hope his success can act as a role model for all future aspiring GPs wanting to get involved in commissioning!

More examples of our achievements are on page 14.

What would you say is the CCG's greatest strength?

I think our biggest strength is the CCG team, having GPs, nurses, pharmacists and managers working alongside each other, all with the same aim, to improve services for patients but all bringing different skills to the party. Harnessing those joint skills, experience and endeavours, gives us a huge strength.

What has been your biggest concern?

My biggest concern is that although we are working very hard here in the CCG and despite having fantastic health services in Sheffield provided through GPs and hospitals, the health inequalities gap between the two halves of the city is not reducing. For example, people in Dore and Millhouses can expect to live 7 to 10 years longer than people in Burngreave or Firth Park. In the north of the city, people are likely to spend the last quarter of their life with some kind of health problem. We have too many people smoking, and almost 60% of the adult population is overweight or obese. We are making some progress on increasing exercise in the city but we need to become much fitter and we still drink too much alcohol. Inequalities in health in Sheffield have been known about for over 100 years, they are significant and persistent, in spite of much good work that has been done to address them.

Every organisation in the city has a role to play in this and we need plans for making a difference now - for example targeted cholesterol and blood pressure management in high risk populations; plans for the near future, for example projects focused on lifestyles - support to stop smoking, and public policies such as creating healthier environments near schools; and plans for the distant future that consider the impact of other social issues such as poverty, employment and housing.

We continue to work with our partners across the city and through the Health and Wellbeing Board to work out how we can really make a difference to this. Our social values are really important because we have to recognise that factors outside of health make a massive impact on people's health. We are developing a Commissioning for Social Value Strategy, we are partners in the city's Tackling Poverty Strategy and the approach we are taking to bringing care closer to people's homes is also going to see us working really closely with other services in the communities to ensure we don't just see people's health needs in isolation.

> *Our main priority is to get on and deliver the best possible health care for the people in Sheffield*

It's also a concern for me, as it is across the country, that our GPs are coming under increasing pressure, seeing an increase in patient demand due to people living longer, and more people living with complex illnesses and long-term conditions, such as diabetes and heart disease. There are significant workforce issues nationally with fewer GPs entering the profession and more leaving it early. Tackling this is so important. We are launching our Primary Care Strategy which talks about proposals for addressing this, but as with everything we are doing it's so important that we see the whole and many of the other transformational changes that we are making are all designed to make it easier for people to see a healthcare professional close to where they live, when they need to, whilst reducing this pressure that our practices are under.

Sheffield has fantastic hospitals providing fantastic services but there are a number of 'core constitutional rights and pledges' – things that the Government has promised our citizens of their health services and we monitor whether the hospitals meet these pledges. Unfortunately this year across all of the NHS providers in the city, we are only meeting 73% of them – I want to see that figure higher. Going forwards I'm very clear that we need to focus our attentions on working with our providers and getting the very best for people in Sheffield, meeting the promises they've been given.

Finances are always a concern as it's so important that we balance our books, this year there have been a number of ways that we have managed this when at times it looked like we might not. However going forward, it's going to be even trickier than ever. We have received a lower funding increase than the average for the country, and less than we had previously planned for and this presents a major financial challenge for us and means we will have to consider carefully how we plan services for next year. More information can be found in the financial sections of this annual report and in Tim Moorhead's article about the future on page 24.

Blood pressure check for health and wellbeing week.

Where do you feel there's more work to be done and what excites you for the future?

Our main priority is to get on and deliver the best possible health care for the people in Sheffield. We can only achieve this by continuing to work alongside our partners including the hospitals, Sheffield City Council, and, just as importantly our wider voluntary, charitable and faith sector organisations as well as patients and citizens. That's both making sure all the pledges to the public are met and targets reached, to making the big changes we have been working on this year actually happen so that patients start to see improvements to the services they receive as quickly as possible. With so much of the planning already in hand and our strategies – Care Outside of Hospital, Urgent Care, Primary Care and Active Support and Recovery due to be published shortly, this is the year to make the changes a reality.

Supporting people to actually look after themselves and their conditions in their own homes is an exciting opportunity that I really want to see expanded – people who have long term conditions or who are recovering from a spell in hospital don't want to be in and out of hospitals and off to their doctors all the time, so all the work we've started with Sheffield City Council is also so important.

Many of our transformational change programmes will start to deliver the things that people tell us time and again they want to see improved – they want to get appointments to see a healthcare professional close to their homes when they need it – not in a month's time, they want to know where to go when they have an urgent care need, not be confused by the mix of options. It's really exciting for me to be addressing what people keep telling us that they want to see change.

Services working better together is another thing that comes up frequently in our conversations with the public and that's another area where we've started to make positive changes but we want to do much more. We want the patient to receive seamless healthcare whatever their need, so that we see the joins where one organisation offers one set of care, and another offers another, but so that the patient doesn't see those seams.

As of April 2016 we have taken on responsibility for commissioning general practice core services from NHS England, this means that we will be responsible for commissioning even more of the city's health services and will have even stronger relationships with our GPs who offer us great insight into the health needs in our local communities. The next year will be really important for us in establishing processes and relationships to make sure this opportunity is used to its full potential and our patients see the benefit.

Another piece of work that we commenced last year, but which is really important for us to continue to work with our GPs on in the coming year is the 'special cases' process we established. This was to support GP practices whose patient need will be unmet following the national implementation of equalising core contractual funding for GP practices. Because the formula being used across the country to distribute the main funding does not fully reflect our local population's needs around deprivation, we agreed to invest a further £4 million in general practices over the next four years to commission additional services.

As I've mentioned in depth earlier in this interview we still have lots to do around health inequalities and that's a definite focus for us going forwards.

The final opportunity that the future brings is more work with our partners outside Sheffield. As we look to transform healthcare to better meet today's needs there are likely to be more opportunities for us to work together across South Yorkshire and Bassetlaw. We are in the process of putting together a plan with all the health organisations across that sub-region for how we will work together and what it will mean for people in Sheffield and beyond.

Final thoughts?

As I've said to the CCG team we really have got it all here – an engaged staff, members, partners and providers. Yes the finances are challenging, yes we have big plans but this is the moment we can all make a difference.

What difference have we made for the people of Sheffield in 2015/16?

5000 citizens in Sheffield have developed a care plan with a health care professional to help them be more involved in decision-making about their care, and discuss opportunities to self-care. People have told us that they have found the care planning process:

"Very useful and reassuring"
"Very useful being actively involved as opposed to being just told what was happening"
"Most Informative, care taken to explain in detail"

WORKING with the Big Lottery funded Age Better programme in Sheffield we are reducing social isolation and loneliness in older people. There are a number of innovative projects underway to help citizens who are socially isolated or at high risk of social isolation to be better connected to their community. In the first nine months 456 people have taken part in the projects across the programme.

We have had a fantastic response from both the volunteers and the beneficiaries of the schemes:

"Once I wasn't able to get out of the house on my own I thought that was it for ever getting out again and would have to say goodbye all of the friends that I had made at the club I went to every Tuesday. I can't believe that there's someone who is willing to give their time to help me get there every week."

PATIENTS attending hospital for treatment primarily for physical health problems, or for symptoms of physical health conditions, can now access psychiatric treatment every day up to midnight in A&E at Sheffield Teaching Hospitals thanks to increasing the Mental Health Liaison service, in some cases this means we are able to support people so they don't have to be admitted to hospital.

PATIENTS requiring support from the mental health out of hours service can now receive that support for longer hours as the CCG has invested to enable the service to operate between 7.30pm and 8.00am daily with increased staffing levels during busy periods up to midnight.

MORE people who are stressed, low in mood (depression) or very nervous (anxiety) will now be able to get psychological treatments, sometimes referred to as talking therapies. Waiting times are also shorter thanks to the CCG and Sheffield Health and Social Care NHS Foundation Trust, securing additional national funding for the Sheffield Improving Access to Psychological Therapies Service (IAPT).

MORE local support is available for people with learning disabilities so that they aren't placed inappropriately in out of city care and can live closer to their families. We are also extending this work across South Yorkshire and North Lincolnshire and have developed our plan to reduce inappropriate hospital care, by further improving alternative local community services and accommodation.

FOR the first time a dedicated, age appropriate mental health service is now available for 16 and 17 year olds.

CHILDREN and young people can be seen by a specialist in a general practice based allergy clinic instead of having to go to hospital thanks to a new 'Itchy, Wheezy, Sneezy' project.

WOMEN can receive gynaecological testing at their GP practice rather than attending the hospital as part of a pipelle sampling pilot.

PATIENTS no longer need to travel to hospital for a specialist clinician to diagnose dermatology conditions, as the dermatology pilot has supported hospital clinicians to be able to view photographic images of skin lesions.

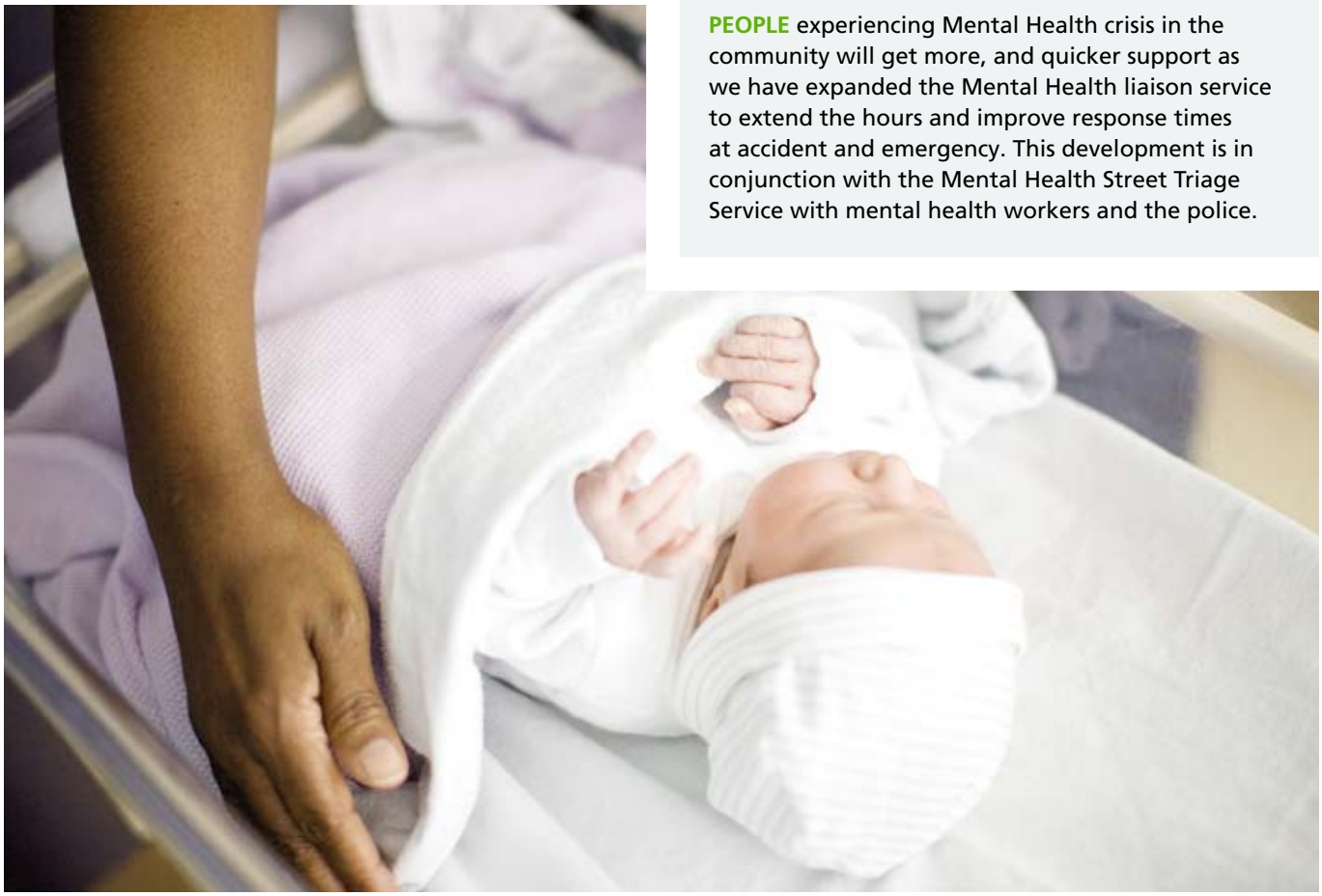
MORE people can now book a hospital appointment electronically using Choose and Book eReferral, which means patients can choose the hospital they go to and a date and time of appointment to suit them thanks to our work with Sheffield Teaching Hospitals.

PATIENTS requiring additional treatment when they've been visited by a paramedic can now be supported and treated at home thanks to a clinical protocol we have implemented for the paramedics to be able to contact and organise Sheffield Teaching Hospitals. services. This prevented over 400 people attending hospital unnecessarily in the first quarter of this year.

WE have reduced the amount of time people arriving in hospital by ambulance have to wait to be transferred into the hospital by working with ambulance services and the accident and emergency department to produce a self-handover clinical protocol which will also free up ambulance vehicles more quickly as well as reducing patient delays.

FAMILIES of children with Continuing Health Care (CHC) needs can have greater choice and flexibility around the support provided for their child after we developed the first personal health budgets for children that qualify for CHC.

PEOPLE experiencing Mental Health crisis in the community will get more, and quicker support as we have expanded the Mental Health liaison service to extend the hours and improve response times at accident and emergency. This development is in conjunction with the Mental Health Street Triage Service with mental health workers and the police.



LESS people who require a psychiatric intensive care service will have to travel outside of Sheffield after a Psychiatric Intensive Care Unit opened in December to offer an improved therapeutic environment for patients.

MORE people are being diagnosed with memory conditions (Sheffield diagnosis rate is 15% higher than national rates) and therefore people are getting better access to treatment. Waiting times are also decreasing for the memory service.

VICTIMS of Child Sexual Exploitation will receive the support they require to ensure their health needs are met thanks to a new health service for victims of CSE, which is integrated with the city's CSE service delivered by Sheffield City Council.

PREGNANT women and new mums will receive clearer information on the support available to them and how to access it as the CCG has finalised an improved pathway for perinatal mental health involving universal health services, maternity services and mental health services.

PATIENTS in the city have been benefiting from more access to health and care services out of hours, increased pharmacy support and a range of other schemes through our work with Primary Care Sheffield who were awarded Prime Ministers Challenge Funds and are now piloting 16 innovative schemes across the city (the largest PMCF pilot in the country).

PATIENTS have already started benefitting from, and will continue to see additional, technological advances which are an important part of helping services work together better and supporting people to look after themselves in their homes and communities as we were key participants in a successful bid which generated an additional investment pot for technology development in Sheffield of £1.8m.

PATIENTS are being supported to self-care and manage their conditions through the use of a tool that GPs use to assess patient motivation. Sheffield is one of six sites around the country being supported by the Department of Health to trial the PAM (Patient Activation Measure).

PATIENTS with chronic health conditions for whom physical activity is part of their treatment will find it easier thanks to the UK-first National Centre for Sport and Exercise Medicine, which opened at Concord in September and is designed to bring together clinical services, sport and exercise specialists and health professionals.

SHEFFIELD patients were the first to benefit from the nationwide rollout of the summary care record through community pharmacies. A Summary Care Record provides key clinical information about a patient, from their GP practice. It is used by authorised healthcare professionals, with the patient's consent, to support their care and treatment providing healthcare staff with faster, secure access to essential information about a patient.

CHILDREN and young people and their families in Sheffield are benefitting from a whole host of improvements to emotional wellbeing and mental health services as we have invested over £1 million to transform services and provision, including: Commissioning young people to transform our services with us; Reducing waiting times to access care and treatment; Providing more services for young people with or at risk of development of eating disorders; providing more digital information for families and children and young people on mental health and emotional wellbeing support and providing mental health support and services into schools, and developing the skills of the workforce within education and community settings.

PATIENTS with gastro conditions will now only receive gastroscopies if that is the only solution. Gastroenterology consultants told us they felt that many patients could avoid having to undergo this unpleasant procedure if we offered better education and support for GPs so we have implemented new guidelines.

PATIENTS with eye conditions are benefitting from a new treatment – Oraya Therapy – which means some patients no longer need as many eye injections.

PATIENTS of St Luke's Hospice are benefitting from a number of new initiatives using technology to enhance patient and family care, including the Enhanced Community Palliative Support Service which uses new technology to allow a senior nurse or doctor to monitor multiple patients from a remote setting, providing direction to the community nurses working with patients and their families in the patients' homes.

Working closely with our partners to provide the best healthcare

In Sheffield we are really lucky to have great high quality NHS and social care organisations looking after our patients.

Here we explain who we work with and what they do…

Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
– is the major provider of adult health care for the city and also in the community. The Trust manages the five NHS adult hospitals in Sheffield: the Northern General, Royal Hallamshire, Jessop Wing, Weston Park and Charles Clifford Dental Hospital.

Sheffield Children's NHS Foundation Trust (SCHFT)
– is one of only four dedicated children's hospital trusts in the UK providing integrated, highly specialist healthcare for children and young people in Sheffield, South Yorkshire and beyond.

Sheffield Health and Social Care NHS Foundation Trust (SHSC)
– provides mental health and social care services which include a full range of specialist adult and older people's services, psychology and therapy agencies as well as specialist learning disability services, substance misuse and community equipment services.

Primary Care Sheffield (PCS)
– is a GP led, social purpose company spanning the majority of Sheffield practices, which aims to improve patient care through a unified supportive approach to general practice in the city.

Sheffield GP Provider Board (GPPB)
– acts as a unified voice for primary care providers in the city and works collaboratively with other partners to ensure high quality, primary care services.

Sheffield City Council (SCC)
– is the major provider of social care in the city and they also took on responsibilities for public health in 2013. They are equal partners with the CCG on the Health and Wellbeing Board. In April 2015 our CCG and Sheffield City Council came together and pooled their £270 million health and social care budget transforming Sheffield's health and social care services to make care more coordinated and seamless.

Healthwatch Sheffield
– is the local consumer watchdog for health and social care services helping adults, children and young people influence and improve how services are designed and run. We work closely together around patient and public engagement to ensure that the patient voice is heard and that it is at the heart of any commissioning decisions. For more information visit:
www.healthwatchsheffield.co.uk.

NHS England
– took on many of the functions of the former primary care trusts (PCTs) in April 2013 with regard to the commissioning of primary care health services (GPs, Dentists, Optometrists, Pharmacists), as well as some nationally-based functions previously undertaken by the Department of Health. From April 2016 NHS Sheffield CCG will progress to Level 3 co-commissioning of primary care which means we will assume full responsibility for commissioning GP core services, whilst NHS England legally retain liability for the performance of primary medical care commissioning.

OTHER PARTNERS

Our CCG also commissions services from a range of other providers, including nursing and residential homes where there are NHS funded clients, other NHS providers (for example who might be outside of Sheffield), independent sector providers and voluntary organisations.

Each month the CCG publishes details about all of our spend that is over £25,000.00. All providers who provide services over this cost will be listed on this document: **www.sheffieldccg.nhs.uk/about-us/spending-over-25k.htm.**

Through the HWBB we have also worked together to make sure the local NHS and Sheffield City Council talk with people on similar matters together and just once so we are not all asking people the same questions!

Our strategic partnerships

We are members of a number of partnership boards and other planning groups some of which focus on particular health services and health conditions.

We are also members of the Sheffield Executive Board and maintain relationships with individual organisations through regular meetings, including with voluntary, community and faith organisations.

Some of our key strategic partnerships include:

The Sheffield Health and Wellbeing Board (HWBB)

This is a strategic partnership mainly with Sheffield City Council, with NHS England and Healthwatch also involved.

Through the partnership we assess the current and future health, care and wellbeing needs of local people. This is called the Joint Strategic Needs Assessment and can be viewed here **www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA.html.**

This year we have worked closely with the HWBB around our '2020 vision' engagement activity to jointly engage with people across the city on how health and social care should look by the year 2020.

Commissioners Working Together

This is a group of healthcare commissioners working together across South and Mid Yorkshire, Bassetlaw and North Derbyshire to look at how we buy services that affect a larger population than just Sheffield. Sheffield CCG is one of 8 CCGs in the group.

Some people have better experiences, better outcomes and better access to services than others. ***To ensure that everyone experiences the highest quality and safest service possible, the partnership is working together*** with all local hospitals and care providers, staff and patient groups to understand how best to do this for the benefit of everyone in the region.

Over the last year, Commissioners Working Together have focused on four key areas – reviewing both hyper acute stroke services and children's surgery and anaesthesia, urgent and emergency care and have developed a partnership with Macmillan for people living with and beyond cancer.

For more information visit: **www.smybndccgs.nhs.uk/.**

We want to hear from you!

Listening to our citizens is so important. How do we make changes to benefit you if we don't ask you about the services you've received and how we can make them better. This year we have received direct feedback from over 1000 individuals and have attended 51 community groups and events.

The main things that people have talked to us about are:

- Access to GP appointments
- Confusion about what services to use
- System not working cohesively
- Staff attitude and communication
- Differing experiences and knowledge of services
- Alternative services available closer to home
- Discharge failures
- People want their mental health needs treated as equal to their physical needs

On the back of that feedback we have made a number of changes, many of which you'll have read about in this annual report, and have a number of further changes in the pipeline. Examples include:

- We have increased psychiatric treatment support for patients attending A&E for physical health problems - now available every day to midnight meaning people have access to mental health support during evenings which in some cases can mean they do not need to be admitted to hospital.
- We are making it easier for you to get an appointment to see a health professional in your community through our Primary Care Strategy.
- We have started to have conversations with our partners across the City about organising health and social care services that work together across neighbourhood footprints – we will be talking to you about this soon.
- Our Readers' Panel review documents which help us to produce better information for the public of Sheffield.

Involve Me is our network of patients and the public who want to hear more about what we do. We have 727 members who have different levels of involvement with us. Some just receive our electronic newsletters, others are much more active. For example we recruited a number of local people who offer a different perspective, to be involved in our discussions around our plans, early decision making, prescribing and the recruitment of staff.

If you would like to find out more about how we involve the public in our decisions, sign up to our Involve Me network by emailing us at sheccg.engagementactivity@nhs.net. You can also find out more and get involved via our social media – Find us on twitter @ **NHSSheffieldCCG** and **Facebook/Sheffield CCG.**

Find out more about what we have been talking to the people of Sheffield about at www.sheffieldccg.nhs.uk/get-involved/archive.htm including:

- Urgent Care Strategy Review
- A 2020 Vision for Health and Social Care in Sheffield
- Clinical Assessment, Services, Education, Support (CASES)
- Improving Cancer Care in Sheffield
- Children's surgery and anaesthetics
- Critical care for people who have had a stroke

Making sure we think about everyone's needs

We are committed to making sure that equality and diversity is a priority when planning and commissioning local healthcare and have effectively met our statutory duties over the past year. These include:

- Equality Impact Assessments have been carried out on all relevant policies to make sure all communities and groups of people have been considered when we implement changes
- CCG staff members have participated in mandatory equality and diversity training so that we all understand the diverse population we serve
- We work with our staff and providers to ensure compliance with our Public Sector Equality Duties, Equality Delivery System 2, Workforce Race Equality Standard and the new Accessible Information Standard

Find out more about our Equality and Diversity work at:
www.sheffieldccg.nhs.uk/our-information/equality.htm

Sustainability and Carbon Management

Just like everyone else in the country we have a responsibility to be green

The CCG Sustainability and Carbon Management Group, led by a Governing Body GP member and an Executive Director meets quarterly and its work so far includes:

- Supporting colleagues, providers and GP practices to be sustainable.
- Overseeing work in our offices including recycling (paper, pens, batteries, ink cartridges, glass, and cans), reducing waste, rules based printing, and reducing travel through the use of technology.
- Doing what we can to minimise patient and service user carbon impact by maximising the use of technology and providing care closer to home to reduce patient travel.
- A public and practice campaign on waste.
- Continuing to support the work reported last year on practice Sustainability Health-Checks to reduce energy bills, improve environmental performance and engage local community groups.

The CCG was also pleased to be invited to take part in the city's Green Commission. Dr Marion Sloan was the CCG's lead, and helped to determine the Green Commitment set out in the commission's report, with the following ambitions:

- Connected city - It is easy to move around Sheffield in a safe, clean, integrated, affordable, high quality, low emission transport system.
- Transformative energy - Energy is generated and distributed locally and individuals and businesses are engaged with energy efficiency and demand reduction.
- European green city - Sheffield is a green city both in its urban core and its surrounding landscape.
- Learning city - Sheffield is committed to continuously learning about how to make Sheffield a smart, sustainable future city.

CHIEF NURSE, KEVIN CLIFFORD ON WHY FOR NHS SHEFFIELD CCG, QUALITY ASSURANCE OF THE SERVICES THAT WE COMMISSION IS PARAMOUNT

If it's not good enough for my mum it's not good enough for anyone…

"Quality of care should be important to everyone in the NHS – clinical or not, we must all ask ourselves what do we want to achieve for the people of Sheffield, not just the right services, but the right services of the highest quality. If it's not good enough for my mum it's not good enough for anyone – fundamentally that's what defines quality. We, in the NHS, are responsible for spending lots of the tax payers' money and we know that quality is the most important thing for a patient's experience of the NHS.

Each month the quality team assesses performance against key local and national quality measures for the monthly Quality and Outcomes Report to the public Governing Body meeting. This includes CCG and provider performance on patient experience, the prevention of infections resulting from medical care or treatment in hospital and serious incidents. The Report describes how, in partnership with our providers, we are meeting the CCG's commitment to ensure that the commissioning decisions and actions we take improve health care for the people of Sheffield and to ensure patients receive the highest quality of care.

In the last year we've continued to strengthen our approach to managing quality in Sheffield. I was pleased to appoint a Quality Manager with a focus on patient experience, and to increase the Quality in Care Homes team so that they're able to quality manage more care homes.

We also had a pleasing result last year in the narrative return from the CQC when they came and did an inspection on Safeguarding Children

"In the last year we've continued to strengthen our approach to managing quality in Sheffield"

"What we all have in common is we want the very best for our patients"

and Looked After Young People. CQC inspections of safeguarding don't provide a judgement as they do for NHS provider inspections but we faired really well in comparison with other CCGs, with a small number of recommendations.

Medicines Management faced some challenges in the past year, with spend on prescribing up by 10% on the same time last year. The team have risen to the challenge and working with the Medical Director have put in place some innovative measures in a bid to make sure the NHS isn't unnecessarily spending money.

This has been my last full year as Chief Nurse as I am retiring in the summer. Knowing I'm coming to the end of my career after 39 years in the NHS, the ambition to deliver is as strong today as when I joined as a 16 year old. I'm confident that I'm leaving the quality of care for the people in Sheffield in good hands. The clinical quality team has had some incredibly enthusiastic new people join us recently bringing a fresh voice and with them in place we have a great mix of very experienced people and new people. What we all have in common is we want the very best for our patients.

As tough as times get (and they've never been tougher) we must remember our values – clinical quality is at the core of why we all work for the NHS."

QUALITY & OUTCOMES

The monthly Quality & Outcomes reports can be found on our website in the Governing Body Meetings section:

www.sheffieldccg.nhs.uk/about-us/GB-meetings

Reports on Safeguarding (Quarterly), Serious Incidents (Monthly) and Compliments and Complaints (Quarterly) can also be found there.

Transforming the future

by Dr Tim Moorhead, Chair, NHS Sheffield CCG

Our focus as an organisation is making sure we make the best use of our money for the benefit of our whole community across Sheffield. We face a significant reduction in funding available to the CCG to spend on health care in 2016/17, mainly because of recent changes to the formula used by central government to allocate the NHS budget. Our funding 'gap' for 2016/7 is nearly £19million.

This means we have to make some tough choices about where to spend our funding and find more creative ways to ensure services address our population health needs. This includes finding new and more effective ways to deliver services which encourage us to take more responsibility for our own health and wellbeing. It also means that every penny will count, and we will need to work closely with providers of health and care services to ensure they work together to create cost effective and streamlined services.

The work that GPs do for our local communities is vital in helping us to shape services that will deliver this new way of working. The CCG will take on new responsibilities in 2016/7 which will enable us to work even more closely with GPs and practice staff to redesign services that best meet the needs of their local populations. These new responsibilities, termed co-commissioning, mean the CCG will become the manager of contracts for the delivery of core general practice functions.

We really welcome this development. Co-commissioning is one of a series of changes set out in the 'NHS Five Year Forward View' (www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf). This document provides us with a clear indication of how the Department of Health want NHS services to develop across England over the next 4-5years. We think the ideas in this document reflect what we want to do in Sheffield, such as developing a stronger voice for local communities in the design and delivery of services in their area and promoting care outside of a hospital building. These are key themes in our soon to be launched Primary Care Strategy and our Care Outside of Hospital Strategy.

We strongly believe that by building services closer to where people live,

involving and coordinating care across existing community resources, we can help achieve more effective services. We think this will improve access to healthcare by using the skills across teams and organisations in a different way. This will mean patients will increasingly receive advice from health and care professionals, such as pharmacists, physician associates, nurse practitioners, practice nurses, healthcare assistants and other staff. GPs will be able to focus more of their time using their expertise to treat patients with the most complex need such as those with more than one long term condition, for example, people with diabetes, ongoing problems with breathing, blood circulation or their mental health. In this community-based approach we will encourage better links between social care, voluntary, community and faith organisations as well as other public sector organisations such as police, fire, housing and employment agencies.

We think that these communities would work best at a population level of between 30-50,000 people. We have called these population sizes 'Neighbourhoods'. The creation of Neighbourhoods also means that GP practices will need to work together more, coordinating the right care, the best mix of skills and staff to meet the needs of their local population and which avoid duplication of effort and waste resources. For example, patients are often concerned that they have a number of visits by different people from different organisations often asking the same questions! Under this new, more coordinated model, this should be reduced considerably if not totally.

We recognise that for some services, delivery across a larger population size might be a better use of people's skills and make more effective use of the funding we have available. The CCG will play a key role in helping local communities to identify where it makes sense for these services to work across more than one neighbourhood and we will work closely with Sheffield City Council, our GPs and our hospitals to bring about the changes we all agree are the right ones for the people of Sheffield. We aim to deliver this new way of working across Sheffield by 2019.

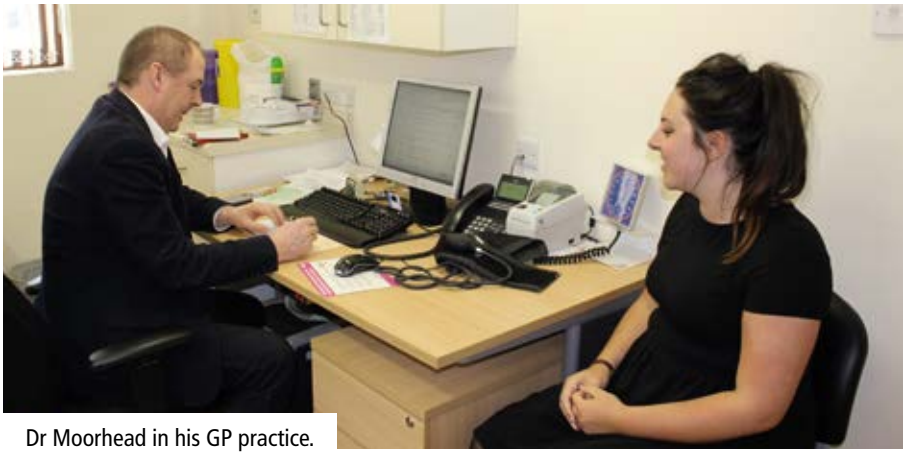
> *Services will be designed for the specific needs of a local population*
>
> Dr Tim Moorhead

If we are successful in achieving this transformation of services this will mean a real difference to the way local people seek and receive advice to keep them fit and healthy for as long as possible but also to support them when they are ill. Services will be designed for the specific needs of a local population, be much more focussed on keeping people well at home and managing ill health within a home or community setting with far less reliance on hospital based care.

This new way of doing things means we also need to work more closely with organisations outside our immediate Sheffield city boundary. Next year will mean a shift in focus to us working with our healthcare partners across a wider regional footprint. Myself and my team at the CCG will be more involved in strategic discussions about what health services should look like across the whole of South Yorkshire, not just Sheffield.

We will also continue to work with Sheffield City Council towards tighter integration of health and social care commissioning in the city, working together to develop ways of ensuring we make the best use of public funding to improve health and care for those where it's most needed. We believe that by working more closely we can help shape the delivery of services that mean people born in some areas of Sheffield no longer live 10 years longer than people born in another area. We want all our citizens to have a more equal opportunity to live life to the full.

Please keep an eye on our website and social media sites for all the latest information from our CCG as we go forward, working with our partner organisations and the people of Sheffield to transform the future of health care in the city.



Dr Moorhead in his GP practice.

How do we make sure we make a difference?

One of NHS Sheffield CCG's responsibilities is to ensure that the commissioning decisions and actions we take improve health care for the people of Sheffield and ensure patients receive the highest quality of care. We use a whole host of measures to monitor performance to make sure we can do this.

These include nationally developed measures of:

- the quality of health services, health outcomes, patient experience, patient safety – such as the NHS Outcomes Framework
- financial management and sustainability
- how well the CCG is performing in leading the local health and care system – such as CCG Assurance Framework
- how well the CCG is performing in its role as an employer - NHS Staff Survey

We also use local assessment and monitoring; contractual activity and performance; soft intelligence to ensure providers the CCG commissions services from are delivering services to the highest standard; and an internal programme management system to ensure delivery of the key projects and programmes for achievement of CCG ambitions.

Provider and System Performance

Contract monitoring and performance management is an integral part of the core business of the CCG in ensuring delivery of safe, high quality, sustainable health and care services.

The performance of providers in relation to NHS constitution pledges, Health outcome measures and contractual requirements is monitored monthly through contract monitoring meetings and reported routinely to the CCG Governing Body with recommendations for Governing Body action where appropriate.

In the event that a provider is not achieving a key performance element, or is showing a deterioration in performance, additional monitoring and performance management processes are implemented with the provider. These include clarifying the underlying causes for underachievement or deterioration in performance and specific actions the provider is taking to improve the position.

The improvement plan will be subject to more frequent monitoring than the routine monthly contract meetings. The CCG will work with the provider to consider what support might be offered to help secure improvement, for example via clinical working groups, use of external reviews and expertise from NHS Improvement bodies.

Should the required improvement not be achieved, the CCG will issue contract performance notices and apply appropriate contractual penalties.

Development of Sheffield CCG approach during 2015/16

During 2015/16 the CCG has further developed and strengthened its overall approach to provider performance.

An Integrated Performance & Delivery Board (IPDB) has been established to triangulate contracting, finance, performance measures and quality, identify underachievement or deterioration in provider and/or CCG performance and identify remedial actions. Chaired by an Executive Director, the IPDB is supported by clinical leads and Deputy Directors across the CCG responsible for the respective functions within the organisation.

We have also introduced a Contract Management Board for each provider with membership at Director level from both CCG and the provider. This complements the existing contract monitoring arrangements whilst providing a more robust oversight and escalation route. The Contract Management boards meet monthly and cover all aspects of contract management, including quality, performance measures, activity and finance. They receive issues of escalation from routine contract monitoring/management on areas of underachievement and hold providers to account. Additionally, they provide opportunity to discuss the implementation of key strategic objectives and goals of both the CCG and provider organisation.

2016/17 Governing Body

CCG Assurance Framework

At a national level, NHS England assess how well each CCG is fulfilling its function of commissioning safe, good quality, sustainable services and compassionate care. Consideration is given to how well each CCG is demonstrating such elements as:

- Effective leadership, governance, partnership working and patient and public engagement.
- robust planning and delivery of improvements in health services and health outcomes within the resources available
- strong financial management and delivery of sustainable health services for the people of Sheffield

Sheffield CCG's overall annual assessment for 2015/16 is still to be confirmed. On the basis of quarterly, interim discussions with NHS England during the year, the overall assessment outcome is anticipated to be one of "Assured as good". This reflects the position of Sheffield CCG as a well-led organisation, with a robust approach to planning, making effective use of resources to deliver improvements in health services and health outcomes within its financial allocation, whilst working with providers to address some ongoing challenges. These challenges which are being experienced in Sheffield, as they are nationally, are in relation to demand on A&E and wider hospital services, and the impact on waiting times for patients to be seen and treated.

Looking ahead to 2016/17, remedial action plans and improvement trajectories are in place with Sheffield providers. These will be fundamental to ensuring the delivery of NHS constitution and transformational challenges and thus the CCG's aspiration to return an overall assurance position of "Outstanding".

CCG Improvement and Assessment Framework for 2016/17

The CCG has actively participated in consultations and webinars to inform development of the new CCG Improvement and Assessment Framework.

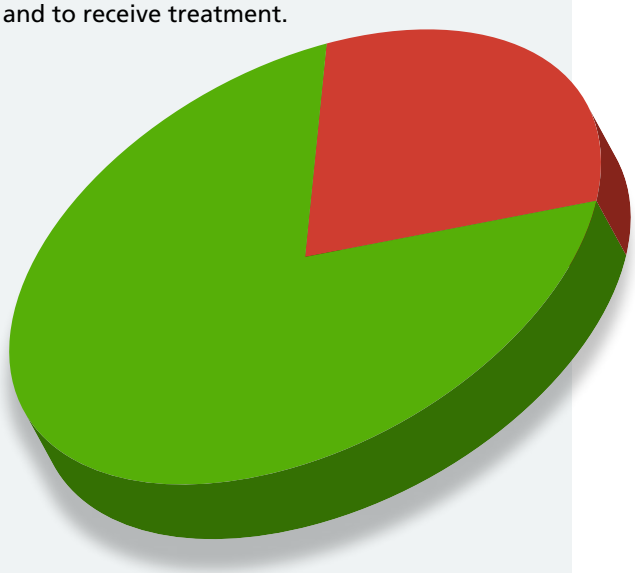
Once confirmed and in place, the new framework will be used by the CCG to support progress monitoring and to secure benchmarking intelligence to inform discussions at Contract Management Boards, Delivery Boards and the Systems Resilience Group.

NHS Constitution rights and pledges

NHS Constitution rights and pledges are an important aspect of what we are committed to delivering for the people of Sheffield and are the NHS' commitment to patients on how long they wait to be seen and to receive treatment.

During 2015/16 67% (10 out of 15) of the core NHS Constitution rights and pledges are being successfully delivered - a marginal change from the 13 out of 17 2014/15 core measures which were successfully delivered in 2014/15.

NHS Constitution – Core Measures (15): 2015/16 position



Summary of Performance 2015/16

NB. Full year data is not available until May 2016, this table reflects our year position at time of publication

PERFORMANCE MEASURE	HOW WE ARE DOING
Referral To Treatment waiting times for non-urgent consultant-led treatment Patients referred to see a specialist should be seen and, where necessary, receive treatment in a timely fashion. The majority of patients should be seen and start any necessary treatment within 18 weeks from their referral.	92% of patients waiting to be seen and where necessary treated are waiting less than 18 weeks.
Cancer waits It is important for patients with cancer or its symptoms to be seen by the right person, with appropriate expertise, within two weeks. This is to ensure early diagnosis and so is central to improving outcomes. If diagnosed with cancer, patients need to receive treatment within clinically appropriate timeframes to help ensure the best possible outcomes.	We are successfully meeting key cancer waiting times for patients to be seen within 2 weeks of referral by a GP and to receive diagnosis and start treatment within 2 months of referral by a GP.
Diagnostic test waiting times Prompt access to diagnostic tests is important in ensuring early diagnosis and so is central to improving outcomes for patients.	Challenges in relation to demand on A&E and wider hospital services have been experienced in Sheffield, as they have been nationally. The CCG has worked closely with providers to ensure quality of care and patient experience is being maintained whilst action is taken to improve waiting times.
A&E waits It is important that patients receive the care they need in a timely fashion and within 4 hours of their arrival at A&E, but without their care being rushed.	Challenges in relation to demand on A&E and wider hospital services have been experienced in Sheffield, as they have been nationally. The CCG has worked closely with providers to ensure quality of care and patient experience is being maintained whilst action is taken to improve waiting times.

Treating and caring for people in a safe environment and protecting them from harm	Sheffield has maintained its overall position on preventing health care acquired infections, and only 1 case of MRSA has been attributed to the CCG during 2015/16.
Estimated diagnosis rate for people with dementia	The rate of diagnosis of Dementia in Sheffield is currently 14.5% higher than national rates and people with Dementia are getting better access to treatment following a significant reduction in Memory Service waiting times in the last year.
Mental Health - IAPT (Improving Access to Psychological Therapies)	Sheffield has continued to reduce the level of admissions to hospital for conditions which, with effective community care and case management, should not usually require hospital admission.
Avoidable emergency admissions	Sheffield has continued to reduce the level of admissions to hospital for conditions which, with effective community care and case management, should not usually require hospital admission.
Better care fund To deliver the benefits of a truly patient centred integrated health and social care system, the CCG is leading, together with Sheffield City Council, creation of a new governance structure for the delivery of system-wide transformation objectives. Through these new structures (the Transforming Sheffield Programme) a whole system approach is being developed to service transformation, supported by a range of delivery boards which will focus on delivery of a small number of key priorities.	2015/16 has seen improvements in the following Better Care Fund measures: • percentage of people still at home after 91 days following discharge. • reducing the number of hospital bed nights due to emergency admissions for Ambulatory Care Sensitive (ACS) conditions - i.e. conditions which with effective community care and case management should not usually require hospital admission.

Date: 26 May 2016
Signed by:

Maddy Ruff
Accountable Officer

Maintaining sound financial health

2015/16 was another successful year in terms of compliance with our statutory duty of delivering financial balance against the resources allocated to the CCG by NHS England. Taking both our allocation for programme (commissioning) expenditure and our Running Cost Allowance (RCA) we reported a surplus of £7.5m or 1%, in line with our agreed financial plan. This surplus will be carried forward into 2016/17.

Our programme allocation which we use to commission health care services for the people of Sheffield was £736m and we underspent against this by £4.1m or 0.6%.

Our running cost allowance was £12.6m. This is used to fund our commissioning and governance costs and the clinical engagement activities of the CCG and its localities. As Sheffield CCG is a large CCG we benefit from economies of scale.

Despite a reduction to the allowance compared to previous years, we were still able to maintain our policy of underspending against the RCA, allowing the balance to be spent on patient care. In 2015/16 our actual spend was £10.7 m (£18.13 per head of population). In addition, we received Quality Premium funding of £1.5m based on our performance against agreed national criteria in 2014/15. Whilst the funding was added to our RCA, it was used to support service developments in primary care including IT infrastructure. These costs have to be charged to our programme allocation and hence the total underspend against our RCA was £3.4m which contributes to the overall surplus.

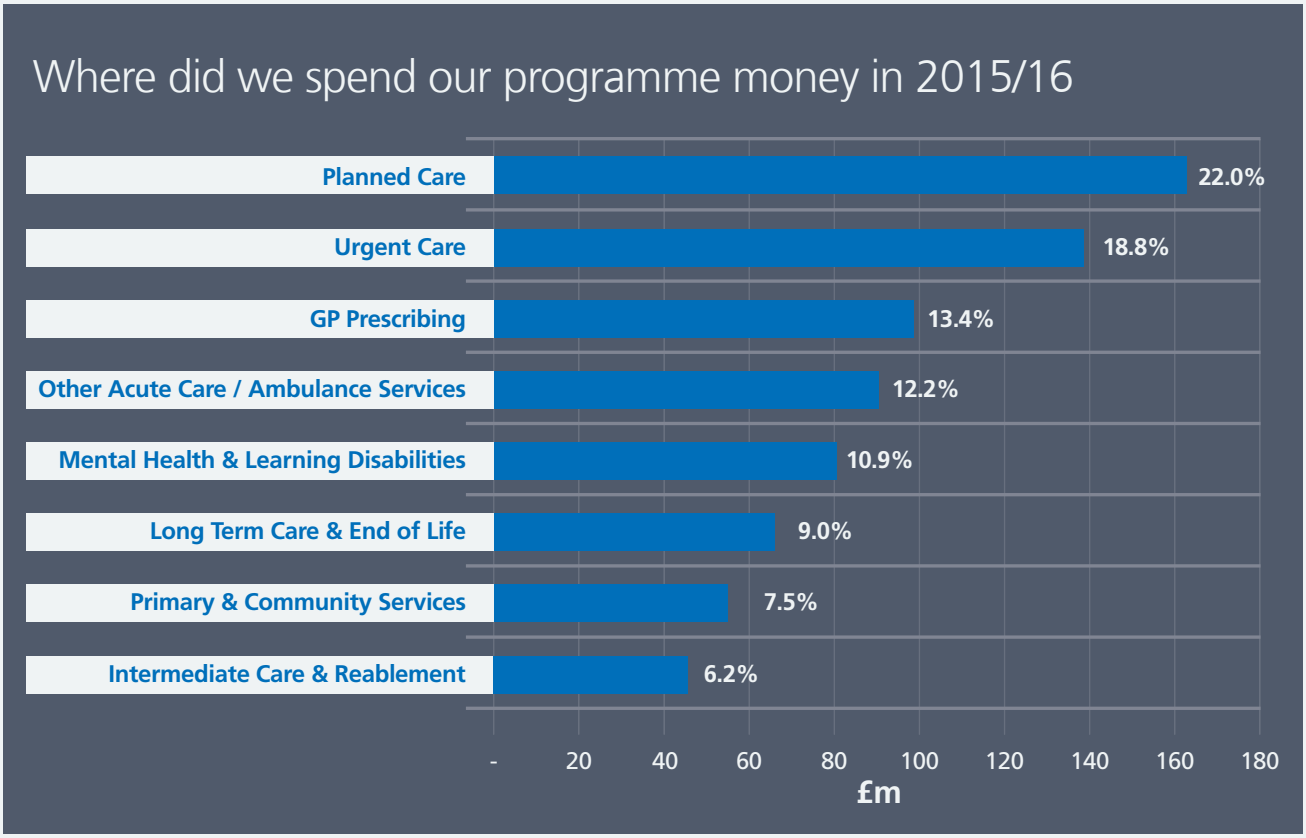
The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. The CCG has not formally signed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

			PRIOR YEAR COMPARATOR	
	2015-16 NUMBER	2015-16 WW£000	2014-15 NUMBER	2014-15 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	13,168	£107,909	13,945	£94,388
Total Non-NHS Trade Invoices Paid Within Target	13,011	£107,233	13,743	£93,861
Percentage of Non NHS Trade Invoices Paid Within Target	98.81%	99.37%	98.55%	99.44%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,447	£574,025	3,527	£570,694
Total NHS Trade Invoices Paid Within Target	3,418	£573,952	3,505	£570,655
Percentage of NHS Trade Invoices Paid Within Target	99.16%	99.99%	99.38%	99.99%

How did the CCG spend its Programme (Commissioning) Budget?

Overall, we spent an average of £1,273 per person on health care for the people of Sheffield. In 2014/15 spend was an average of £1,211 per person. The increase is in line with the allocation increase received in 2015/16.

The table below provides an analysis of how we invested our total resources in 2015/16. The analysis includes spend against external income as well our revenue resources received from NHS England. The distribution of spend is similar to 2014/15. Our spend on primary and community care is only for locally commissioned services and does not include the funding for GP Practices for core services where the contracts are held by NHS England.



Looking to the Future

CCGs were notified of their financial allocations for the next 5 years in January 2016. The headline national news is of significant additional funding for the NHS in 2016/17 and as part of this an average growth in funding of 3.4% for CCGs. However, because Sheffield CCG is deemed to have historic funding which is 8.1% in excess of its "fair shares" allocation using the new funding formula approved by NHS England's Board, we have received an uplift of only 2.2% (£16m). We have a range of pre-commitments and pressures to meet which means the CCG has assessed as part of its planning process that we can only plan for a 0.5% of £3.5m surplus (rather than the 1% expected by NHS England) and to do this we need to deliver £19.5m of efficiency savings across all areas of spend which will be very challenging.

At the same time as preparing detailed financial plans for 2016/17, the CCG is also working with all key partners across the South Yorkshire and Bassetlaw area on our joint 5 year Sustainability and Transformation plan, which includes making an assessment of the overall financial challenge we face and how we might meet this challenge through transforming services. We have to make a first joint submission to NHS England by the end of June 2016.

Corporate Governance Report

Directors Report

NHS Sheffield CCG Governing Body – Composition and Profiles

The CCG Governing Body is responsible for NHS clinical commissioning decisions across Sheffield. They meet formally once a month and are a mixture of NHS clinicians, experienced NHS managers and lay members

Dr Tim Moorhead, Chair

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

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

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

Maddy Ruff, Accountable Officer (from 1 September 2015)

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

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

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

Julia Newton, Chief Finance Officer

Julia Newton was appointed as Director of Finance at NHS Sheffield CCG in July 2012. A chartered accountant, Julia has held a number of senior finance posts since joining the NHS in 1992 including Director of Finance at NHS Sheffield. Julia is our lead executive director for contracting and procurement, as well as overseeing all aspects of financial planning, accounting and governance. She is also undertaking the lead finance role for all CCGs in South Yorkshire and Bassetlaw in the formulation of the five year region wide plans.

Kevin Clifford, Chief Nurse

Kevin Clifford was appointed to the Chief Nurse post in September 2012. Kevin joined NHS Sheffield in March 2010 as Chief Operating Officer for Provider Services and since September 2012 has fulfilled his role as Nurse member of the Sheffield CCG. Kevin, a registered nurse since 1983, previously worked at Sheffield Teaching Hospitals NHS Foundation Trust where he was Nurse Director for Emergency Care and Director of Clinical Operations. Kevin is Vice Chair of the Quality Assurance Committee. Once completing his nurse training he obtained a BSC in Nursing Studies at Leeds Polytechnic and a MSc in Health Economics and Management at SCHARR, University of Sheffield. More recently, in 2011 Kevin completed the Top Manager Programme at the Kings Fund.

Tim Furness, Chief of Business Planning and Partnerships

Tim Furness was appointed to his Director role in the CCG in September 2012. He joined the NHS in 1990 and has worked in primary care commissioning since becoming a GP Fundholding Manager in 1993. He has lived in Sheffield since coming here as a student in 1979. He is committed to making a difference to patient care and outcomes and is particularly interested in tackling health inequalities in the city and ensuring equality of access to services for all citizens of the city. His experience in commissioning organisations since 1993 helps us to make sure our business processes achieve change for patients.

Idris Griffiths, Chief Operating Officer (Acting Accountable Officer from 1 April 2015 to 31 August 2015)

Idris has been an Executive Director at the CCG since it was established in 2013 and has worked in the NHS for over 25 years. Prior to working in commissioning, Idris held a number of senior roles in community services and acute hospitals, including the roles of Deputy Director of Operations and Assistant Director of Strategy and Turnaround. Idris is passionate about addressing health inequalities and supporting people with long term conditions to live independently. Idris works collaboratively with staff, the public and across organisations to continually improve health and social care. Idris has an MBA and the Chartered Institute of Personnel and Development post graduate diploma.

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 PEC Chair. During that time he is 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 with Dr Richard Oliver, 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, as well as sitting on the CCG Governing Body and being an active member of the organisation's executive team. He will always be passionate about the NHS, preserving and championing its founding principles, to deliver the best possible care for the people of his adopted city.

Dr Amir Afzal, Central Locality Appointed Representative

Amir is a Sheffield GP and has worked at Duke Medical Centre as a Partner since 1994 working with some of the most vulnerable people in society. He is now senior partner at the practice. Amir is also the central locality representative on the CCG Board having worked with the central locality previously.

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 the human touch are not lost.

Dr Ngozi Anumba, Hallam and South Locality Appointed Representative (from 18 May 2015)

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

Dr Nikki Bates, Elected Member

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

Nikki has a special interest in the health of Young People and Students and works with the Children's and Young Peoples Portfolio within the CCG. She is also a Partner Governor at Sheffield Children's Hospital where she is keen to help develop services for Sheffield children. To give our children the Best Start in life is a key aim and priority of Sheffield CCG and Sheffield City Council.

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

Dr Anil Gill, Elected Member

Dr Anil Gill has been a GP since 1999 and has worked in Sheffield since 2005. He is the Senior Partner at Selborne Road Medical Centre.

He was elected by his GP colleagues across Sheffield to join the CCG from its inception in 1 April 2013. His particular interests are acute care and his early work with the CCG involved developing IT connectivity between primary and secondary care thus enabling improved record sharing and patient care.

He has a national role as a Medical Director for NHS Pathways which provides clinical assessment in the urgent care environment. He uses his clinical experience as a GP to improve patient safety within his national work, and assists the CCG in developing new models of urgent care provision within Sheffield. He fully supports the drive to better coordinate social and health care.

Dr Marion Sloan, Elected Member

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

She 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 has worked with Primary Care Sheffield and Heeley Development Trust developing the Practice as a community hub. Activities including coffee mornings to provide social interaction , talks by expert patients and demos from the Third Sector, empowering people through education to be motivated to promote their own health through a healthy lifestyle.

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

Dr Leigh Sorsbie, North Locality Appointed Representative

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

She is passionate about ensuring high-quality, evidenced-based clinical care is available for everyone within the city, regardless of postcode or background. Her work in Firth Park has enabled her to experience the challenges faced by communities in ethnically diverse areas of high deprivation, and 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 & also on families and in the wider community. She sits on the Mental Health commissioning team, working together to ensure that mental health problems are given an equal prominence as physical health problems, both in terms of treatment and prevention.

Leigh also works as a GP appraiser, providing ongoing support to practising GPs throughout Sheffield.

Dr Ted Turner, Elected Member

Ted graduated in 1988 and has been a GP at Shiregreen Medical Centre in Sheffield since 1995. Ted's interests include dermatology and skin surgery, cardiovascular medicine and care of the elderly. Ted is a member of the Remuneration and Terms of Service Committee and the Sheffield Health and Wellbeing Board. He is Governing Body lead for patient and public involvement.

Dr Devaka Fernando, Secondary Care Doctor (from 16 July 2015)

Professor Devaka Fernando is a consultant endocrinologist, trained in clinical endocrinology, clinical epidemiology and medical management. He has been service director, head of service and associate medical director at Sherwood Forest Hospitals NHS Foundation trust and was a member of the governing body of Thanet CCG. Devaka has also been a health service development consultant to the World Bank in projects in South East Asia and has been an invited speaker at the Health Informatics and Medical Management Society meetings in Europe, Australia and South East Asia. He serves on the Diabetes Forum, which is a parliamentary advisory think tank. Devaka lives in Sheffield and is a user of health care resources in the city. He has also been a youth rugby coach.

John Boyington CBE, Lay Member

John worked for over 40 years in health services, both in the NHS and Civil Service. He originally trained as a nurse in Sheffield and has held chief executive posts in NHS Trusts and a PCT. He received the CBE in 2007 for leading national prisoner health care reforms and for five years was Director of the World Health Organisation (WHO) Collaborating Centre for prisons and public health. John is Vice Chair of the CCG Governing Body and Chair of the Audit and Integrated Governance and Remuneration and Terms of Service Committees, and has lead responsibility for governance. He is passionate about change in the NHS to ensure that services deliver what people need in a way that is easily accessible.

Amanda Forrest, Lay Member

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

Mark Gamsu, Lay Member

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

Phil Taylor, Lay Member (from 1 March 2016)

Phil was appointed as a lay member in March this year with responsibility for audit, governance and strategy. He is a qualified accountant and has had wide Director level experience in the NHS and Department of Health since he joined the NHS in 1991 as Finance Director of the Northern General Hospital. He has been chair of the Healthcare Financial Management Association and Senior Independent Trustee of the NHS Confederation. Phil believes that excellent governance is crucial for the quality of health and wellbeing services in Sheffield and is committed to improving value for money. He has a mentoring qualification and is currently the chair of the Sheffield Hospitals Charity.

Register of Interests of Governing Body Members

The CCG maintains a Register of Interests. An extract of the Register giving the position for Governing Body Members at 31 March 2016 can be found at Appendix A on pages 60-61 of this Accountability Report.

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 interests within its Constitution.

Declaration:

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

- *So far as the member is aware, that there is no relevant audit information of which the CCG's external auditor is unaware; and,*
- *That the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information*

Audit and Integrated Governance Committee

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

- John Boyington CBE, Lay Member (Chair up to 2 March 2016)
- Phil Taylor, Lay Member (Chair) (from 3 March 2016)
- Amanda Forrest, Lay Member (Deputy Chair)
- Dr Ngozi Anumba, CCG GP (from 15 May 2015)
- Dr Leigh Sorsbie, CCG GP

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

Information on personal data related incidents

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

Our Member Practices

The following is a list of all of NHS Sheffield CCG's 86 GP member practices listed by localities

LOCALITY	PRACTICE NAME	PRACTICE ADDRESS	TOWN	POSTCODE
Central	Abbey Lane Surgery	23 Abbey Lane	Sheffield	S8 0BJ
Central	Baslow Road,Shoreham Street and York Road Surgeries	148 Baslow Road, Totley	Sheffield	S17 4DR
Central	Carrfield Medical Centre	Carrfield Street	Sheffield	S8 9SG
Central	Clover Group Practice	Highgate Surgery, Highgate, Tinsley	Sheffield	S9 1WN
Central	Darnall Health Centre (Mehrotra)	2 York Road	Sheffield	S9 5DH
Central	Dovercourt Surgery	3 Skye Edge Avenue	Sheffield	S2 5FX
Central	Duke Medical Centre	28 Talbot Road	Sheffield	S2 2TD
Central	East Bank Medical Centre	555 East Bank Road	Sheffield	S2 2AG
Central	Gleadless Medical Centre	636 Gleadless Road	Sheffield	S14 1PQ
Central	Handsworth Medical Practice	432 Handsworth Road	Sheffield	S13 9BZ
Central	Heeley Green Surgery	302 Gleadless Road	Sheffield	S2 3AJ
Central	Manor Park Medical Centre	204 Harborough Avenue	Sheffield	S2 1QU
Central	Manor Top Medical Centre (Read)	Rosehearty Ridgeway Rd	Sheffield	S12 2SS
Central	Manor Top Medical Centre (Sharma)	Rosehearty Ridgeway Rd	Sheffield	S12 2SS
Central	Norfolk Park Medical Practice	Tower Drive	Sheffield	S2 3RE
Central	Park Health Centre	190 Duke Street	Sheffield	S2 5QQ
Central	Sharrow Lane Medical Centre	129 Sharrow Lane	Sheffield	S11 8AN
Central	Sloan Medical Centre	2 Little London Road	Sheffield	S8 0YH
Central	The Mathews Practice Belgrave	Belgrave MC, 22 Asline Road	Sheffield	S2 4UJ
Central	The Medical Centre	1a Ingfield Avenue	Sheffield	S9 1WZ
Central	Veritas Health Centre	243-245 Chesterfield Rd	Sheffield	S8 0RT
Central	White House Surgery	1 Fairfax Rise	Sheffield	S2 1SL
Central	Woodseats Medical Centre	4 Cobnar Road	Sheffield	S8 8QB
HAS	Avenue Medical Practice	7 Reney Avenue	Sheffield	S8 7FH

Table cont. >

> Table cont.

HAS	Bents Green Surgery	98 Bents Road	Sheffield	S11 9RL
HAS	Birley Health Centre	120 Birley Lane	Sheffield	S12 3BP
HAS	Carterknowle And Dore Medical Practice	1 Carterknowle Road	Sheffield	S7 2DW
HAS	Charnock Health Primary Care Centre	White Lane	Sheffield	S12 3GH
HAS	Falkland House	2a Falkland Road	Sheffield	S11 7PL
HAS	Greystones Medical Centre	33 Greystones Rd	Sheffield	S11 7BJ
HAS	Hackenthorpe Medical Centre	Main Street, Hackenthorpe	Sheffield	S12 4LA
HAS	Jaunty Springs Health Centre	53 Jaunty Way	Sheffield	S12 3DZ
HAS	Manchester Road Surgery	484 Manchester Road	Sheffield	S10 5PN
HAS	Meadowgreen Health Centre	Old School Medical Centre, School Lane	Sheffield	S8 7RL
HAS	Mosborough Health Centre	34 Queen Street	Sheffield	S20 5BQ
HAS	Nethergreen Surgery	34-36 Nethergreen Road	Sheffield	S11 7EJ
HAS	Owlthorpe Medical Centre	Moorthorpe Bank	Sheffield	S20 6PD
HAS	Richmond Medical Centre	462 Richmond Road	Sheffield	S13 8NA
HAS	Rustlings Road Medical Centre	105 Rustlings Road	Sheffield	S11 7AB
HAS	Selborne Road Medical Centre	1 Selborne Road	Sheffield	S10 5ND
HAS	Sothall Medical Centre	24 Eckington Road	Sheffield	S20 1HQ
HAS	Stonecroft Medical Centre	871 Gleadless Road	Sheffield	S12 2LJ
HAS	The Hollies Medical Centre	20 St Andrews Road	Sheffield	S11 9AL
HAS	The Medical Centre Crystal Peaks	15 Peaks Mount	Sheffield	S20 7HZ
HAS	Totley Rise Medical Centre	96 Baslow Road	Sheffield	S17 4DQ
HAS	Westfield Health Centre	Westfield Northway	Sheffield	S20 8NZ
HAS	Woodhouse Health Centre	5-7 Skelton Lane, Woodhouse	Sheffield	S13 7LY
North	Barnsley Road Surgery	899 Barnsley Road	Sheffield	S5 0QJ
North	Bluebell Medical Centre	356 Bluebell Road	Sheffield	S5 6BS
North	Buchanan Road Surgery	72 Buchanan Road	Sheffield	S5 8AL
North	Burncross Surgery	1 Bevan Way, Chapeltown	Sheffield	S35 1RN
North	Burngreave Surgery	5 Burngreave Road	Sheffield	S3 9DA
North	Crookes Valley Medical Centre	1 Barber Road	Sheffield	S10 1EA
North	Dunninc Road Surgery	28 Dunninc Road, Shiregreen	Sheffield	S5 0AE
North	Elm Lane Surgery	104 Elm Lane	Sheffield	S5 7TW
North	Firth Park Surgery	400 Firth Park Road	Sheffield	S5 6HH
North	Foxhill Medical Centre	363 Halifax Road	Sheffield	S6 1AF
North	Grenoside Surgery	60 Greno Crescent, Grenoside	Sheffield	S35 8NX
North	Mill Road Surgery	98a Mill Road	Sheffield	S35 9XQ
North	Norwood Medical Centre	360 Herries Road	Sheffield	S5 7HD
North	Page Hall Medical Centre	101 Owler Lane	Sheffield	S4 8GB
North	Pitsmoor Surgery	151 Burngreave Road	Sheffield	S3 9DL
North	Sheffield Medical Centre	21 Spital Street	Sheffield	S3 9LB
North	Shiregreen Medical Centre	492 Bellhouse Road	Sheffield	S5 0RG
North	Southey Green Medical Centre	281 Southey Green Road	Sheffield	S5 7QB
North	The Ecclesfield Group Practice	96a Mill Road, Ecclesfield	Sheffield	S35 9XQ
North	The Health Care Surgery	63 Palgrave Road	Sheffield	S5 8GS
North	Upperthorpe Medical Centre	30 Addy Street, Upperthorpe	Sheffield	S6 3FT
North	Upwell Street Surgery	93 Upwell Street	Sheffield	S4 8AN
North	Wincobank Medical Centre	205 Tyler Street	Sheffield	S9 1DJ
West	Broomhill Surgery	5 Lawson Road	Sheffield	S10 5BU
West	Deepcar Medical Centre	271 Manchester Rd, Deepcar	Sheffield	S36 2RA
West	Devonshire Green Medical Centre	126 Devonshire Street	Sheffield	S3 7SF
West	Dykes Hall Medical Centre	156 Dykes Hall Road	Sheffield	S6 4GQ
West	Far Lane Medical Centre	1 Far Lane	Sheffield	S6 4FA
West	Harold Street Medical Centre	2 Harold Street	Sheffield	S6 3QW
West	Oughtibridge Surgery	Church Street, Oughtibridge	Sheffield	S35 0FW
West	Porter Brook Medical Centre	9 Sunderland Street	Sheffield	S11 8HN
West	Sheffield City GP HC (REG)	Rockingham House, 75 Broad Lane	Sheffield	S1 3PB

Table cont. >

> Table cont.

West	Stannington Medical Centre (Shurmer)	Uppergate Road	Sheffield	S6 6BX
West	Stocksbridge Medical Group	Johnson Street, Stocksbridge	Sheffield	S36 1BX
West	The Crookes Practice	203 School Road	Sheffield	S10 1GN
West	Tramways Medical Centre (Milner)	54a Holme Lane	Sheffield	S6 4JQ
West	Tramways Medical Centre (O'Connell)	54 Holme Lane	Sheffield	S6 4JQ
West	University Health Service Health Centre	53 Gell Street	Sheffield	S3 7QP
West	Walkley House Medical Centre	23 Greenhow Street	Sheffield	S6 3TN

Statement of Accountable Officer's Responsibilities

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

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

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

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

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

Date: 26 May 2016
Signed by:

Maddy Ruff
Accountable Officer

Annual Governance Statement

1 Introduction

NHS Sheffield CCG was licensed from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the NHS Act 2006.

As at 1 April 2015, the CCG was licenced without conditions.

The CCG was created as a whole city CCG (with four localities) and a geography coterminous with our Local Authority, Sheffield City Council. During 2015/16 the CCG has pursued a wide ranging programme of organisational development (OD), including governance issues, overseen by the Governing Body. The OD Steering Group monitors progress, and has included governance as a principal risk on our Assurance Framework so that a continual focus remains on ensuring CCG processes are robust. The CCG aims to be a strong and effective clinically led commissioning organisation, both within local and national networks, to achieve high quality, value for money services for the people of Sheffield, and robust governance is essential to achieving that aim.

2 Scope of responsibility

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

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

3 Compliance with the Corporate Governance Code

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

3.1 Principle Leadership

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

The Chair is responsible for leadership of the Governing Body and ensuring its effectiveness on all aspects of its role and in particular a clear process for decision making. Our three Lay Members, with an additional lay member joining the CCG from 1 March 2016, are valued for their impartial focus and expertise, their role is to oversee key elements of governance including audit, remuneration, and engagement, including conflicts of interest. We rely on their constructive challenge as well as them assisting in the development of strategy. All committees are chaired by a Lay Member.

The Governing Body sets the CCG's strategic aims and, with a revenue resource limit of £735.8m for programme spend and £14.2m for running costs for 2015/16, ensures that the necessary financial and human resources are in place for the organisation to meet its objectives.

3.2 Principle of Effectiveness

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

A comprehensive OD programme is in place, primarily targeting the needs of Governing Body members, but also open to Commissioning Executive Team clinical leads, enabling them to regularly update and refresh their skills and knowledge and support the CCG's programme for succession planning.

To enable the Governing Body to discharge its duties, information is received in a timely manner well in advance of meetings, with a choice of formats (hard or electronic).

All papers presented at Governing Body and Committee meetings follow a recommended format including a standard front sheet, with three important functions:

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

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

3.3 Principle of Accountability

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

- Papers presented to each Governing Body meeting, (e.g. Finance, Quality and Delivery reports)
- The development and publication of an Annual Plan
- The development of publication of an Annual Report
- Meetings of the Members' Council.

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

3.4 Principle of Remuneration

The Remuneration Committee oversees the appointment of all Governing Body Members and has delegated authority to determine their remuneration and conditions of service, taking into account any national directions or guidance on these matters. The Committee has the delegated authority to review the performance of the Chief Officer (Accountable Officer) and other senior CCG employees and determine any financial awards as appropriate.

3.5 Principle of Relations with Stakeholders

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

We seek to cultivate a mutual understanding of objectives.

We undertake this by sharing information in a variety of ways including:

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

4 Clinical Commissioning Group Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

"The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it."

4.1 Constitution

NHS Sheffield CCG is a member organisation comprising 86 member practices and our Constitution has been approved by them. The Constitution reflects how the organisation operates. It sets out the CCG's powers and functions and describes our mission, values and aims and how these are delivered though the governance framework.

The Constitution includes:

- Membership and the area we cover
- Our Mission, Values and Aims
- Functions and duties
- Decision Making: The General Structure
- Roles and Responsibilities
- Standards of Business Conduct and Managing Conflicts of Interest
- The CCG as Employer
- Transparency and Ways of Working
- Standing Orders, Scheme of Reservation and Delegation and our Prime Financial Policies
- Terms of reference of the CCG's formal Committees and sub-Committee

The Constitution was reviewed and updated three times throughout 2015 – 16. The following key changes were proposed and agreed by NHS England:

- The job title of the Chief Officer was changed to Accountable Officer
- The job title of Clinical Director was changed to Medical Director
- Clarity regarding delegation of functions by Governing Body Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this is permitted by their Terms of Reference
- The Governing Body can now co-opt other non-voting attendees as it sees fit from time to time
- The Hallam and South Consortium locality changed its name to Hallam and South Locality (HAS)
- The Valley Medical Centre changed its name to Stocksbridge Medical Group
- Addition of Primary Care Commissioning Committee with Terms of Reference for the establishment of the Primary Care Commissioning Committee
- Two lay members were identified as having in addition to their other responsibilities, a lead on primary care commissioning
- A fourth lay member was recruited to the Governing Body
- Change of role of the Vice Chair of the Governing Body who will lead on primary care commissioning
- General changes to the Role of the Lay Member with a lead role in overseeing key elements of financial management

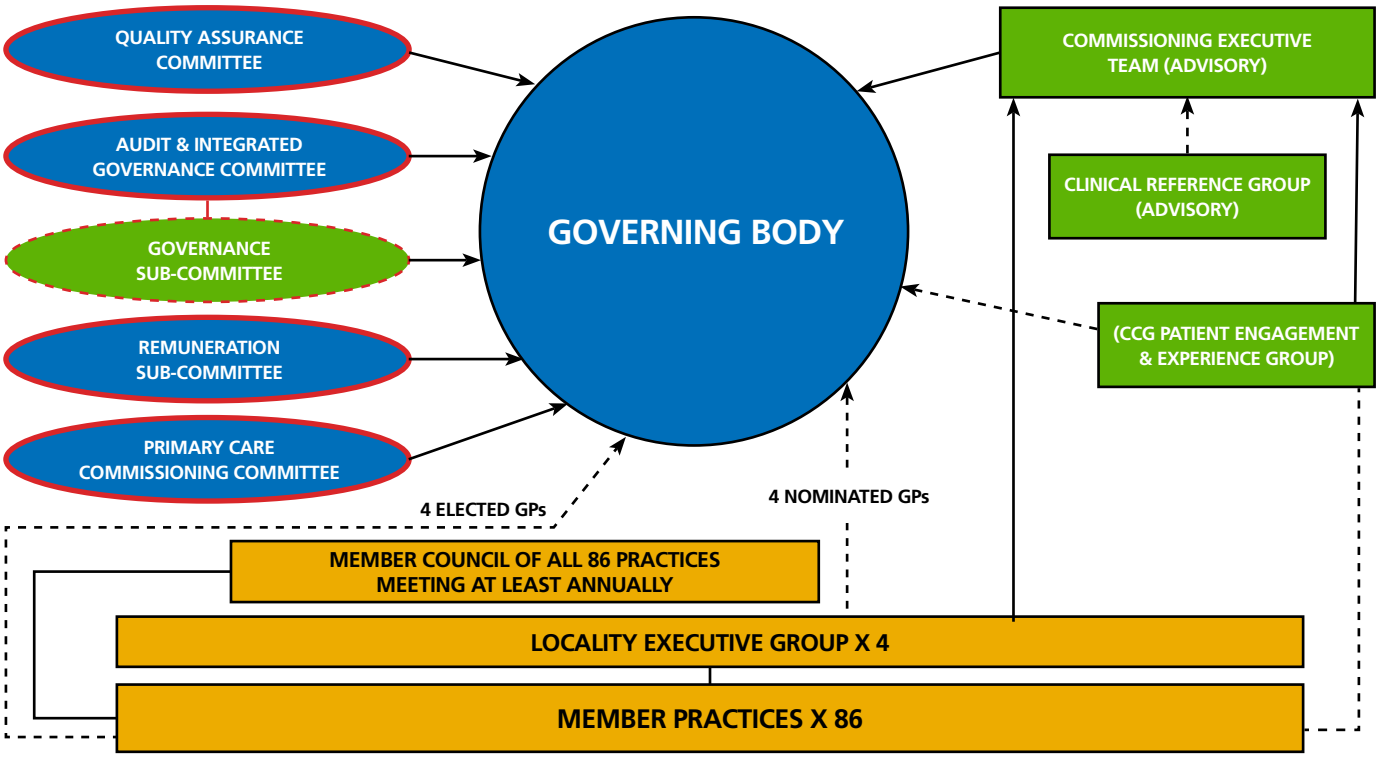
- General changes to the role of the lay member with the lead role in championing patient and public participation
- General changes to the role of the two lay members identified to support and oversee key arrangements in respect of primary care commissioning.
- The number of GP practices changed from 87 to 86.

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

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

Fig 1

NHS Sheffield CCG - Governance Structure Overview – 2015/16



4.2 Governing Body, Committees, Sub-committees and Joint Committees

The Governing Body met on the first Thursday of each month throughout the period 1 April 2015 to 3 December 2015 with the exception of August (no meeting took place) and was quorate at each meeting. An additional meeting to discuss the Redistribution of Personal Medical Services (PMS) Premium Funding was held in July.

Following senior management discussion a recommendation was made to the December meeting that the Governing Body would meet in public bimonthly with effect from 1 January 2016. The rationale for this proposal was to enable the CCG to dedicate more time to development of strategy, which will often include discussion of issues that cannot yet be discussed in public, and to clearly separate the Governing Body's strategic and assurance roles. Governing Body would alternate meetings held in public with private strategy development meetings. The Governing Body has subsequently met in pubic bi-monthly from 1 January 2016 when the meeting was held on the second Thursday.

Attendance is monitored as part of the CCG monitoring systems and details of attendance are available on all Governing Body minutes which are published on the CCG webpage www.sheffieldccg.nhs.uk/about-us/GB-meetings.htm

The Governing Body has a clear division of individual's responsibilities, with no one individual having unfettered powers of decision. It is collectively responsible for the long term success of the CCG and comprises:

- CCG Chair
- Chief Officer (from June 2015 Accountable Officer)
- Medical Director from 1 April 2015 (previously Clinical Director)
- 4 Elected GP members
- 4 Locality appointed GP members (one is the CCG Chair)
- 3 Lay Members (one is the CCG Vice Chair, with an additional lay member appointed from 1 March 2016)
- Secondary Care Doctor
- Chief of Business Planning & Partnerships
- Chief Operating Officer
- Director of Finance
- Chief Nurse

The Chair is responsible for leadership and ensuring effectiveness of the Governing Body. The Governing Body and its committees draw their membership from a broad pool of NHS clinicians, staff, and lay members, providing the appropriate balance of skills, experience, independence and knowledge of the organisation to enable them to discharge their respective duties and responsibilities effectively.

The CCG aspires to be a strong and forward thinking organisation. Its success depends on strong partnerships with constituent practices, local communities and external organisations. Members of the Governing Body have proactively sought strong relationships collectively and individually through:

- "Board to Board" meetings where the Governing Body met with the Boards of our Foundation Trusts
- Executive to Executive meetings with the Local Authority held on four occasions throughout the year
- Joint working through Partnerships Boards with the Local Authority
- Joint working through partnership arrangements with neighbouring CCGs and Core City CCGs
- A joint arrangement with the CCG's from South Yorkshire and Bassetlaw, Hardwick and North Derbyshire for the CCG Collaborative Commissioning Network (known as CCGCOM)
- Joint working with the Sheffield Universities for the delivery of education and development; the CCG is working with Sheffield Universities and Yorkshire and Humber Commissioning Support (YHCS) to develop a bespoke programme for clinical leadership and succession planning.
- Joint working with NHS England at both national and local area team levels

4.2.1 Performance / Highlights of Governing Body:

The Governing Body is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. During 2015/16 it has maintained sound risk management and internal control systems as described in the Risk Management and Internal Control Framework sections.

A range of governance and strategic reports have been considered by the Governing Body including assurances on quality, finance and performance. Meetings are held in public and agendas, papers, and minutes are published on the CCG website. All Governing Body agendas include the requirement for declarations of interest. The Governing Body receives information in a timely manner in a form and of a quality appropriate to enable it to discharge its duties. This continues to be a priority area for 2015/16.

Between April and December 2015 monthly Governing Body Meetings held in public commenced at 4.00 pm. From January 2016, bi-monthly Governing Body meetings held in public are conducted between 2.00 pm – 4.15 pm followed by meeting in private.

Executive directors, clinical leads and lay members are subject to formal assessment and appraisal processes. A comprehensive induction and bespoke development programme is in place for all Governing Body members, the 2015/16 Programme has included:

- Information Governance awareness
- Procurement and Competition Law
- Integration
- Finance, Commissioning Contracts and Sanctions
- Making system change happen timely, defining the problems and creating the solutions
- Developing and Communicating the Culture/Exemplary Engagement and Customer Focus (this included patient participation, equality, exemplary engagement, quality, majoring on safeguarding as a commissioner
- Planning - Commissioning Intentions 2015/16
- Media Training Refresher / Public Speaking

4.3 Committees

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

- Audit and Integrated Governance
- Quality Assurance
- Remuneration and Terms of Service
- Primary Care Commissioning Committee

Each Committee has formal terms of reference which form part of our Constitution, and provides summary reports to the Governing Body. The terms of reference of each of these committees were reviewed as part of the Constitution reviews undertaken in June, September 2015 and January 2016, ensuring they remained fit-for-purpose and offered stringent governance assurance.

4.3.1 Audit and Integrated Governance Committee (AIGC)

This Committee is chaired by the lay member with a lead role in overseeing key elements of financial management and audit. 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.

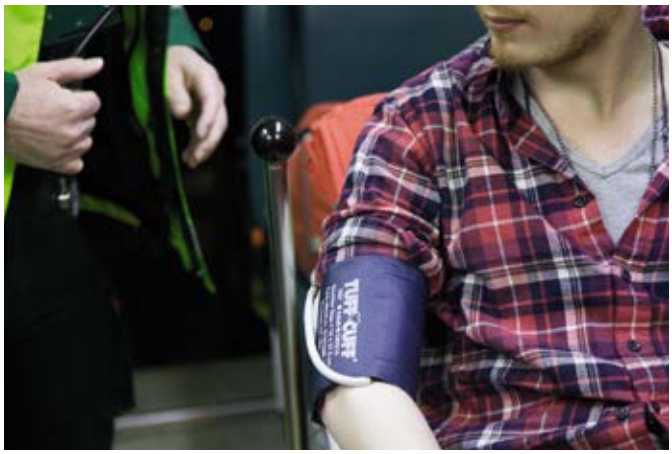
The Committee also has delegated authority to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the CCG's activities.

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

Performance / Highlights of Audit and Integrated Governance Committee

Key areas of the committee's work in 2015/16 included:

- Approval of the annual programme of work to be undertaken,



- Review of Internal Audit and Counter Fraud Services; in year monitoring and delivery against plans
- Review of policies against NHS Protect Standards for Bribery and Corruption against the Bribery Act 2010
- Updates from external auditors
- Ongoing review of various aspects of internal control, including updates on key quality and performance issues from the Quality Assurance Committee
- Review of the Governing Body Assurance Framework with particular focus on ongoing identified gaps in control and/or assurance.
- Review of attendance at Governing Body and its committees
- Annual review of the CCG's Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies
- Preparing for the process of appointing external auditors in 2016.

4.3.2 Quality Assurance Committee (QAC)

This 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 exceptional reporting to Governing Body on quality concerns and good practice. During the year it has streamlined reporting and prioritised areas for discussions with providers where serious concerns are raised, to enable decision making on future actions.

Performance / Highlights of Quality Assurance Committee:

Key areas of the Committee work during the 2015/16.

- The Committee has continued to develop and deliver its responsibilities. Specifically, the Committee has:
- Systematically reviewed provider's performance in relation all areas of quality including performance against national reviews and priorities.
- Reviewed feedback relating to providers from the Care Quality Commission and other regulatory bodies and taken action with providers where appropriate.
- Monitored patient safety issues, including Serious Incident, Never Events, targets and plans to reduce Hospital and community acquired infection.

- Approved strategies for Commissioning for Quality and Safeguarding, incorporating lessons learned from national reviews such as Winterbourne View.
- Monitored patient feedback from both provider and public websites.
- Received feedback from subgroups and made decision's relation to any further actions.
- Reviewed and approved clinical policies and procedures.
- Received reviews from Internal Audit relating to the internal functions of the CCG's clinical governance systems.
- Provided Feedback to Governing Body on a Quarterly basis.
- The chair and officers met with the chair of the children's hospital and discussed areas of common interest and concern, and agreed to hold a committee to committee meeting to work together for the future.

4.3.3 Remuneration Committee

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

In May 2015 the Committee confirmed the appointments of Dr Ngozi Anumba, GP Locality Representative for Hallam and South and in July 2015 Dr Devaka Fernando, Secondary Care doctor as members of the Governing Body. Both have a three year tenure of office.

Performance / Highlights of Remuneration Committee:

During 2015/16 key areas considered by the Committee included:

- Review of Remuneration Committee Terms of Reference
- CCG Senior Officers' Remuneration
- Governing Body GPs, Secondary Care Doctor, Medical Director, Lay Members', Commissioning Executive Team (CET) and Clinical Directors' Remuneration
- Managing the Accountable Officer recruitment process
- Managing the Secondary Care Doctor recruitment process
- Managing the Governing Body Nominated Locality GP Representative process
- Outcomes of relevant performance reviews

4.3.4 Primary Care Commissioning Committee

The Committee formally came into existence in November 2015 and has met on two occasions. The Committee formally accepted responsibility for commissioning primary care services on behalf of the CCG from April 1st 2016.

Performance / Highlights of Primary Care Commissioning Committee

During 2015/16 key areas considered by the Committee included:

- Approval of the Assessment Review Process for Agreeing Special Cases Applications
- Approval of the Locally Commissioned Service (LCS) mechanism to support the equalisation of GP Finances
- Monitoring of the development of the Primary Care Strategy
- Oversee the implementation of primary care co-commissioning with the CCG
- Review of the implementation of the Primary Care Transformation Fund initiative
- Scrutiny of the procurement of Alternative Provider Medical Services (APMS)

4.4 Committee Membership and Attendance

The table below sets out details of membership and attendance at each of the CCG's Committees. All meetings of all Committees were quorate throughout the year

COMMITTEE	MEMBERSHIP	ROLE	ATTENDANCE	
All Committees meet quarterly or as necessary			actual	possible
Audit & Integrated Governance	John Boyington	Lay Member and Chair (up to 29.2.16)	4	4
	Phil Taylor	Lay Member and Chair (from 1.3.16)	1	1
	Amanda Forrest	Lay Member and Vice Chair	4	4
	Ngozi Anumba	CCG GP Governing Body Member	3	3
	Leigh Sorsbie	CCG GP Governing Body Member	2	4
Quality Assurance	Amanda Forrest	Lay Member and Chair	4	4
	Kevin Clifford	Chief Nurse and Vice Chair	2	4
	Amir Afzal	CCG GP Lead for Quality	2	4
	Devaka Fernando	Secondary Care Doctor (from 16.7.15)	1	3
	Jane Harriman	Deputy Chief Nurse	4	4
	Zak McMurray	Medical Director	4	4
Primary Care Commissioning (meets monthly)	John Boyington	Lay Member and Chair	2	2
	Mark Gamsu	Lay Member and Vice Chair	1	2
	Kevin Clifford	Chief Nurse	1	2
	Julia Newton	Director of Finance	2	2
	Maddy Ruff	Accountable Officer	1	2
Remuneration Committee	John Boyington	Lay Member and Chair	4	4
	Amanda Forrest	Lay Member and Vice Chair	4	4
	Amir Afzal	CCG GP Governing Body Member	4	4
	Nikki Bates	CCG GP Governing Body Member	1	4
	Ted Turner	CCG GP Governing Body Member	4	4

4.5 Sub Committees

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

It receives reports on high level risks, reviews the risk register and scrutinises any new organisational risks and their associated risk scores. The Sub-committee receives reports from a number of sub groups including information governance, freedom of information, health and safety and the Equalities Action Group. Reports to the sub-committee include quarterly updates in relation to workforce planning, finance, and legal claims and litigation and Compliments and Complaints. The Sub-committee also receives reports with regard to the review and implementation of CCG policies. All corporate and HR policies are approved by this sub-committee.

Performance / Highlights of Governance Sub-Committee

During 2015/16 key areas considered by the Committee included:

- The Governing Body Assurance Framework (GBAF) is reviewed at each meeting
- Principal risks were reviewed and challenged and in particular identified gaps in controls and/or assurances were challenged by its members
- The operational risk register was reviewed at each meeting and the scores of all new risks scrutinised and approved
- Review and refresh of the incident reporting system, resulting in a more efficient process which was relevant to CCG staff, providing assurance that actions were taken following reported incidents in order to minimise the likelihood of future re-occurrence
- Assurance was received with regard to Information Governance systems and processes, including IG toolkit, Freedom of Information requests and the Publication Scheme
- Positive assurance was received in support of health and safety initiatives, premises inspections and fire risk assessments
- On-going review of the policy management system for the review and updating of all corporate, human resources, clinical and financial policies

4.6 Joint Committees

The CCG is not party to any formal joint Committees. However, a joint arrangement is in place with the Clinical Commissioning Groups from South Yorkshire and Bassetlaw, Hardwick and North Derbyshire and Wakefield which form the CCG Collaborative Commissioning known as Commissioners Working Together which works under an agreed MOU and terms of reference to collaboratively commission services where the CCGs agree that will be

benefit from working together. The Committee does not have delegated authority from Governing Bodies, but operates with the authority of its members - Chairs and Chief Officers - with decisions not delegated to those members being referred to respective Governing Bodies. The CCG also works collaboratively with NHS England and the CCGs across Yorkshire and the Humber to commission specialised services. Again, there is no delegated responsibility from the governing body, and statutory responsibility remains with NHS England.

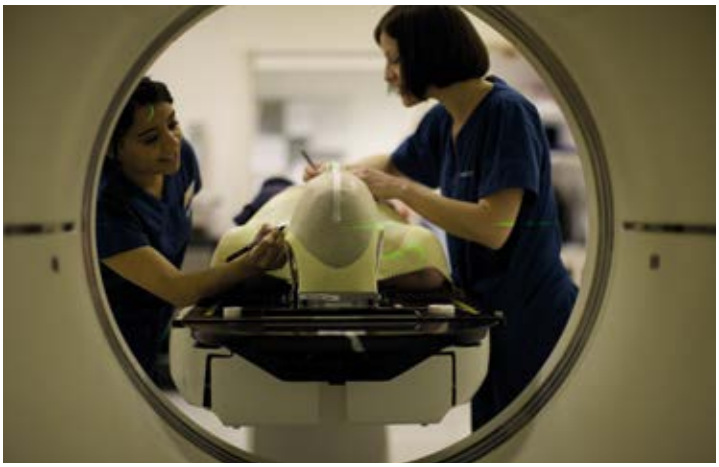
Similarly, as the CCG develops integrated commissioning arrangements with Sheffield City Council, working groups have been established to oversee the development of those arrangements and of commissioning plans for 2015/16. Whilst there is no delegated authority the working groups operate within existing arrangements.

5 The Clinical Commissioning Group Risk Management Framework

The CCG's Risk Management Strategy and Action Plan, together with its policies and procedures, have been in place throughout 2015/16, and are reviewed annually. Responsibility for approval of the CCG's risk management arrangements is delegated to the Audit and Integrated Governance Committee. Preparation and review of the Governing Body Assurance Framework and operational Risk Register with recommendations for action to AIGC and Governing Body is delegated to the Governance Sub-committee.

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

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



the lead officer for implementing the system of internal control, including the Risk Management Strategy.

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

- Identify and control risks which may adversely affect the operational ability of the CCG
- Compare risks using a grading system
- Where possible, eliminate or transfer risks or reduce them to an acceptable and cost effective level, otherwise ensure the organisation openly accepts the remaining risks

Risks are identified from a number of sources, including the Governing Body, executive directors, staff, Governing Body Assurance Framework, internal and external audit reports and risk assessments. Monitoring, evaluation and control have been further developed throughout the year and all identified risks are included on the operational risk register or assurance framework. The Governance Sub-committee receives a report on all new risks and progress on addressing the high level risks at every meeting. Further details on our risk assessment methodology can be found in section 7 of this report.

Risk management is embedded within the organisation through delivery of the Risk Management Strategy and also through assessments of specific risks including information governance, equality impact assessments and business continuity. Attendance at risk management and equality and diversity training is mandatory for all staff.

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

- assurance that identified risks are being controlled
- evidence of the CCG's compliance with the requirements of the Equality Act 2010
- evidence of public engagement

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

A counter fraud, bribery and corruption report is received at each meeting of the Audit and Integrated Governance Committee, the aim of which is to ensure members are made aware of work undertaken by the Local Counter Fraud Specialist (LCFS). The content is formatted to report upon compliance with NHS Protect's Standards for Commissioners: Fraud, bribery and corruption, covering the following areas:

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

The CCG is able to assure itself of the validity of its Annual Governance Statement through review and challenge of the statement by the Audit and Integrated Governance Committee and review by the senior management team.

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

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

In addition to direct contact with our citizens through public meetings, we consult with relevant Overview and Scrutiny Committees, and work in partnership with our local Healthwatch and local voluntary and community groups.

5.1 Risk Assessment in Relation to Governance, Risk Management and Internal Control

The CCG has sought to ensure that risk assessment and management is embedded throughout the organisation, with risks being identified from a number of sources, including the Governing Body, senior management, staff and reports from internal audit. Monitoring, evaluation and control systems have been reviewed and improved throughout the year. All identified operational risks are included on our operational Risk Register and all strategic risks on the Governing Body Assurance Framework (GBAF).

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

The Audit and Integrated Governance Committee has responsibility for oversight of the CCG's risk management arrangements and receives update reports at each of its quarterly meetings.

The Governing Body considers specific risk issues and receives minutes from its Committees. The Governing Body also routinely receives information on Serious Untoward Incidents (SUIs) including lessons identified and learned.

A meeting of senior risk owners was held on 9 March 2015 to discuss the content of the GBAF in relation to the organisation's 5 year strategic ambitions and to ensure that risks remained relevant for the financial year ahead. This was followed by a 'Confirm and Challenge' session attended by Directors who reviewed and challenged the scores of all principle risks highlighted on the refreshed GB Assurance Framework. The Governing Body was provided with details of the refreshed GBAF at its meeting in June 2015 which included details of the changes to be taken forward for 2015/16. The Governing Body has received further update reports on a quarterly basis throughout the year.

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

5.2 Risk Assessment Methodology

A standard 5 x 5 matrix was used to assess risk which incorporates both consequence and likelihood as detailed below:

RISK MATRIX		LIKELIHOOD				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
CONSEQUENCE	1 Negligible	1	2	3	4	5
	2 Minor	2	4	6	8	10
	3 Moderate	3	6	9	12	15
	4 Major	4	8	12	16	20
	5 Extreme	5	10	15	20	25

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

In accordance with the CCG's Risk Management Strategy, senior managers have initial responsibility for identifying and managing operational risks within their areas of responsibility and all staff are required to report potential risks to their line manager. When a risk has been confirmed it is added to the operational Risk Register and rated using the standard NHS 5 x 5 scoring system. During 201516 this has been via the on-line reporting software. The system ensures risks are reviewed by the risk owner, senior manager and director during the 13 week review cycle. All teams are encouraged to review their risks at monthly team meetings.

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

5.3 Governing Body Assurance Framework (GBAF)

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

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

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

The GBAF is the responsibility of the Head of Governance and Planning, reporting to the Director of Delivery and is formally reviewed by each Risk Lead (Executive Directors) on a quarterly basis. This is to ensure the controls and assurances remain valid and any identified gaps are mitigated by timely implementation and are

clearly defined. A separate worksheet was added to the GBAF framework during the year on which any gaps in control/assurance were identified, together with an action plan and target date for closure of the gap.

There have been 14 strategic risks on the GBAF since it was approved in June 2015. Initially one risk was categorised as very high (score of 15); a further two categorised as high (scores of 12); the remaining eleven risks categorised as medium (score of 4- 9); At the end of quarter 4 (31 March 2016), , our assessment is that one risk is categorised as very high and 2 as high. The final year end position is as follows:

Risk Score	Number	Category of Rating
15	1	V High High
12	2	High
4-9	11	Medium

During the year action plans were put in place for any gaps in control and assurance identified, and risks monitored.

5.4 Operational Risk Register

Current Risks

At 31 March 2016 there were 43 risks identified and added to the Operational Risk Register. Of these, 15 risks were classified as high and 6 risks identified as Very High; 18 risks were rated moderate and 4 low level.

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

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

All risks which had been static for more than four cycles were reviewed in quarter by a sub-group of the Governance Sub-committee. Following the review risk owners/senior managers were contacted and asked to review again their risks to identify any additional controls and assurances which might mitigate the level of risk. For some risks, owners were asked to provide additional clarity with regard to detail on specific areas of their risk. Each of the risks identified were reviewed with a number of risks closed as a result of the exercise. The Risk Report to Governance Sub-committee now includes details of those risks which have remained static in score.

6 The Clinical Commissioning Group Internal Control Framework

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

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

The Governing Body Assurance Framework (GBAF) is the key document which provides an overview of the controls and assurances in place to ensure that the CCG is able to achieve its strategic objectives and manage the principal risks identified.

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

The CCG uses three risk scores:

- **Initial Risk Score:** This is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risks and is used as a benchmark against which the effect of risk management will be measured.
- **Current Risk Score**: This is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans to mitigate the risks are developed and implemented.
- **Target (Appetite) Risk Score:** This is the score that is expected after the action plan has been fully implemented.

Our GBAF is discussed in more detail in section 7 below.

6.1 Information Governance

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

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

The CCG completed its Information Governance Toolkit in 2015/16 and achieved the required minimum level 2 in all relevant standards, which cover the areas of:

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

The review of the CCG's arrangements for Information Governance by internal audit had an outcome demonstrating 'Significant Assurance'.

The CCG has had no Serious Untoward Incidents relating to data security breaches in 2015/16.

The CCG operates effectively with pseudonymised data for secondary uses.

As the CCG has recently transferred Continuing Health Care services back into the CCG we will again be operating some direct patient care services which handle patient identifiable data.

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

The Governing Body has overarching responsibility for ensuring the CCG has appropriate arrangements in place to exercise it functions effectively, efficiently, and economically and is supported in doing so via the GBAF.

The Director of Finance, who is a member of Governing Body, is responsible for providing financial advice and for supervising financial control and accounting systems. She presents a monthly finance report to Governing Body, encouraging open debate and understanding from its members.

The Audit and Integrated Governance Committee (AIGC) receives regular reports on a range of governance issues including from both internal and external auditors. The CCG's systems of budgetary control and financial reporting have been reviewed by Internal Audit whose report provided Significant Assurance.

The AIGC will have the opportunity to scrutinise in detail the CCG's financial statements for 2015/16 at its meeting on 26 May 2016, together with the report from external audit, before these are presented to Governing Body on 26 May 2016 for adoption.

7. Review of the effectiveness of Governance, Risk Management and Internal Control

As Interim Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

7.1 Capacity to Handle Risk

All staff are required to complete risk management training. Through this training programme, staff are equipped to identify and manage risk in a manner appropriate to their authority and duties.

Executive directors meet annually to review the principal risks facing delivery of the organisation's objectives, the outcome from this meeting will form the basis of the refreshed GBAF for the following year.

Risks are routinely discussed at team meetings, with the operational Risk Register updated on-line by risk owners. There are risk protocols in place to assist staff in the development and maintenance of both the operational Risk Register and GBAF.

7.2 Review of Effectiveness

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

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

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

The following committees and officers have played a significant part in maintaining and reviewing the effectiveness of the system of internal control in 2015/16 and have managed risks assigned to them:

COMMITTEE	CHAIR
Governing Body	Dr Tim Moorhead
Audit and Integrated Governance Committee (AIGC)	Mr John Boyington, CBE, Mr Phil Taylor, from 1.4.16
Quality Assurance Committee (QAC)	Ms Amanda Forrest
Remuneration Committee	Mr John Boyington, CBE
Primary Care Co-Commissioning Committee	Mr John Boyington, CBE

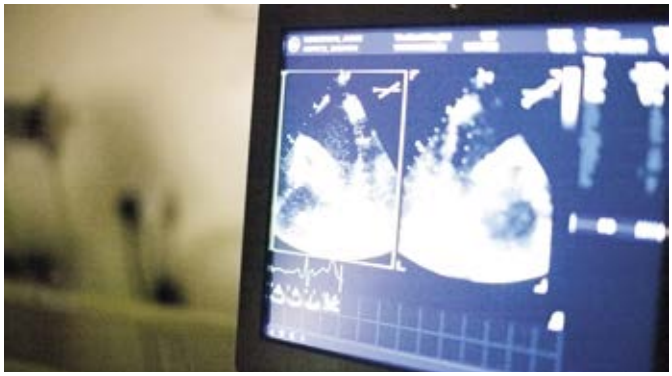
- **The Governing Body** is responsible for providing clear commitment and direction for risk management within the CCG. The Governing Body delegates responsibility for risk management to the Audit and Integrated Governance Committee. It is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. During 2015/16 it has maintained sound risk management and internal control systems as described in the risk management section of this statement.

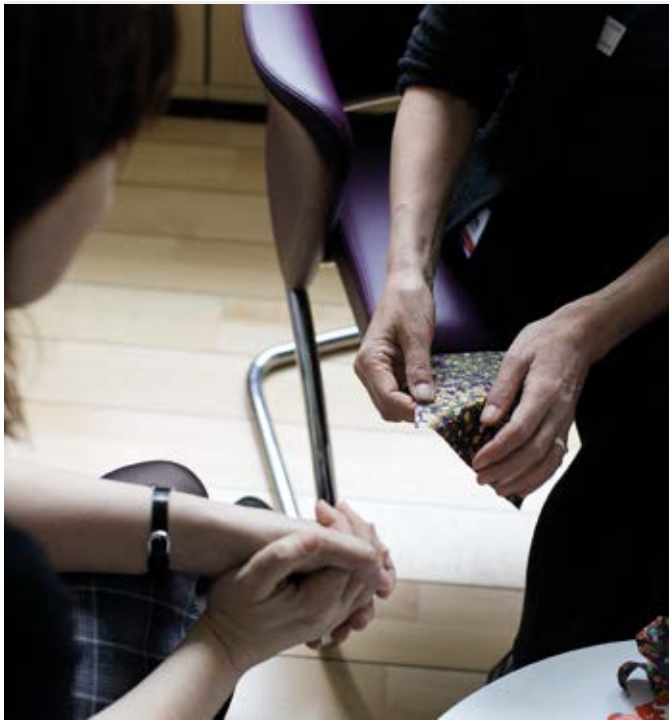
  The Governing Body has established formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with internal audit.

- **The Audit and Integrated Governance Committee** is responsible for providing an independent overview of the arrangements for risk management within the CCG, with specific responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews all internal and external audits.
- **Quality Assurance Committee** has overarching responsibility for clinical risk management and provides assurance to the Governing Body that appropriate clinical risk management arrangements are in place across the organisation. Its work programme addresses safeguarding, infection control, quality in contracts, incidents and medicines management.
- **Primary Care Commissioning Committee (PCCC)** is a committee of the Governing Body. The Committee has been established to enable the members to make collective decisions on the review, planning and procurement of primary care services in Sheffield under delegated authority from NHS England. In performing its role, the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG. Minutes of each meeting of the PCCC are forwarded to NHS England – North and the Governing Body of NHS Sheffield CCG for information, including the minutes of any Sub-committees to which responsibilities are delegated.

My review was also informed by:

- Delivery of Audit Plans by External and Internal Auditors.
- Results from the Staff Survey.
- Results from NHS England Stakeholder Survey
- Annual Operational Plan
- Information Governance Toolkit Assessment
- Monthly Delivery and Performance Reports
- Regular reviews of corporate risk registers
- Regular reports to the Governing Body from each of the formal committees
- Quarterly Assurance Framework Reports to NHS England
- NHS England Assurance Review
- Audit reports on Yorkshire and Humber Commissioning Support (YHCS) from which the CCG purchases some services.





At 31 March 2016, the Governing Body Assurance Framework identified the following outstanding gaps in control within the GBAF:

RISK REF	PRINCIPAL RISK	IDENTIFIED GAP IN CONTROL
2.2	CCG unable to influence equality of access to healthcare because insufficient or ineffective mechanisms to change	Current lack of data and contractual levers
4.4	Inability to secure partnerships with our main providers that help us to deliver our commissioning plans, including QIPP.	Current lack of formal joint planning process
4.5	Contractual and financial constraints facing local practices resulting in an inability of some practices to deliver existing non-core work and/or expand service provision as envisaged in commissioning plans.	Locally Commissioner Service being offered to practices. Funding gaps in practice baselines remain

The above gaps in control have robust action plans and have been built into 2016/17 Framework.

7.3 Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG group, 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:

> From my review of your systems of internal control, primarily through the operation of your Governing Body Assurance Framework (GBAF), risk management arrangements, individual assignments and follow-up of actions I have undertaken, I am providing Significant Assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. (see Appendix B for full report)

During the year Internal Audit issued no reports which identified governance, risk management and/or control issues which were significant to the organisation.

7.4 Data Quality

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

7.5 Business Critical Models

Sheffield CCG have no business critical models meeting the threshold criteria as outlined in the McPherson report.

7.6 Data Security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment. There were no Serious Untoward Incidents relating to data security breaches in 2015/16.

7.7 Discharge of Statutory Functions

Arrangements put in place by the CCG and explained within the corporate governance framework have been developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of the Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the 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 CCG's statutory duties.

Quarterly assurance reviews with the NHS England - North (Yorkshire and Humber) continue, which also cover discharge of statutory functions with positive outcomes in 2015/16.

8. Yorkshire & Humber Commissioning Support (YHCS)

NHS Sheffield CCG commissioned a number of services from YHCS throughout 2015/16. During the year YHCS failed to meet the threshold required for admission to a Lead Provider Framework for the provision of end-to-end services with the result the CCG was unable to commission the full cohort of services originally purchased. The CCG worked in partnership with NHS England and 22 other CCGs across the Yorkshire & Humber region to transition to new models of service by 31 March 2016. This resulted in a number of services being procured by tender against the Framework to eMBED and certain other services being transferred to North East Commissioning. In addition, a variety of staff also joined the CCG to provide a number of functions. This was complemented by the adoption of a number of hosting arrangements between local CCGs for the provision of a range of corresponding services. The transition was managed effectively and hosting arrangements are governed by Memorandums of Understanding (MoU) between participating CCGs.

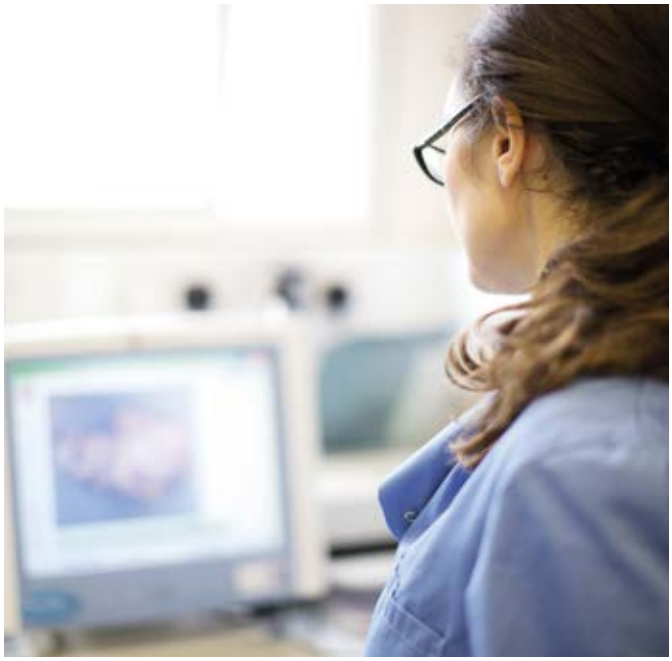
9. Conclusion

No significant internal control weaknesses have been identified during the year.

Date: 26 May 2016
Signed by:

Maddy Ruff
Accountable Officer

Remuneration and Staff Report



Remuneration Report

1 Remuneration Committee

Details of the membership of the Remuneration Committee can be found within the Annual Governance Statement (p45). The Committee is responsible for advising about the appropriate remuneration and terms of service for the Accountable Officer, executive directors and other senior managers, as well as monitoring and evaluating their performance.

2 Senior Managers' Remuneration and Terms of Service

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

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

The Accountable Officer of the CCG has determined that this definition applies to all voting members of Governing Body as set out in the CCG's Constitution. Profiles of each Governing Body member can be found in the Directors' Report section (p32) of this Annual Report.

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

Senior Managers' remuneration for 2015/16 was determined by the Remuneration Committee and took account of national guidance, the prevailing economic climate, local market conditions and the requirement to obtain best possible value for money. The costs of posts are met from the notified CCG running cost allowance.

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

- The Agenda for Change guidance from NHS Employers including the staffing body pay and employment conditions in relation to senior managers' remuneration to ensure parity as far as reasonably practicable. The zero per cent cost of living rise for staff subject to Agenda for Change was mirrored for senior managers / Governing Body members.
- 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 CCG Chief Officers (Accountable Officers) and Chief Finance Officers (Directors of Finance). This covers basic salary, recruitment and retention premia where deemed applicable and additional payments for additional duties.

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

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

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

The Remuneration Committee sets the framework within which the terms and conditions of the Very Senior Managers are developed and agreed. It also receives reports on performance against standards set in relation to local and national targets from the CCG's strategic and operational plans for the Accountable Officer and Director of Finance. The remuneration is set through a process that is based on a consistent framework and independent decision of performance measures against an individual's performance with due consideration to comparative salary data, the labour market, the financial circumstances of the organisation plus any national guidance. Performance related pay was paid to the Director of Finance at 3% of

basic salary following assessment of individual performance in 2014/15 and a subsequent recommendation by the Remuneration Committee. No assessment was made for the previous Accountable Officer (Mr Ian Atkinson) as he had left the employment of the CCG.

Executive Directors are on permanent contracts and six months' notice is required by either party to terminate the contract. The only contractual liability on the CCG's termination of an executive's contract is six months' notice. All other Governing Body members are appointed for a period of up to three years, with a notice period of three months. Further information can be found in the CCG's Standing Orders which are available on our website as part of our constitution:

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

The table below provides, for each senior manager who has served on the Governing Body in 2015/16, further information on their service contract.

NAME	TITLE	CONTRACT COMMENCEMENT *	CONTRACT EXPIRATION
Dr Tim Moorhead	As Chair As Locality Appointed GP	1st April 2013 1st November 2014	31st October 2018 31st September 2017
Mrs Madeline Ruff	Accountable Officer	1st September 2015	Substantive post
Mr Kevin Clifford	Chief Nurse	1st April 2013	Substantive post
Mr Tim Furness	Chief of Business Planning and Partnerships	1st April 2013	Substantive post
Mr Idris Griffiths	Chief Operating Officer Accountable Officer (acting)	1st April 2013 1st April 2015	Substantive post 31st August 2015
Miss Julia Newton	Director of Finance	1st April 2013	Substantive post
Mrs Rachel Gillott	Chief Operating Officer (acting)	1st April 2015	31st August 2015
Dr Zak McMurray	Medical Director	1st April 2013	Substantive post
Dr Nikki Bates	GP Elected Member	1st January 2014	1st January 2017
Dr Anil Gill	GP Elected Member	1st October 2013	1st October 2016
Dr Marion Sloan	GP Elected Member	1st October 2013	1st October 2016
Dr Ted Turner	GP Elected Member	1st October 2013	1st October 2016
Dr Amir Afzal	Locality Appointed GP	1st November 2014	31st October 2017
Dr Ngozi Anumba	Locality Appointed GP	14th May 2015	13th May 2018
Dr Leigh Sorsbie	Locality Appointed GP	1st November 2014	31st October 2017
Prof Devaka Fernando	Secondary Care Doctor	16th July 2015	15th July 2018
Mr John Boyington	Lay member	1st July 2013	31st March 2018
Ms Amanda Forrest	Lay member	1st July 2013	31st March 2017
Prof Mark Gamsu	Lay member	1st July 2013	30th June 2016
Mr Philip Taylor	Lay member	1st March 2016	28th February 2019

* Contract commencement relates to the commencement date of the current contract not necessarily the initial appointment date e.g. for GP elected members where they have been re-elected, the commencement date relates to their current term of office.

3 Salaries and Allowances (subject to audit)

The tables at Appendix Ci and Cii detail the salaries and allowance for all the senior managers of the CCG, as defined above.

4 Payments for Loss of Office (subject to audit)

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

5 Payments to Past Senior Managers (subject to audit)

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

6 Pension Benefits (subject to audit)

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

7 Fair Pay disclosure (subject to audit)

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

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

The mid-point of banded remuneration of the highest paid member in NHS Sheffield CCG in the financial year 2015/16 was £163,800 (£162,500 in 2014/15). This was 4.68 (4.07 times in 2014/15) times the median remuneration of the workforce which was £35,009 (£39,953 in 2014/15).

There has been no material change year-on year to the remuneration of the highest paid member of the CCG, however there has been a reduction in the median remuneration of all CCG staff. This is due to the following reasons;

- There was a change in the composition of the workforce. The size of the workforce rose significantly in 2015/16, the main reason for the increase was due to staff transferring from Yorkshire and the Humber Commissioning Support Unit to the CCG on 1st December 2015. The average gross pay of the new employees lower than the median salary in 2014/15.
- There was a pay increase of 1% for all staff in the banding range of 2 – 8b.

In 2015/16 no employees received remuneration in excess of the highest paid member of the Governing Body.

Remuneration for CCG employees ranged from £6,117 to £163,800.

Staff Report

1 Senior Managers

Number of senior civil service staff (or senior managers) by band.

PAY BAND	NO. OF EMPLOYEES
Very Senior Managers (VSM)	2
Personal Salary	31

This information includes multiple post holders so in some cases an employee may be counted more than once.

2 Staff Numbers

The table below summarises the average number of people employed by Sheffield CCG in 2015/16, together with the net employee benefits costs.

	TOTAL	PERMANENTLY EMPLOYED	OTHER
Average number of Employees	162	156	6
Net employee benefit costs	9,391	8,485	906

3 Staff Composition

The table below provides an analysis of the number of persons of each gender who were Governing Body, Very Senior Managers and total employees of the company

	FEMALE	MALE
Governing Body	5	12
Very Senior Managers (VSM)	2	0
All employees	210	45

This information includes multiple post holders so in some cases an employee may be counted more than once.

4 Sickness absence data

The sickness absence rate for the organisation is 3.3%. Sickness absence is managed in accordance with agreed policies and procedures which include employee wellbeing services of Occupational Health, counselling and physiotherapy.

5 Staff policies applied during the financial year:

5.1 Equality Impact Assessment

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

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

5.2 Training

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

5.3 Equality of Opportunity

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

The five commitments are as follows:

- To interview all applicants with a disability who meet the minimum criteria for a job vacancy and consider them on their abilities
- Consult employees with a disability
- Retaining people who become disabled
- Developing awareness
- Reviewing progress and keeping people informed

6 Expenditure on consultancy

Sheffield CCG spent £327k on consultancy services in 2015/16. £33k related to consultancy spend commissioned with partners, including Sheffield City Council. Sheffield CCG received income to cover a proportion of these costs, with the net cost to Sheffield CCG being £16k. The remaining £294k was commissioned solely by Sheffield CCG. Expenditure was committed in accordance with the guidance issued by NHS England in respect of expenditure controls on consultancy costs. As of 2 June 2015, the Department of Health has specified that CCGs need to secure advance approval from NHS England before procuring, letting or extending a consultancy project over £50,000. No consultancy project exceeded £50,000 in 2015/16.

7 Off-payroll engagements

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

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

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

	NUMBER
Number of existing engagements as of 31 March 2016	40
The number that have existed:	
• For less than one year at the time of reporting	12
• For between one and two years at the time of reporting	11
• For between two and three years at the time of reporting	17
• For between three and four years at the time of reporting	0
• For four or more years at the time of reporting	0

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

	NUMBER
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016.	14
Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to income tax and national insurance obligations.	14
Number for whom assurance has been requested (new and existing engagements)	40
Of which the number:	
• For whom assurance has been received	40
• For whom assurance has not been received	0
• That have been terminated as a result of assurance not being received.	0

	NUMBER
Number of off-payroll engagements of Governing Body members during the financial year.	2
Number of individuals on payroll and off-payroll of Governing Body members during the financial year (this figure includes both off-payroll and on-payroll engagements).	20

8 Exit Packages

No payments were made in 2015/16 in relation to exit packages or severance payments as a result of the termination of employment contracts (2014/15: £nil).

Date: 26 May 2016
Signed by:

Maddy Ruff
Accountable Officer

The Register of Interest – Appendix A

NHS Sheffield Clinical Commissioning Group Governing Body Register of Interest

(1 April 2015 to 31 March 2016)

GOVERNING BODY (CORE MEMBERS)		
NAME	POSITION/ ROLE	INTEREST DECLARED
Amir Afzal	CCG GP Locality representative	• Senior Partner, Duke Medical Centre • GP Appraiser • Director, Central Care Sheffield Ltd (not trading) • Director, Saihara Care Ltd (Care agency based in London) • B-TAK Enterprise Ltd (Rental of furnished offices company run by brother)
Ngozi Anumba	CCG GP Locality representative (from 21.5.15)	• GP Partner, Woodhouse Health Centre • Director, Woodhouse Healthcare Services Ltd (community pharmacy) (from 2.3.16) • Trustee, City Hearts (unpaid) (from 2.3.16)
Nikki Bates	CCG GP Elected City-wide Representative	• GP Partner, Porter Brook Medical Centre • Practice is provider of Occupational Health Services for students at Sheffield Hallam University • GP Appraiser • Minority stakeholder in Rivelin Healthcare Ltd • Partner Governor, Sheffield Children's NHS Foundation Trust
John Boyington CBE	Lay Member and Chair (up to 31.3.16)	• Chairman (up to 8.1.16) and Trustee (unpaid), Croft House Settlement a registered charity providing premises and facilities for voluntary groups to meet in Sheffield city centre • Chairman (2 days per week paid), Bury GP Practices Ltd, a Company Limited by shares which is a provider of health services in Bury, Greater Manchester • Chairman (unpaid) of Masonic Care Ltd, a charitable Company providing residential care to 12 people with a learning disability in Thorne, South Yorkshire • Trustee of the Masonic Charitable Foundation, a charity providing local, national and international support to Freemasons and to the community at large (from 8.1.16) • Member of the Charitable Support Executive Committee • Member of the Community Support sub-committee • Member of the Medical Research sub-committee • Trustee (up to 7.1.16 and Director (from 8.1.16) of the Royal Masonic Benevolent Institution Care Company, a subsidiary charity of The MCF providing care to 1,000 people in 17 homes across England and Wales. The position is non-remunerated. The nearest care home is situated in York
Kevin Clifford	Chief Nurse	• Honorary Lecturer, Faculty of Medicine, Dentistry & Health, University of Sheffield
Richard Davidson	Secondary Care Doctor (up to 2.4.15)	• Clinical Lead for Transformation, Bradford Teaching Hospitals NHS Foundation Trust • Director, Yorkshire Medical Logistics Ltd
Devaka Fernando	Secondary Care Doctor (from 16.7.15)	• Consultant Endocrinologist and Honorary Professor, Sherwood Forest Hospitals NHS Foundation Trust • Honorary Professor (supervision of PhD students), University of Kent, Canterbury
Amanda Forrest	Lay Member	• Partner Governor, STHFT (from 21 April 2015) • Team Associate, University of Durham (2 year contract freelance) (from 17.9.15) • Team Associate, University of Sheffield (2 year contract freelance) (from 17.9.15) • Investigator, Sheffield City Council (freelance)

Table cont. >

> Table cont.

Tim Furness	Chief of Business Planning and Partnerships	• Nil return
Mark Gamsu	Lay Member	• Director, Local Democracy and Health Ltd (public health consultancy) • Co-ordinator of European Health Equity Programme, UK Health Forum (national voluntary organisation) • Trustee, Voluntary Action Sheffield • Trustee, Sheffield Mental Health CAB • Trustee, Community Legal Advice Service South Yorkshire • Committee Member, Darnall Wellbeing • Trustee, Citizens Advice • Trustee, INVOLVE Yorkshire and Humber
Anil Gill	CCG GP Elected City-wide Representative	• GP appraiser (ad hoc basis) • GP Principal, Selborne Road Medical Centre
Rachel Gillott	Interim Chief Operating Officer (1.4.15 to 31.8.15)	• Chair of Governors, Windmill Hill Primary School
Idris Griffiths	Interim Accountable Officer (1.4.15 to 31.8.15) Chief Operating Officer (from 1.9.15)	• Nil return
Zak McMurray	Medical Director	• Shareholder, Woodhouse Health Care Services Ltd • Trustee, Talbot Trusts • Spouse is Director of North East Derbyshire Healthcare (from 23.2.16)
Tim Moorhead	CCG GP Locality representative CCG Chair	• Senior Partner, Oughtibridge Surgery • Minority shareholder, Rivelin Healthcare Ltd • Executive Member of Local Medical Committee
Julia Newton	Chief Finance Officer	• Nil return
Maddy Ruff	Accountable Officer (from 2.9.15)	• Nil return
Marion Sloan	CCG GP Elected City-wide Representative	• GP Principal, Sloan Medical Centre • Clinical Assessor, STHFT • Lead GP, Gastroenterology Community Service • Sessional GP, GP Collaborative
Leigh Sorsbie	CCG GP Locality representative	• GP Partner, Firth Park Surgery • Partner Governor, SHSCFT
Phil Taylor	Lay Member (from 1.3.16) and Chair (from 1.4.16)	• Managing Director, Phil Taylor Associates Ltd (Management Consultancy) • Chair of Trustees, Sheffield Hospitals Charity • Treasurer, Dore Club
Ted Turner	CCG GP Elected City-wide Representative	• GP Partner and Principal, Shiregreen Medical Centre • Trustee, SOAR Southey and Owlerton Area Regeneration • Committee Member, Sheffield Local Medical Committee

Appendix B

Head of Internal Audit Opinion – Executive Summary

The purpose of my annual Head of Internal Audit Opinion (HoIAO) is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This opinion, in turn, assists the Governing Body in the completion of its AGS.

My opinion is set out as follows:

2.1 Overall opinion;
2.2 Basis of the opinion; and
2.3 Summary Commentary.

2.1 Overall Opinion

From my review of your systems of internal control, primarily through the operation of your Governing Body Assurance Framework (GBAF), risk management arrangements, individual assignments and follow-up of actions I have undertaken, I am providing Significant Assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

2.2 Basis of the Opinion

The basis for forming my opinion is as follows:

a) An assessment of the design and operation of the underpinning Governing Body Assurance Framework (GBAF) and supporting processes. (Guidance requires that I weight the opinion towards the suitability of the Assurance Framework. and indicates that where I am unable to conclude that an appropriate Assurance Framework process is in place, I am obligated to issue an overall opinion of Limited Assurance. This is regardless of the level of assurances provided in respect of individual audit assignments).

b) An assessment of the range of individual opinions arising from risk-based audit assignments contained within Internal Audit risk-based plans that have been reported upon throughout the year (Outturn of Internal Audit Plan). This assessment has taken account of the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified.

c) An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

Department of Health guidance requires that, when determining my opinion, I place greatest emphasis on points a) and b) above.

My opinion is one source of assurance that the organisation has in providing its Annual Governance Statement (AGS) and other third party assurances should also be considered. In addition the organisation should take account of other independent assurances that are considered relevant.

1.3 Summary Commentary

I have summarised below the context for my opinion and, together with the opinion, this should be read in its entirety. My detailed commentary, including any areas for improvement that I consider the organisation should take forward during 2016/17, are contained within Section 3 of this report. The issues highlighted in this summary and the more detailed commentary should be considered by the organisation when completing its AGS.

In recognition of how the organisation has developed during 2015/16 and in consideration of the work that we have undertaken and our knowledge of your organisation, I have provided below an assessment of where, in my opinion, the CCG is in terms of meeting expected good practice across the four areas of consideration for the Head of Internal Audit Opinion. This will allow the organisation to clearly see where good processes are embedded and those areas where further development is recommended.

Key to RAG Rating:

	Full Assurance
	Significant Assurance
	Moderate Assurance
	Limited Assurance
	No Assurance

Definitions of Assurance Levels can be found at **Appendix C**

OPINION AREA	SUMMARY
Design & Operation of the GBAF	Through our attendance at Governance Sub Committee and the AIGC, and through ongoing contact with key officers, we have observed the development and maintenance of the GBAF. In forming our opinion, we have reviewed the process for a sample of risks, controls and assurances within the content of the GBAF, to evaluate the extent of its usefulness in managing high level risks. The CCG has a structured approach to the design and operation of the GBAF, with attention being paid to ensuring the risks are appropriately articulated, and the nature of potential gaps in controls and assurances, and potential mitigating actions, are carefully considered. There is regular review of the contents of the GBAF, with appropriate challenge. For the sample of controls and assurances we reviewed, there was evidence that these were relevant to the risks concerned.
Governance & Risk Management Arrangements	The Governance Sub Committee maintains control over risk management throughout the year, with a systematic approach to monitoring the risk framework within the CCG. From attendance at this committee, we have been able to observe evidence of review, challenge and escalation of issues. The AIGC and the Governing Body are able, through regular reporting, to maintain an overview of risk management within the organisation. Some progress has been made in ensuring overarching risk management arrangements are up to date following the transfer of functions from the CSU, but this needs to extend to supporting policies and reinforced by training. The CCG has recognised the need to identify, document and assure itself on the risk arrangements in place below corporate level.
Outturn of Internal Audit Plan	To date, all finalised reports gave significant assurance, with no high risk recommendations.
Follow-Up of Actions	The CCG has a systematic approach to ensure the AIGC is kept informed on the implementation status of agreed internal audit recommendations, with a regular report being submitted as a standing item to each meeting. We undertake specific follow up reviews, as well as following up during cyclical reviews, to provide an independent check on the extent to which recommendations have been implemented. This coordinated approach provides ongoing management assurance, and independent audit assurance, that recommendations have been implemented.

I would like to take this opportunity to thank the CCG for the co-operation and assistance provided to my team during the year.

Tim Thomas
Director

Remuneration Report: Senior Managers: Salaries and Allowances

Appendix Ci

THIS STATEMENT IS SUBJECT TO REVIEW BY EXTERNAL AUDIT AND WILL INFORM THEIR AUDIT OPINION

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

Notes

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

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

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

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

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

Remuneration Report: Senior Managers: Salaries and Allowances

Appendix Cii

THIS STATEMENT IS SUBJECT TO REVIEW BY EXTERNAL AUDIT AND WILL INFORM THEIR AUDIT OPINION

	2014-15					
Name and Title	**Salary**	**Expense**	**Performance**	**Long term**	**All Pension**	**TOTAL**
	(bands of £5k)	Payments (taxable) (rounded to the nearest £100)	Pay and bonuses (bands of £5k)	Performance pay and bonuses (bands of £5k)	Related Benefits (bands of £2.5k)	(bands of £5k)
	£000	£00	£000	£000	£000	£000
T Moorhead Chair of the Governing Body	95- 100	0	0	0	17.5 - 20.0	115 - 120
I Atkinson (up to 31 March 2015) Accountable Officer	135 - 140	2	0 - 5	0	10.0 - 12.5	150 - 155
K Clifford Chief Nurse	95 - 100	2	0	0	0 - 2.5	100 - 105
T Furness Chief of Business Planning and Partnerships	95 - 100	2	0	0	42.5 - 45.0	140 - 145
I Griffiths Chief Operating Officer	95 - 100	0	0	0	40.0 - 42.5	140 - 145
J Newton Director of Finance	105 - 110	1	0 - 5	0	5.0 - 7.5	115 - 120
Z McMurray Clinical Director	80 - 85	0	0	0	0	80 - 85
N Bates GP Elected Member	10 - 15	0	0	0	0	10 - 15
A Gill GP Elected Member	10 - 15	0	0	0	20.0 - 22.5	30 - 35
M Sloan GP Elected Member	10 - 15	0	0	0	0	10 - 15
T Turner GP Elected Member	10 - 15	0	0	0	0	10 - 15
A Afzal Locality appointed GP	10 - 15	0	0	0	0	5 - 10
A McGinty (up to 31 March 2015) Locality appointed GP	10 - 15	0	0	0	0	5 - 10
L Sorsbie Locality appointed GP	10 - 15	0	0	0	7.5 - 10.0	20 - 25
R Davidson * (up to 2 April 2015) Secondary Care Doctor	5 - 10	1	0	0	0	5 - 10
J Boyington CBE Vice Chair and Lay Member	10 - 15	0	0	0	0	10 - 15
A Forrest Lay Member	10 - 15	1	0	0	0	10 - 15
M Gamsu Lay Member	10 - 15	0	0	0	0	10 - 15

Notes

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

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

*Remuneration for R Davidson is made via invoice, on a contracted for services basis (i.e. not as an employee). Sheffield CCG is not responsible for making any relevant pensions contributions.

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.

Pension Benefits - 2015-16

Appendix Ciii

THIS STATEMENT IS SUBJECT TO REVIEW BY EXTERNAL AUDIT AND WILL INFORM THEIR AUDIT OPINION

Name and Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2016 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 1 April 2015 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £'00
T Moorhead, Chair of the Governing Body	0 - 2.5	2.5 - 5.0	15 - 20	55 - 60	354	330	20	0
M Ruff , Accountable Officer (1 September 2015 to present)	0 - 2.5	0 - 2.5	40 - 45	125 - 130	794	741	26	0
I Griffiths, Accountable Officer (acting 1 April 2015 to 31 August 2015) Chief Operating Officer (1 September 2015 to present)	5.0 - 7.5	15.0 - 17.5	35 - 40	105 - 110	665	561	97	0
K Clifford, Chief Nurse	0 - 2.5	0 - 2.5	45 - 50	135 - 140	895	864	20	0
T Furness, Chief of Business Planning and Partnerships	0 - 2.5	2.5 - 5.0	30 - 35	100 - 105	667	637	22	0
R Gillott, Chief Operating Officer (acting 1 April 2015 to 31 August 2015)	0 - 2.5	0 - 2.5	20 - 25	60 - 65	331	301	11	0
J Newton, Director of Finance	0 - 2.5	2.5 - 5.0	30 - 35	90 - 95	591	556	29	0
*Z McMurray, Medical Director	0	0	0	0	0	0	0	0
N Bates, GP Elected Member	0 - 2.5	0 - 2.5	5 - 10	20 - 25	136	132	3	0
A Gill, GP Elected Member	(2.5 - 5.0)	(10.0 - 12.5)	5 - 10	25 - 30	197	261	(67)	0
*M Sloan, GP Elected Member	0	0	0	0	0	0	0	0
T Turner, GP Elected Member	0 - 2.5	0 - 2.5	10 - 15	30 - 35	192	188	2	0
*A Afzal, Locality appointed GP	0	0	0	0	0	0	0	0
N Anumba, Locality appointed GP (14 May 2015 to present)	0 - 2.5	(2.5) - 0	0 - 5	5 - 10	48	44	3	0
L Sorsbie, Locality appointed GP	0 - 2.5	(2.5) - 0	10 - 15	25 - 30	180	172	6	0
*D Fernando, Secondary Care Doctor * (16 July 2015 to present)	0	0	0	0	0	0	0	0

*Dr McMurray, Dr Sloan, Dr Afzal and Dr Fernando do not make contributions to the NHS Pension Scheme and hence no information is available to the CCG.

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

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

Cash Equivalent Transfer Values

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

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

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

The values in the table are calculated by comparing the accrued pension/lump sum as at 31 March 16 against the accrued pension/lump sum at 31 March 15 which is then adjusted by a a factor of 1.2% to account for inflation (1.2% is a figure stated 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 31 March 2016 and/or that the remuneration of the individual has decreased in the current financial year compared to the previous financial year.

KPMG

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

We have audited the financial statements of NHS Sheffield CCG for the year ended 31 March 2016, comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows and related notes, under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Members of the Governing Body of NHS 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 of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

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

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

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

Scope of the audit of the financial statements

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

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

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

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

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

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on regularity

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

Opinion on other matters

In our opinion:

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

KPMG

Matters on which we are required to report by exception

We are required to report to you if:

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

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

Certificate

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

Clare Partridge

Clare Partridge for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
KPMG LLP
1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA

26 May 2016

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Annual Accounts for the Period

1st April 2015

to 31st March 2016

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 2016 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.

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2015-16

CONTENTS **Page Number**

The Primary Statements:

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2015-16

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

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	4.1.1	9,756	7,125
Operating Expenses	5	740,970	714,966
Other operating revenue	2	(8,278)	(6,310)
Net operating expenditure before interest		**742,448**	**715,781**
Investment Revenue		0	0
Other (gains)/losses		0	0
Finance costs		0	0
Net operating expenditure for the financial year		**742,448**	**715,781**
Net (gain)/loss on transfers by absorption		0	0
Total Net Expenditure for the year		**742,448**	**715,781**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	7,045	5,588
Operating Expenses	5	4,772	6,743
Other operating revenue	2	(1,120)	(1,493)
Net administration costs before interest		**10,697**	**10,838**
Programme Income and Expenditure			
Employee benefits	4.1.1	2,711	1,537
Operating Expenses	5	736,198	708,223
Other operating revenue	2	(7,158)	(4,817)
Net programme expenditure before interest		**731,751**	**704,943**

Other Comprehensive Net Expenditure	2015-16 £000	2014-15 £000
Impairments and reversals	0	0
Net gain/(loss) on revaluation of property, plant & equipment	0	0
Net gain/(loss) on revaluation of intangibles	0	0
Net gain/(loss) on revaluation of financial assets	0	0
Movements in other reserves	0	0
Net gain/(loss) on available for sale financial assets	0	0
Net gain/(loss) on assets held for sale	0	0
Net actuarial gain/(loss) on pension schemes	0	0
Share of (profit)/loss of associates and joint ventures	0	0
Reclassification Adjustments		
On disposal of available for sale financial assets	0	0
Total comprehensive net expenditure for the year	**742,448**	**715,781**

The notes on pages 5 to 25 form part of this statement

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2015-16

Statement of Financial Position as at 31-March-2016

	Note	2015-16 £000	2014-15 £000
Non-current assets:			
Property, plant and equipment	8	0	0
Intangible assets		0	0
Investment property		0	0
Trade and other receivables	9	0	0
Other financial assets		0	0
Total non-current assets		0	0
Current assets:			
Inventories		0	0
Trade and other receivables	9	10,254	6,710
Other financial assets		0	0
Other current assets		0	0
Cash and cash equivalents	10	60	121
Total current assets		**10,314**	6,831
Non-current assets held for sale		0	0
Total current assets		**10,314**	6,831
Total assets		**10,314**	6,831
Current liabilities			
Trade and other payables	11	(37,544)	(30,833)
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions	12	0	0
Total current liabilities		**(37,544)**	(30,833)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(27,230)**	(24,002)
Non-current liabilities			
Trade and other payables	11	0	0
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions	12	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(27,230)**	(24,002)
Financed by Taxpayers' Equity			
General fund		(27,230)	(24,002)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(27,230)**	(24,002)

The notes on pages 5 to 25 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 26 May 2016 and signed on its behalf by:

Maddy Ruff

Maddy Ruff
Accountable Officer

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2015-16

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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(24,002)	0	0	**(24,002)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	**(24,002)**	**0**	**0**	**(24,002)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(742,448)	-	-	(742,448)
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**	**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	**(742,448)**	**0**	**0**	**(742,448)**
Net funding	739,220	0	0	739,220
Balance at 31 March 2016	**(27,230)**	**0**	**0**	**(27,230)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	**(26,040)**	**0**	**0**	**(26,040)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(26,040)**	**0**	**0**	**(26,040)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating costs for the financial year	(715,781)			(715,781)
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**	**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	**(715,781)**	**0**	**0**	**(715,781)**
Net funding	717,819	0	0	717,819
Balance at 31 March 2015	**(24,002)**	**0**	**0**	**(24,002)**

The notes on pages 5 to 25 form part of this statement

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2015-16

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

	Note	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(742,448)	(715,781)
Depreciation and amortisation		0	0
Impairments and reversals		0	0
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	(3,544)	911
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	6,711	(2,901)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	12	0	0
Increase/(decrease) in provisions	12	0	0
Net Cash Inflow (Outflow) from Operating Activities		**(739,281)**	(717,771)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(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
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		**0**	0
Net Cash Inflow (Outflow) before Financing		**(739,281)**	(717,771)
Cash Flows from Financing Activities			
Net Funding Received		739,220	717,819
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
Net Cash Inflow (Outflow) from Financing Activities		**739,220**	717,819
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(61)**	48
Cash & Cash Equivalents at the Beginning of the Financial Year		**121**	73
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		**60**	121

The notes on pages 5 to 25 form part of this statement

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2015-16

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts have been prepared on the going concern basis.

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

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 **Acquisitions & Discontinued Operations**

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.4 **Pooled Budgets**

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

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

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

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

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

1.5 **Critical Accounting Judgements & Key Sources of Estimation Uncertainty**

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

1.5.1 ***Critical Judgements in Applying Accounting Policies***

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

- Operating lease commitments - Sheffield CCG has in substance a property lease arrangement with NHS Property Services Ltd relating to the headquarters site. As it has been determined that Sheffield CCG 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.

1.5.2 **Key Sources of Estimation Uncertainty**

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

- Basis of estimation of key accruals - The CCG has included certain accruals within the financial statements which are estimates. The basis of the estimation of key accruals have been approved by the Chief Finance Officer and reported to the Audit & Integrated Governance Group. The key areas requiring estimation were healthcare contracts and prescribing expenditure.

1.6 **Revenue**

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

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

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2015-16

Notes to the financial statements

1.7.2 **Retirement Benefit Costs**

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

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

1.8 **Other Expenses**

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

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

1.9 **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 **Valuation**

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

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.

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

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

1.9.3 **Subsequent Expenditure**

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

1.10 **Depreciation & Impairments**

Assets held for sale are not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of 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 their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible 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.

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

1.11 **Leases**

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

1.11.1 **The Clinical Commissioning Group as Lessee**

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

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

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

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2015-16

Notes to the financial statements

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.

1.11.2 **The Clinical Commissioning Group as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

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.

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:

- Timing of cash flows (0 to 5 years inclusive): Minus 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)

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

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

1.14 **Clinical Negligence Costs**

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

1.15 **Non-clinical Risk Pooling**

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

1.16 **Continuing healthcare risk pooling**

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

1.17 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.17.1 **Financial Assets at Fair Value Through Profit and Loss**

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

1.17.2 **Available For Sale Financial Assets**

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

1.17.3 **Loans & Receivables**

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

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

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

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

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2015-16

Notes to the financial statements

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.
If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.18 **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.
Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

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

1.21 **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.
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 **Joint Operations**

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

1.23 **Research & Development**

Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

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

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

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

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

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2015-16

2 Other Operating Revenue

	2015-16 Total	2015-16 Admin	2015-16 Programme	2014-15 Total
	£000	£000	£000	£000
Recoveries in respect of employee benefits	365	275	90	343
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	120	120	0	303
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	376	358	18	265
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	841	214	627	845
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	6,576	153	6,423	4,554
Total other operating revenue	**8,278**	**1,120**	**7,158**	**6,310**

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

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 2015/16, revenue shown under 'Other revenue' includes £2.9m income received from Sheffield Teaching Hospitals NHS Foundation Trust, in their role as lead provider for Musculo Skeletal (MSK) Services to cover expenditure incurred by NHS Sheffield Clinical Commissioning Group for MSK services from specific providers; and £2.7m income received from Sheffield City Council (SCC), the main elements of which related to the following: recharge of care costs for care where SCC have funding responsibility (£1.2m); the recharge of prescribing costs for the services that SCC commission (£1.1m); and the SCC contribution to the Community Equipment Service which was administered by NHS Sheffield Clinical Commissioning Group up to June 2015, after which point responsibility transferred to SCC (£0.2m). Of the remaining £0.9m, £0.5m relates to pharmaceutical rebate schemes.

For 2014/15, for 'Other revenue' shown, £2.9m relates to income received from Sheffield City Council (SCC) for the following: recharge of care costs for care where SCC have funding responsibility (£1m); the recharge of prescribing costs for the services that SCC commission (£1m); and the SCC contribution to the Community Equipment Service Pooled Budget hosted by NHS Sheffield Clinical Commissioning Group (£0.9m). Of the remaining £1.7m income, £0.9m relates to income from other CCGs as NHS Sheffield Clinical Commissioning Group acts as lead commissioner for patient transport services; £0.4m relates to income from pharmaceutical rebate schemes and £0.1m relates to income from the Borders Agency for healthcare costs associated with resettlement patients.

3 Revenue

	2015-16 Total	2015-16 Admin	2015-16 Programme	2014-15 Total
	£000	£000	£000	£000
From rendering of services	8,278	1,120	7,158	6,310
From sale of goods	0	0	0	0
Total	**8,278**	**1,120**	**7,158**	**6,310**

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4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total			Admin			Programme		
2015-16	**Total**	**Permanent Employees**	**Other**	**Total**	**Permanent Employees**	**Other**	**Total**	**Permanent Employees**	**Other**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Employee Benefits									
Salaries and wages	8,122	7,250	872	5,821	5,500	321	2,301	1,750	551
Social security costs	655	637	18	503	498	5	152	139	13
Employer Contributions to NHS Pension scheme	979	963	16	721	716	5	258	247	11
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**9,756**	**8,850**	**906**	**7,045**	**6,714**	**331**	**2,711**	**2,136**	**575**
Less recoveries in respect of employee benefits (note 4.1.2)	(365)	(365)	0	(275)	(275)	0	(90)	(90)	0
Total - Net admin employee benefits including capitalised costs	**9,391**	**8,485**	**906**	**6,770**	**6,439**	**331**	**2,621**	**2,046**	**575**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**9,391**	**8,485**	**906**	**6,770**	**6,439**	**331**	**2,621**	**2,046**	**575**

4.1.1 Employee benefits

	Total			Admin			Programme		
2014-15	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	5,869	5,705	164	4,602	4,438	164	1,267	1,267	0
Social security costs	511	511	0	409	409	0	102	102	0
Employer Contributions to NHS Pension scheme	745	745	0	577	577	0	168	168	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**7,125**	**6,961**	**164**	**5,588**	**5,424**	**164**	**1,537**	**1,537**	**0**
Less recoveries in respect of employee benefits (note 4.1.2)	(343)	(343)	0	(341)	(341)	0	(2)	(2)	0
Total - Net admin employee benefits including capitalised costs	**6,782**	**6,618**	**164**	**5,247**	**5,083**	**164**	**1,535**	**1,535**	**0**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**6,782**	**6,618**	**164**	**5,247**	**5,083**	**164**	**1,535**	**1,535**	**0**

4.1.2 Recoveries in respect of employee benefits

	2015-16			2014-15
	Total	**Permanent Employees**	**Other**	Total
	£000	**£000**	**£000**	£000
Employee Benefits - Revenue				
Salaries and wages	(301)	(301)	0	(281)
Social security costs	(25)	(25)	0	(26)
Employer contributions to the NHS Pension Scheme	(39)	(39)	0	(36)
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	**(365)**	**(365)**	**0**	**(343)**

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4.2 Average number of people employed

	2015-16 Total Number	2015-16 Permanently employed Number	2015-16 Other Number	2014-15 Total Number
Total	**162**	**156**	**6**	123
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

4.3 Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	760	495
Total Staff Years	147	111
Average working Days Lost	**5**	**4**

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	0	0
	£000	£000
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme. Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme.

4.4 Pension costs

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

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

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

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

4.4.1 Full actuarial (funding) valuation

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

For 2015-16, employers' contributions of £987,678 were payable to the NHS Pensions Scheme (2014-15: £780,294) at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014.

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5. Operating expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	8,947	6,236	2,711	6,342
Executive governing body members	809	809	0	783
Total gross employee benefits	**9,756**	**7,045**	**2,711**	**7,125**
Other costs				
Services from other CCGs and NHS England	3,003	1,844	1,159	4,670
Services from foundation trusts	505,700	13	505,687	503,435
Services from other NHS trusts	23,365	50	23,315	22,784
Purchase of healthcare from non-NHS bodies	94,915	0	94,915	77,533
Chair and Non Executive Members	307	307	0	373
Supplies and services – general	1,892	1,275	617	2,300
Consultancy services	327	231	96	249
Establishment	530	281	249	329
Transport	26	23	3	23
Premises	2,204	359	1,845	2,145
Impairments and reversals of receivables	123	0	123	0
Audit fees	86	86	0	114
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
Prescribing costs	96,787	0	96,787	90,740
Pharmaceutical services	410	0	410	373
General ophthalmic services	255	0	255	235
GPMS/APMS and PCTMS	7,572	0	7,572	7,851
Other professional fees excl. audit	231	22	209	180
Grants to other public bodies	345	0	345	200
Research and development (excluding staff costs)	131	110	21	278
Education and training	131	110	21	83
CHC Risk Pool contributions	2,569	0	2,569	1,019
Other expenditure	61	61	0	52
Total other costs	**740,970**	**4,772**	**736,198**	**714,966**
Total operating expenses	**750,726**	**11,817**	**738,909**	**722,091**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

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6.1 Better Payment Practice Code

Measure of compliance	**2015-16 Number**	**2015-16 £000**	2014-15 Number	2014-15 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	13,168	107,909	13,945	94,388
Total Non-NHS Trade Invoices paid within target	13,011	107,233	13,743	93,861
Percentage of Non-NHS Trade invoices paid within target	**98.81%**	**99.37%**	**98.55%**	**99.44%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,447	574,025	3,527	570,694
Total NHS Trade Invoices Paid within target	3,418	573,952	3,505	570,655
Percentage of NHS Trade Invoices paid within target	**99.16%**	**99.99%**	**99.38%**	**99.99%**

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

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2015-16 £000**	2014-15 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

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7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense	**2015-16**				2014-15			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£000	**£000**	**£000**	**£000**	£000	£000	£000	£000
Payments recognised as an expense								
Minimum lease payments	0	559	6	**565**	0	554	0	**554**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**559**	**6**	**565**	**0**	**554**	**0**	**554**

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 2015-16 is £259k (2014-15 £254k).

NHS Sheffield Clinical Commissioning Group has entered into a financial arrangement involving the use of Walk In Centre premises with One Medicare Limited. Whilst this arrangement falls within the definition of an operating lease, rental charges for future years have not been agreed as there is no formal contract in place. 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 2015-16 is £300k (2014-15 £300k).

7.1.2 Future minimum lease payments	**2015-16**				2014-15			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£000	**£000**	**£000**	**£000**	£000	£000	£000	£000
Payable:								
No later than one year	0	0	9	**9**	0	-	-	**0**
Between one and five years	0	0	9	**9**	0	-	-	**0**
After five years	0	0	0	**0**	0	-	-	**0**
Total	**0**	**0**	**18**	**18**	**0**	**0**	**0**	**0**

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8 Property, plant and equipment

2015-16	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost/Valuation At 01-April-2015	0	0	0	0	0	0	0	205	205
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation At 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**205**	**205**
Depreciation 01-April-2015	0	0	0	0	0	0	0	205	205
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**205**	**205**
Net Book Value at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Purchased	0	0	0	0	0	0	0	0	0
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Asset financing:									
Owned	0	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Balance at 01-April-2015	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
At 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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8 Property, plant and equipment cont'd

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

	2015-16	2014-15
	£000	£000
Land	0	0
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	0	0
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	0	0
Furniture & fittings	0	10

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9 Trade and other receivables	Current 2015-16 £000	Non-current 2015-16 £000	Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: Revenue	2,214	0	619	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	3,354	0	3,131	0
NHS accrued income	1,271	0	212	0
Non-NHS receivables: Revenue	487	0	449	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments	77	0	17	0
Non-NHS accrued income	2,930	0	2,276	0
Provision for the impairment of receivables	(123)	0	0	0
VAT	36	0	6	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	8	0	0	0
Total Trade & other receivables	**10,254**	**0**	**6,710**	**0**
Total current and non current	**10,254**		**6,710**	
Included above:				
Prepaid pensions contributions	0		0	

The credit quality of any other receivables, that are neither past due or impaired, are all assessed to be fully recoverable.

9.1 Receivables past their due date but not impaired	2015-16 £000	2014-15 £000
By up to three months	1,643	569
By three to six months	871	7
By more than six months	0	49
Total	**2,514**	**625**

£262k of the amount above has subsequently been recovered post the statement of financial position date.

NHS Sheffield Clinical Commissioning Group did not hold any collateral against receivables outstanding as at 31 March 2016.

9.2 Provision for impairment of receivables	2015-16 £000	2014-15 £000
Balance at 01-April-2015	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	(123)	0
Transfer (to) from other public sector body	0	0
Balance at 31-March-2016	**(123)**	**0**

A bad debt provision has been created for non-NHS receivables overdue to cover instances of no activity against a debt and disputed invoices. These receivables have been provided for at a rate of 10% for 1 - 90 days overdue and 50% for over 90 days. No collateral is held against any outstanding amounts.

	2015-16 %	2014-15 %
Receivables are provided against at the following rates:		
NHS debt	0	0
Debt with a payment plan in place that is being adhered to	0	0
All other non-NHS debt between 1 - 90 days overdue	10%	0
All other non-NHS debt between 91 - 120 days overdue	50%	0
All other non-NHS debt over 121 days overdue	50%	0

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10 Cash and cash equivalents

	2015-16	2014-15
	£000	£000
Balance at 01-April-2015	121	73
Net change in year	(61)	48
Balance at 31-March-2016	**60**	**121**
Made up of:		
Cash with the Government Banking Service	60	121
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**60**	**121**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31-March-2016	**60**	**121**
Patients' money held by the clinical commissioning group, not included above	0	0

11 Trade and other payables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	0	0	0	0
NHS payables: revenue	2,354	0	1,681	0
NHS payables: capital	0	0	0	0
NHS accruals	4,893	0	5,266	0
NHS deferred income	0	0	0	0
Non-NHS payables: revenue	4,094	0	1,569	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals	25,658	0	21,811	0
Non-NHS deferred income	0	0	0	0
Social security costs	118	0	83	0
VAT	0	0	0	0
Tax	119	0	87	0
Payments received on account	0	0	0	0
Other payables	308	0	336	0
Total Trade & Other Payables	**37,544**	**0**	**30,833**	**0**
Total current and non-current	**37,544**		**30,833**	

Non-NHS accruals includes £16.1m Prescribing accrual, £6m re Continuing Healthcare accruals, £1.3m in relation to non NHS contracts and £1.8m in relation to primary care (31 March 2015: £15.7m Prescribing accrual and £6.1m relating to Continuing Healthcare and Non NHS contract accruals).

Other payables include £187k outstanding pension contributions at 31 March 2016 (31 March 2015: £127k).

12 Provisions

NHS Sheffield Clinical Commissioning Group had no provisions as at 31 March 2016 (as at 31 March 2015 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 2016 is £2,516k (31 March 2015: £3,677k).

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13 Commitments

13.1 Other financial commitments

The NHS Sheffield Clinical Commissioning Group has entered into a non-cancellable contract (which is not a lease, private finance initiative contract or other service concession arrangement) with eMBED Health Consortium to provide IT support and Business Intelligence services. The payments to which the clinical commissioning group are committed are as follows:-

	2015-16	2014-15
	£000	£000
In not more than one year	1,424	23
In more than one year but not more than five years	3,666	0
In more than five years	0	0
Total	**5,090**	**23**

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 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 clinical commissioning group therefore has low exposure to interest rate fluctuations.

14.1.3 Credit risk

Because the majority of the NHS Sheffield Clinical Commissioning Group and revenue comes from 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.

14.1.3 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.

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14 Financial instruments cont'd

14.2 Financial assets

	At 'fair value through profit and loss' 2015-16 £000	Loans and Receivables 2015-16 £000	Available for Sale 2015-16 £000	Total 2015-16 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	3,485	0	3,485
· Non-NHS	0	3,417	0	3,417
Cash at bank and in hand	0	60	0	60
Other financial assets	0	8	0	8
Total at 31-March-2016	**0**	**6,970**	**0**	**6,970**

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	619	0	619
· Non-NHS	0	449	0	449
Cash at bank and in hand	0	121	0	121
Other financial assets	0	0	0	0
Total at 31-March-2016	**0**	**1,189**	**0**	**1,188**

14.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	Other 2015-16 £000	Total 2015-16 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	7,247	7,247
· Non-NHS	0	30,060	30,060
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31-March-2016	**0**	**37,307**	**37,307**

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	6,947	6,947
· Non-NHS	0	23,716	23,716
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31-March-2016	**0**	**30,663**	**30,663**

14.4 Maturity of financial liabilities

	Payable to DH	Payable to Other bodies	Total
	£'000	£'000	£'000
In one year or less	0	37,307	37,307
In more than one year but not more than two years	0	0	0
In more than two years but not more than five years	0	0	0
In more than five years	0	0	0
Total at 31-March-2016	**0**	**37,307**	**37,307**

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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 Services	750,726	(8,278)	**742,448**	10,314	(37,544)	**(27,230)**

During the year NHS Sheffield Clinical Commissioning Group paid £376,499k, approx. 50% of total expenditure, (2014-15: £375,158k approx. 52%) to Sheffield Teaching Hospitals NHS Foundation Trust for the purchase of healthcare and other services provided.

During the year NHS Sheffield Clinical Commissioning Group paid £80,478k, approx. 11% of total expenditure (2014-15: £83,387k approx. 12%) to Sheffield Health and Social Care NHS Foundation Trust for the purchase of healthcare and other services provided.

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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.

NHS Sheffield Clinical Commissioning Group and Sheffield City Council entered into a new Section 75 agreement covering the Better Care Fund with effect from 1 April 2015. The establishment of this pool which is hosted by Sheffield City Council incorporates the Learning Disabilities Accommodation and Services, and the Community Equipment and adaptation services that were reported last year under separate Section 75 agreements.

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:

	2015/16			2014/15		
	NHS Sheffield CCG	**Sheffield City Council**	**Total**	NHS Sheffield CCG	Sheffield City Council	Total
Service Area	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000
The Better Care Fund	180,478	102,065	282,543	0	0	0
Learning Disabilities Accommodation and Services	0	0	0	665	1,100	1,765
Community Equipment and Adaptations Services	0	0	0	2,133	860	2,993
	180,478	**102,065**	**282,543**	**2,798**	**1,960**	**4,758**

The CCG net contribution to the Better Care Fund for 2015/16 shown above is included within the expenditure recorded in note 5 to these accounts (Services from foundation trusts £107,736k; Purchase of healthcare from non-NHS bodies £73,021k; GPMS/APMS and PCTMS £1,226k; Other professional fees excl. audit £64k; and Establishment £2k) and within the revenue recorded in note 2 to these accounts (-£1,571k Non-patient care services to other bodies) .

The memorandum account for the pooled budget is:

The Better Care Fund

	2015/16	2014/15
Income	**£'000**	£'000
NHS Sheffield Clinical Commissioning Group	180,478	0
Sheffield City Council	102,065	0
	282,543	**0**
Allocation of expenditure		
Theme 1 - People Keeping Well in their Local Community	(8,454)	0
Theme 2 - Active Support and Recovery	(53,358)	0
Theme 3 - Independent Living Solutions	(4,380)	0
Theme 4 - Ongoing Care	(154,438)	0
Theme 5 - Adult inpatient Medical Emergency Admissions	(59,385)	0
Theme 6 - Capital Grants	(2,528)	0
	(282,543)	**0**

Learning Disabilities Accommodation and Services

The pool was hosted by Sheffield City Council and the money was used to purchase accommodation and support provider services both in the independent sector and NHS and Community in-house services. This pool arrangement ended in 2014/15 and is now incorporated within the Better Care Fund Pool

The memorandum account for the pooled budget is:

	2015/16	2014/15
Income and Expenditure	**£'000**	£'000
NHS Sheffield Clinical Commissioning Group	0	665
Sheffield City Council	0	1,100
Learning Disabilities Respite Services	**0**	**1,765**

Community Equipment and Adaptations Services

The pool was hosted by NHS Sheffield Clinical Commissioning Group and the money was used to purchase equipment for clients who have received an Occupational Therapy Assessment. This pool arrangement ended in 2014/15 and is now incorporated within the Better Care Fund Pool.

The memorandum account for the pooled budget is:

	2015/16	2014/15
Income and Expenditure	**£'000**	£'000
NHS Sheffield Clinical Commissioning Group	0	2,133
Sheffield City Council	0	860
Community Equipment and Adaptations Services	**0**	**2,993**

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17 Related party transactions

Details of related party transactions for 2015-16:

Name & Role of Individual at the CCG	Related Parties for which transactions made & Role of Individual in the Related Party	Purpose of Payment	Payments to Related Party £000	Receipts from Related Partv £000	Amounts owed to Related Partv £000	Amounts due from Related Partv £000
Dr Amir Afzal - Locality Appointed GP	Duke Medical Centre - Senior Partner	Practice Payments	83	0	17	0
Dr N Anumba - Locality Appointed GP	Woodhouse Health Centre - GP Partner	Practice Payments	213	0	47	0
	Woodhouse Healthcare Services Ltd - Director	Contract Payments	9	0	0	0
Dr Nikki Bates - GP Elected Member	Porterbrook Medical Centre - GP Partner	Practice Payments	182	(1)	57	0
	Rivelin Healthcare Ltd - Minority Stakeholder	Contract Payments	63	0	5	0
Mark Gamsu - Lay Member	Darnall Wellbeing - Committee Member	Rent of Building	0	0	50	0
	Voluntary Action Sheffield - Trustee	Contract Payments	32	0	1	0
	Citizens Advice - Trustee	Contract Payments	238	0	0	0
Dr Anil Gill - GP Elected Member	Selborne Road Medical Centre - GP Principal	Practice Payments	16	0	11	0
	Dr Anil Gill	Overpayment of salary	0	0	0	(8)
Dr Zak McMurray - Medical Director	Woodhouse Healthcare Services Ltd - Shareholder	Contract Payments	see above	see above	see above	see above
Dr Tim Moorhead - Chair of the Governing Body	Oughtibridge Surgery - Senior Partner	Practice Payments	298	0	20	0
	Rivelin Healthcare Ltd - Minority Stakeholder	Contract Payments	see above	see above	see above	see above
Dr Marion Sloan - GP Elected Member	Sloan Medical Centre - GP Principal	Practice Payments	127	0	34	0
Dr Leigh Sorsbie - Locality Appointed GP	Firth Park Surgery - GP Partner	Practice Payments	95	0	28	0
Dr Ted Turner - GP Elected Member	Shiregreen Medical Centre - GP Partner & Principal	Practice Payments	85	0	24	0

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

The Department of Health is regarded as a related party. During the year NHS Sheffield Clinical Commissioning Group has had a significant number of material transactions with entities the Department of Health is regarded as the parent. For example:
- 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 these transactions have been with Sheffield City Council.

Prior Year Comparator 2014-15*

Name & Role of Individual at the CCG	Related Parties for which transactions made & Role of Individual in the Related Party	Purpose of Payment	Payments to Related Party £000	Receipts from Related Partv £000	Amounts owed to Related Partv £000	Amounts due from Related Partv £000
Dr Amir Afzal - Locality Appointed GP	Duke Medical Centre - Senior Partner	Practice Payments	94	0	5	0
Ian Atkinson - Accountable Officer	South Yorkshire Housing Association - Non Executive Director	Contract Payments	2,758	0	4	0
Dr Nikki Bates - GP Elected Member	Porterbrook Medical Centre - GP Partner	Practice Payments	186	0	17	0
	Rivelin Healthcare Ltd - Minority Stakeholder	Contract Payments	77	0	0	0
Amanda Forrest - Lay Member	Sheffield Cubed - Director	Contract Payment	20	0	38	0
Mark Gamsu - Lay Member	Darnall Wellbeing - Committee Member	Rent of Building	0	0	41	0
	Voluntary Action Sheffield - Trustee	Contract Payments	28	0	0	0
	Sheffield Citizens Advice - Trustee	Contract Payments	180	0	0	0
Dr Anil Gill - GP Elected Member	Selborne Road Medical Centre - GP Principal	Practice Payments	22	0	2	0
	Dr Anil Gill	Overpayment of salary	0	0	0	(13)
Dr Andrew McGinty - Locality Appointed GP	Woodhouse Health Centre - GP Partner	Practice Payments	237	0	19	0
	Woodhouse Health Services Ltd - Director	Contract Payments	24	0	0	0
	Primary Provider Ltd - Partner	Contract Payments	245	0	63	0
Dr Zak McMurray - Medical Director	Woodhouse Health Centre - GP Partner	Practice Payments	see above	0	see above	0
	Woodhouse Healthcare Services Ltd - Director	Contract Payments	see above	0	see above	0
	Primary Provider Ltd - Shareholder	Contract Payments	see above	0	see above	0
Dr Tim Moorhead - Chair of the Governing Body	Oughtibridge Surgery - Senior Partner	Practice Payments	301	0	16	0
	Rivelin Healthcare Ltd - Minority Stakeholder	Contract Payments	see above	0	see above	0
Dr Marion Sloan - GP Elected Member	Sloan Medical Centre - GP Principal	Practice Payments	162	(5)	11	0
Dr Leigh Sorsbie - Locality Appointed GP	Firth Park Surgery - GP Partner	Practice Payments	201	0	6	0
Dr Ted Turner - GP Elected Member	Shiregreen Medical Centre - GP Partner & Principal	Practice Payments	104	0	9	0
Dr Richard Davidson - Secondary Care Doctor	Yorkshire Medical Logistics - Director	Governing Body Membership	8	0	0	0

*Prior year comparators have been re-stated in a format that is consistent with that reported in 2015-16

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18 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of NHS Sheffield Clinical Commissioning Group for 2015/16. The following event is disclosed for the purpose of completeness and transparency, but is not considered to give rise to any material impact on the clinical commissioning group's financial position at 31 March 2016.

In December 2015, NHS England announced details of the Clinical Commissioning Groups approved to take on greater delegated responsibility or to jointly commission GP services from 1st April 2016. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View.

NHS Sheffield Clinical Commissioning Group has been approved under delegated commissioning arrangements which mean that the CCG will assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1st April 2016. The governance arrangements for commissioning will fall to the Primary Care Commissioning Committee established by the clinical commissioning group in November 2015.

19 Losses and special payments

19.1 Losses

The total number of NHS Sheffield Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2015-16 Number	**Total Value of Cases 2015-16 £'000**	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Administrative write-offs	2	123	0	0
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**2**	**123**	**0**	**0**

19.2 Special payments

	Total Number of Cases 2015-16 Number	**Total Value of Cases 2015-16 £'000**	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	0	0	2	1
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**0**	**0**	**2**	**1**

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20 Financial performance targets

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

NHS Act Section		2015-16 Target	2015-16 Performance	Duty Achieved?
223H (1)	Expenditure not to exceed income*	758,216	750,726	Yes
223I (2)	Capital resource use does not exceed the amount specified in Directions	0	0	
223I (3)	Revenue resource use does not exceed the amount specified in Directions	749,938	742,448	Yes
223J (1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	
223J (2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	14,119	10,697	Yes

NHS Act Section		2014-15 Target	2014-15 Performance	
223H (1)	Expenditure not to exceed income*	733,406	722,091	Yes
223I (2)	Capital resource use does not exceed the amount specified in Directions	0	0	
223I (3)	Revenue resource use does not exceed the amount specified in Directions	727,096	715,781	Yes
223J (1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	
223J (2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	15,816	10,838	Yes

The above information demonstrates that in 2015/16 NHS Sheffield Clinical Commissioning Group income exceeded expenditure, generating a surplus of £7,490k (£11,315k in 2014/15).

*For the purposes of this note, expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as receivable in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

2014/15 figures have been represented to be consistent with the 2015/16 presentation

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