NHS
Sheffield
Clinical Commissioning Group

Annual Report 2014/15

Working with you to make Sheffield
HEALTHIER

Contents

To comply with national guidance, each CCG's Annual Report must contain four sections: Member Practices' Introduction, Strategic Report, Members' Report and a Remuneration Report. Each report has to address a number of specific issues as set out in national guidance. In addition, the CCG is required to publish with its Annual Report three further documents; Statement of the Accountable Officer's Responsibilities, the Annual Governance Statement and the CCG's audited Annual Accounts. The Accounts are preceded by the External Auditor's Opinion on the Accounts.

Member Practices' Introduction
Dr Tim Moorhead, Elected Chair, NHS Sheffield Clinical Commissioning Group, on behalf of the Member Practices

Welcome to the second annual report of the NHS Sheffield Clinical Commissioning Group. It has been an exciting year and we are pleased with our progress as we continue to build on the work from our first year.

In April 2014 the CCG published its 'Commissioning Intentions' for 2014/19. This document included a two year operational plan and a five year strategic plan; these set out our ambitions to improve the health and wellbeing of people in the city, especially those population groups with the poorest health. Our Commissioning Intentions are based on the aims set out in our prospectus and the outcomes that Sheffield's Health and Wellbeing Strategy intends to achieve. The full document can be found on our website http://www.sheffieldccg.nhs.uk/our-information/commissioning-intentions.htm.

Our ambitions for 2019 that we have been working towards this past year include:

- All those who are identified to have an emerging risk of hospital admission are offered a care plan.
- To have an integrated primary and community based health and social care service approach to long-term conditions management to support people living independently at home, reducing emergency hospital admissions by up to 20%.
- Care requiring a specialist clinician will be brought closer to home.
- To reduce the number of excess early deaths in adults with serious mental illness and achieve similar improvements in life expectancy for people with learning disabilities.
- To put in place support and services that will help all children have the best possible start in life.

This report (see section 4 of our strategic report) shows that we are making progress towards fulfilment of our ambitions. Some of the key achievements are described below:

- *We have been working with local practices to develop the GP led local care planning service, which aims to ensure that people who have long term health conditions have a proactive, holistic plan to maximise their independence and reduce deterioration and crises in their health.*
- *We continue to work with partners across the city to improve services for people with mental health problems, dementia and learning disabilities. This year we signed a joint declaration with a number of partner organisations across South Yorkshire (including the Police, service users and carers, and the ambulance service) underpinning our shared commitment to improve care and support for people in mental health crisis. There is a local version of the plan available to view on the national website http://www.crisiscareconcordat.org.uk/.*
- *In order to meet the standards set out in the Winterbourne Concordat (around reducing the number of people with learning disabilities in inappropriate hospital care), we have worked with partners such as independent care providers and Social Services to avoid out of city placements, and have*

established local services in order to enable people to return to Sheffield and live closer to their families.

- *We have developed a new mental health service for 16 and 17 year olds which means that a dedicated, age-appropriate service is now available to this group for the first time.*
- *Working through an innovative partnership with Macmillan Cancer Care, the CCG has supported a citywide cancer survivorship programme, looking at the needs of people living with and beyond cancer, and disseminating the findings of new research.*
- *We have undertaken a review of child safeguarding arrangements with Sheffield Children's NHS Foundation Trust and will be making improvements to a number of services in the next financial year as a result of this work.*
- *We have worked with Sheffield Teaching Hospitals NHS Foundation Trust to enable more people to 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. The majority of hospital appointments can now be made via Choose and Book and more GP practices are now using the system.*
- *We have contributed to a successful Big Lottery bid for the 'Ageing Better' programme, focusing on preventing and reducing social isolation and loneliness in older people, which can lead to mental health problems in this vulnerable group.*
- *Working with Yorkshire Ambulance Service NHS Trust and the Single Point of Access (a service which helps signpost patients to the right part of the health system for their needs) to develop a new service enabling paramedics to arrange additional care and support for patients in their own homes, rather than being transported to hospital as would have happened previously.*
- *Working in partnership with a local pharmacy to provide a wide range of community pharmacy services including minor ailments, out-of-hours and the dispensing of medicines in an emergency. This approach has clearly demonstrated the benefit to local patients and is currently being put onto a formal basis to ensure its sustainability in the coming years.*
- *The new 'Itchy, Wheezy, Sneezy' project has established allergy clinics in general practice that provide allergy care for children and young people based in the community, which means they can be seen by a specialist closer to home, instead of having to go into hospital.*
- *The pipelle sampling pilot for gynaecological investigations has enabled women to receive testing at their GP practice rather than attending the hospital, likewise the dermatology pilot has supported secondary care clinicians to be able to view photographic images of skin lesions in order for them to undertake diagnosis without the need for the patient to travel to hospital.*

As well as supporting innovation and new service improvements, the CCG also has a role in working with partners across our local health system to ensure that services deliver quality and safety, and meet national targets. As extensive media coverage has shown, 2014/15 has proved a challenging year for the NHS across the country, including in areas such as A&E waits, ambulance response times and meeting the NHS Constitution pledge of referral to treatment for non urgent care within 18 weeks. Sheffield has experienced pressure in all these areas, but is working constructively with relevant providers to address the challenges we face in addition to using contractual and other measures. However, Sheffield CCG has continued to show

good performance across a wide range of local and national standards including cancer waiting times. We received from NHS England a non recurrent 'Quality Premium Payment' of £1.7m in recognition of improvements made in the quality of services and health outcomes in Sheffield during 2013/14 which we principally used this year on initiatives to improve quality and access to primary and community services. We anticipate that our performance in 2014/15 will result in a further "Quality Premium Payment" for use during 2015/16. Further information is available in the CCG Quality and Outcomes report (see sections 5 and 8 in the strategic report).

The CCG took the opportunity to review our progress in year, in terms of how we are developing as an organisation. The review confirmed a successful first year of operation and identified a number of recommendations to build a 'Fit for Future' CCG, which is leading the health and care system transformation to make a real difference to the health and wellbeing of our population, and their experience of healthcare. We have agreed a number of actions to build on our success, which include developing the skills and knowledge of our staff; creating a learning organisation; establishing a culture which supports innovation; and ensuring that staff can have a meaningful voice in shaping the CCG's future.

Our original financial plan set a target surplus of £7.2m (which equates to 1% of our allocation, the minimum requirement from NHS England for all CCGs to plan for as part of good financial management). We have actually been able to deliver a surplus of £11.3m (which equates to 1.6% of our final allocation). This is an achievement, in the context of the significant challenges we have set for ourselves around transforming the health system in Sheffield. We are pleased that the CCG will be able to add to our funding for 2015/16 the £4m additional surplus made in 2014/15 to meet increased financial challenges.

I am also pleased to say that, from 1 April 2015, the CCG and Sheffield City Council have in place a £270 million budget to commission appropriate health and social care services across Sheffield. This pooled budget for 2015/16 is one of the biggest in the country and will support transforming Sheffield's health and social care services to make care more co-ordinated and seamless. This ambitious partnership approach will make the best use of local resources, in the context of reduced Local Authority funding. It will allow the CCG and City Council to incentivise creativity and collaboration so I am very excited for the year ahead. I should also mention that this partnership work contributed, alongside the strong Health and Wellbeing Board that I Co-Chair with the Leader of the Council, to our recognition as finalists in the NHS Leadership Academy Awards for 'Collaborative Leadership of the Year'. The CCG were also finalists in the 'Governing Body of the Year' category and it was very pleasing to receive this level of national recognition. The CCG is a key player in a number of other important partnerships in the city and beyond. More details on our partnership work can be found in section 7 of the strategic report.

As part of our partnership work through the Health and Wellbeing Board, we have been working together to take action to reduce health inequalities in the city and I am delighted that this year we have been able to publish a refreshed Health Inequalities Plan – the first time this plan has been refreshed in the city for five years and to my mind, long overdue. For me, tackling health inequalities is core to our business as commissioners of health care and should be embedded through everything we do. Practical action to address inequalities around issues such as stroke, smoking

status, physical inactivity and improved blood sugar control in people with diabetes will result in substantial population health gains, including longer life, as well as reduced healthcare spend. Further information about how we plan to tackle health inequalities can be found in our 2015/16 Commissioning Intentions Plan on our website http://www.sheffieldccg.nhs.uk/our-information/commissioning-intentions.htm.

In the last year the CCG has made communicating and engaging with patients and the public a much higher priority. There are many examples of how this is embedded across the organisation. This work has led to a deeper appreciation of how useful and important the patient voice is in helping develop our programmes of work. In particular, we undertook a substantial engagement exercise as part of our work around improving Musculoskeletal Services. More detail about this and other engagement work during 2014/15 can be found within the Statement of Involvement Report (appendix Ai of the Strategic Report).

The future

The NHS Five Year Forward View was published in October 2014 and sets out a vision for the future of the NHS giving a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services. The full Five Year Forward report can be viewed here. (http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf).

We are, I believe, in a unique position to build on our work so far to make the changes required of the NHS that are set out in the Five Year Forward View and we have already begun to look at the likely service models that need to be shaped to allow these changes to happen. The development of the GP Provider Board, outcome based contracting, tighter integration with social care and greater involvement of patients have all been key parts of our work as city healthcare commissioners during 2014/15. During 2015/16 we will continue to work in partnership with Sheffield City Council, our NHS provider partners and the GP Provider Board to develop a clear vision of how services should be delivered in Sheffield and how we will achieve that vision. In many respects, Sheffield is already well placed to respond positively to the key recommendations, given our work on integrating commissioning functions and supporting the development of more integrated providers.

We recognise that the likely continuing significant constraints on public sector funding in the coming years mean that there will be tough decisions to be made, and we will mobilise our commissioning teams to meet this challenge. One of the developments coming on stream next year is a new primary and community based services model of Active Support and Recovery, delivering proactive support and recovery with a shift in focus towards earlier prevention and proactive care planning, reflecting the new service models envisaged in the Five Year Forward View. Alongside this, we will be looking to radically transform elective care through a new primary care based service, and we will undertake a strategic review of all elements of the urgent care system; all of which I think will be really ground breaking work.

Over the next year, commissioning will become increasingly localised as NHS England, currently responsible for commissioning high cost and specialised services, as well as primary care, will start to delegate some of these responsibilities to CCGs,

as it moves towards more of a system manager role. Our CCG is of the view that this direction of travel is a good strategic fit for us and we are looking forward to working closely with NHS England as a co-commissioner.

Looking back over our second year makes me, as the Chair of the CCG, very proud. I am privileged to work with a talented and dedicated team of clinicians and CCG employed staff who have a wealth of experience and who have all contributed to our success so far. We have all benefitted from the inspiring leadership of our Accountable Officer, Ian Atkinson, and we were sad to see him leave in March 2015 to explore new opportunities, I am however confident that the CCG has robust leadership in place and is in good shape as we look to recruit a new Accountable Officer.

For me, partnership working has been crucial in achieving what we have so far and we need to build on that approach if we are to continue to deliver improvements for Sheffield people. Most importantly, we need to align what we are doing with other programmes of work, such as the Integrated Commissioning Programme with Sheffield City Council and the Prime Minister's Challenge Fund programme of work that the GP Provider Board is leading, as this will reduce duplication and inappropriate use of resources through integration. I now turn to 2015-16 and look forward to what we hope will be another successful year.

Thank you for taking the time to read our annual report, we hope you find it an interesting read.

Dr Tim Moorhead
Chair, NHS Sheffield Clinical Commissioning Group

Signed: Date:

Tim Moorhead

Tim Moorhead
Chair

Strategic Report

1. Introduction

NHS Sheffield Clinical Commissioning Group (CCG) is responsible for commissioning many of Sheffield's healthcare services, particularly secondary care, and works with clinicians, healthcare professionals, and patients and the public, to deliver high quality, efficient and cost effective healthcare services for people across the whole of Sheffield.

This part of the CCG Annual Report will principally inform you about the work of the CCG during 2014/15, which was our second year as a fully authorised CCG. We also look to the future, although this is covered in some detail in the "the future" section of the Member Practices' Introduction.

From the outset, the CCG has demonstrated a clear commitment to an open and transparent approach to conducting our business, and therefore throughout this document, where appropriate, we will refer to documents that are already in the public domain*, many having been received at one of our monthly Governing Body meetings held in public.

The annual report and accounts have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Service Act 2006.

*Referrals within this document are generally to web based resources; however if you are reading this in paper copy and require any of the documents to which we refer in paper copy please contact the CCG who will be happy to provide these for you: sheccg.comms@nhs.net / 0114 305 1398.

2. About Sheffield

NHS Sheffield CCG is a member of the Sheffield First Partnership. Each year the partnership commissions a report called '*The State of Sheffield*'. The most recent report was published in February 2015 and can be read in full here: https://www.sheffieldfirst.com/key-documents/state-of-sheffield.html

This section of the CCG Annual Report draws on "*The State of Sheffield*" and provides some context for the commissioning of health care in our city.

Living in Sheffield

The population of the city has grown over the last 10 years; in particular, there have been increases in the number of younger and older people, and it is more diverse in its ethnic groups and communities. The ethnic minority population of the city is now 19%, more than double that in 2001.

Sheffield's population has continued to grow - from 551,800 in 2011, to 560,100, in 2013, a growth of 1.5%. Sheffield's under 16 population has grown at the same rate as the city as a whole. The working age population has grown relatively slowly since 2011. An exception to this is the 20-24 age group, which has grown by 9% in this

time and the two universities have continued to attract some 20,000 new students to the city – evidence of our image as an attractive place to live and work.

To give two high profile examples, the Crucible Theatre was named “regional theatre of the year” for the second year running, and Sheffield hosted a stage of the Tour de France. The Tramlines music festival continues to grow in popularity, with attendance increasing year on year. These examples demonstrate that Sheffield continues to be a vibrant city with a thriving cultural and sporting scene.

Sheffield is recognised as one of the greenest cities in Europe, with a variety of green spaces close to the city centre – but some areas also suffer from very poor air quality, mainly linked to motor vehicle use.

Working and the overall city economy

The economic performance of Sheffield and recent employment trends reveal a mixed picture. Unemployment claimant rates continue to fall across the city with the number claiming for more than two years, as of October 2014, declining by around 20% in the last 12 months. However, levels of youth unemployment, particularly long term youth unemployment, remain far too high.

The last year has seen encouraging evidence of investment and development, which has created local jobs, for example the expansion of the Children’s Hospital, and new retail and leisure opportunities on The Moor. There are exciting future plans for investment in engineering and advanced manufacturing, which show increasing confidence in the city region’s economy. The Gross Value Added (GVA) measure per head in Sheffield has grown in recent years, but does, however, still lag behind the national average (GVA is a measure of the contribution to the economy of an area: Sheffield’s per head is £17,752; the national average is £21,349).

Building on the success of the City Deal in 2013, Sheffield City Region agreed one of the most significant Growth Deals in 2014. Worth £320m, the deal provided further devolved funding for infrastructure investment and enhanced the developing localised skills model which was established in the City Deal. Sheffield City Region was one of only three places to be given flexibility over how devolved resources are used, emphasising the Government’s trust in local governance and leadership.

Many families, however, continue to struggle on a low income. Recent studies have highlighted that approximately 43% of households in Sheffield are vulnerable to significant levels of financial stress.

In terms of future trends, many of those already in difficulty will potentially face even more extreme hardship. Additional groups currently on the margins of poverty and new groups of households who may have been financially secure previously could have new challenges to face.

Tackling health inequalities

People are living longer in Sheffield and the overall health of the city’s population is improving. Unfortunately, significant inequalities remain: areas of concern include infant mortality rates, unhealthy lifestyles, dementia and poor mental health (particularly amongst the city’s children and young people), in addition to persistent

geographical inequality. There are also large inequalities in life expectancy. For males, the gap between the lowest and highest life expectancy is 8.6 years, whereas for females the gap is 8.2 years. These gaps in life expectancy have not remained static. Whilst inequality in life expectancy has decreased for males, it has increased for females. Health represents a complex set of conditions that are inherently linked to social and economic conditions, with different parts of the city and different communities experiencing a variety of root causes. The Sheffield Health and Wellbeing Board has identified addressing health inequalities as one of its priorities in the Joint Health and Wellbeing Strategy which can be viewed here: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/joint-health-and-wellbeing-strategy.html.

Sheffield launched the Our Fair City campaign in January 2015, aiming to build a social movement in support of fairness and better use the resources of the city and its citizens to promote fairness.

Tackling health inequalities is a significant part of addressing wider inequalities and this remains a key priority for the CCG. This includes addressing variations in life expectancy across the city and the higher prevalence of some long term conditions in some groups of people. Poor health tends to have a more profound impact on people who are already experiencing economic disadvantage, inadequate housing or insecure employment; the staff in our 87 practices have daily experience and insight into these issues.

Staff in general practice are engaged in increasing uptake of regular physical activity, smoking cessation and promotion of healthy weight on a face to face basis; at a strategic level the CCG works on these and other public health priorities with our partners in the Health and Wellbeing Board.

3. About us

NHS Sheffield Clinical Commissioning Group (CCG) is a membership organisation. Our membership comprises of 87 GP practices across the Sheffield locality. A list of the member practices can be found in the members' report section of the annual report, which follows the strategic report.

We are the only CCG in Sheffield and we cover the same population area as the Local Authority - Sheffield City Council.

The CCG works with clinicians, healthcare professionals, patients and the public, to deliver high quality, efficient and cost effective healthcare services for people across the whole of Sheffield.

We have put our clinical leadership arrangements on a firmer footing by appointing through a competitive process, experienced GPs to our five Clinical Directors – one for each of our clinical portfolio areas. These doctors work part time within the CCG to lead quality improvements, service redesign and to support delivery of our clinical priorities. In addition to these appointments, there is a significant and growing number of clinicians who regularly work with us on a number of projects.

We have boosted our engagement with Sheffield citizens through our 'Involve me' engagement network and through our partnership with Healthwatch. More can be read about this within the Statement of Involvement Report (appendix Ai of the Strategic Report).

The CCG's Governing Body includes GPs from across the city, with other healthcare professionals and lay advisors (non NHS, non-clinical people whose job is to 'think as a member of the public') represented.

CCG localities

NHS Sheffield CCG is a large CCG with four strong localities: North, West, Central and Hallam & South. The localities ensure member practices can come together easily to identify health (and increasingly care) needs of their patients across their localities. The localities are accountable to the CCG and are responsible for locally sensitive implementation of commissioning plans and enabling all practices to be involved in the CCG – they support practices in their development and encourage innovation.

4. Strategy and Business

As we have progressed in our journey as a clinically led organisation, we have enhanced the clinical contribution to the delivery of our ambitions set out within our Commissioning Intentions. Our Commissioning Intentions for 2014-19, set out a number of ambitious objectives for the next five years to transform the way healthcare is delivered in Sheffield and improve the health and wellbeing of people in Sheffield, especially those population groups with the poorest health. This document can be found on our website http://www.sheffieldccg.nhs.uk/our-information/commissioning-intentions.htm.

The CCG has set up five clinical portfolios to deliver the Commissioning Intentions. Each portfolio is led by a Clinical Director who is an experienced GP, to work alongside the Heads of Commissioning, who are senior experienced managers, to identify clinical priorities, and to continually improve and develop the services commissioned. These portfolio teams are supported by a range of CCG staff with expertise in quality, public health, finance and contracting. They also draw in clinical advice from other local health care professionals, as well as from patients and the public.

All of the portfolios work closely together to deliver the commissioning intentions as there is significant overlap between the portfolios, but broadly speaking, they can be described as:

Elective Care

This team works to ensure that patients receive their planned care (for example, investigations, surgery, interventions such as physiotherapy) in the most appropriate place within the most appropriate timeframes. Their work also includes exploring how technology can be used to support more streamlined care, for example remote monitoring or virtual consultations; and the most up to date evidence as to how care should be delivered.

Urgent Care

This team is working collaboratively across the health and social care system to ensure that there is joined up urgent care regardless of who provides it. This ranges from extended opening hours in pharmacies for minor ailments right through to accident and emergency at the hospital. A key aspect of the work is developing systems and models of care that are sufficiently resilient to respond to fluctuations in demand in a way that delivers best outcomes for patients and minimise pressure across the rest of the health system, for example in winter months when respiratory related conditions are exacerbated and require a higher level of care. This requires all the parts of the system to work well together, facilitating care outside of hospital that both prevents the need for admission and enables earlier discharge with the right level of support.

The CCG has also been working hard to make it easier for patients to understand which service will best meet their needs when they are ill, and how to access it – particularly in the evenings and at weekends.

Children, Young People and Maternity

This team works closely with Sheffield City Council on a range of priorities for families and children. The portfolio is concerned with improving services for common childhood problems such as continence, as well as working to develop services for children and young people with complex illnesses and disabilities. Developing better transition from children's to adult services has been a key piece of work which will continue, particularly for adolescents with mental health problems and learning disabilities.

Mental Health, Dementia and Learning Disabilities

This year the team has been undertaking some innovative work on prevention of mental ill health, as well as raising awareness and standards of care for the physical health of people with serious and long term mental health problems. The intentions are for these people to have better health, live longer and stop dying earlier. The team also continues to work with other partners in the city to create bespoke care for people with profound learning disabilities and complex medical problems, so that they can be cared for in Sheffield near their families.

For dementia, Sheffield was one of the first cities in the country committed to being a Dementia Friendly Community. This is where local businesses and organisations support people to live well with dementia, helping them remain independent for longer.

A partnership with the Local Authority has led to the establishment of a new Adult Autism and Neurodevelopmental Service, which provides assessment, diagnosis and multi-disciplinary interventions for people with an Autistic Spectrum Disorder.

Other important developments have been the creation of a local team to provide support in the city for people who have been in hospital placements a long distance

away. Improvements have also been made in the level of mental health support available in accident and emergency, for those patients who need it.

Long Term Conditions, Older People, Cancer and End of Life

This team's responsibilities span a wide variety of topics. In the last year, the team has had a major focus on respiratory health, with the aim of preventing crisis admissions amongst people with chronic conditions, and working on improving services for people with diseases such as diabetes. The portfolio has been working in an innovative partnership with the charity Macmillan to spread new knowledge about health issues facing people who survive cancer, and how best to support them. Promoting greater independence and wellbeing for older people is also an important part of the work of this team.

You can read about the portfolio's achievements from 2014/15 in the Quality and Outcomes report on our website:http://www.sheffieldccg.nhs.uk/Downloads/CCG%20Board%20Papers/May%202015%20board%20papers/PAPER%20I%20Quality%20and%20Outcomes%20report.pdf

Integrated Commissioning programme
In addition to these five portfolios we have established an Integrated Commissioning Programme with Sheffield City Council utilising the £270 million pooled budget in place from 1st April 2015. The workstreams in this programme are Keeping People Well in their Community, Independent Living Solutions, Active Support and Recovery and Long Term High Support.

As well as the portfolios, the CCG supports delivery of our priorities through our Programme Management Office (PMO) which we established in October 2014 to enable the organisation to have a more structured and assured approach to programme management and delivery of projects. Using proven programme methodologies, the PMO is designed to assist the CCG in allocating resources (in terms of finance and also staff time), making decisions and tracking progress across the life cycle of projects, including completion and evaluation of impact. The small but experienced team supports ensuring clarity in relation to patient related benefits in the most productive and efficient way and provides a governance and delivery structure to support approval, delivery and evaluation of these. Ultimately, this new approach will ensure that we are delivering high quality, sustainable services that make a real difference to the health and wellbeing of Sheffield people.

As a clinically led organisation, the CCG actively seeks the input of a wide range of clinicians to support the development of clinical policies, patient pathways and service design. We have established a 'virtual' Clinical Reference Group (CRG) to enable peer review of clinical ideas/proposals from a range of clinical backgrounds and experience. The group does not meet physically, but circulates and comments on ideas electronically. It is chaired and co-ordinated by an experienced GP and its recommendations are recorded and fed into the CCG's decision making.

The CCG invests each year in a programme of education for primary care staff. This is developed to support the delivery of our commissioning priorities around quality, safe and effective care and to reinforce the CCG's expectations around what constitutes best practice. These events are run with the goodwill and partnership of

clinical staff in secondary care and we are grateful to them for sharing their time and expertise. The design of the programme is driven by the primary care agenda. In the last 12 months we have provided training on safeguarding adults; mental health; musculoskeletal health; gastro-intestinal conditions; infection prevention and control; respiratory problems; rheumatology; life after cancer; and care planning for people with long term conditions.

We have also offered training to practice managers on equality and diversity, and active listening skills for receptionists and other non-clinical staff, partly in conjunction with Macmillan cancer care.

We have included at Appendix A(ii) and A(iii) our reports regarding sustainability and equality and diversity.

5. Performance – Improving Health Outcomes and Ensuring Highest Quality Care

Throughout the year, each month a report is taken to the Governing Body meeting held in public, setting out our performance against agreed local and national measures. This Quality and Outcomes 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 ensure patients receive the highest quality of care.

The monthly reports can be found on our website in the Governing Body Meetings section: http://www.sheffieldccg.nhs.uk/about-us/GB-meetings.htm

An end of year summary is available in the Quality and Outcomes month 12 report on our website:
http://www.sheffieldccg.nhs.uk/Downloads/CCG%20Board%20Papers/May%202015%20board%20papers/PAPER%20I%20Quality%20and%20Outcomes%20report.pdf

Key points to highlight are:

- The CCG continues to show good performance across a wide range of local and national targets and NHS Constitution pledges. The NHS has faced a number of challenges nationally in 2014/15 and we have experienced these in Sheffield, in particular meeting the A&E wait target for adults (performance at Sheffield Children's has been one of the highest performing A&E departments in the country against the 4 hour target), ambulance response times and meeting the NHS Constitution pledge of referral to treatment for non urgent care within 18 weeks in some specialities. NHS England has confirmed that we have robust plans in place to address the challenges presented by the ongoing demands on A&E services and also on the wider care system including GP and community services.

- Sheffield CCG has been assessed as 'fully assured' for six consecutive quarters since CCG assurance began in April 2013. At the time of writing this report we are not able to report on our assessment for the final two quarters of 2014/15 as this process has not yet been completed.

We publish our findings from each quarterly assessment on our website: http://www.sheffieldccg.nhs.uk/our-information/How_are_we_doing.htm.

- The CCG continued to meet all the NHS Constitution waiting time pledges for patients referred for suspected cancer, in contrast to many other services nationally.

- We received from NHS England a non recurrent 'Quality Premium Payment' of £1.7m in recognition of improvements made in the quality of services and health outcomes in Sheffield during 2013/14 which we principally used this year on initiatives to improve quality and access to primary and community services.

6. Finance

Maintaining sound financial health

In our second year of operation we had two main objectives. Firstly it was important for the CCG to continue to maintain a strong financial position on a sustainable basis. Secondly we wanted to ensure that the investments made supported our strategic objectives (as set out in our Commissioning Intentions), in particular to continue to reduce our historic over reliance on hospital services and invest in care closer to home. 2014/15 proved a successful year in supporting the achievement of both of these aims.

We are able to report continued compliance with our statutory duty of delivering financial balance against the resources allocated to the CCG by NHS England. Taking both our allocation for programme (commissioned) expenditure and our Running Cost Allowance (RCA) we reported a surplus of £11.3m or 1.6%. This was slightly higher than the original national planning requirement of a 1% (£7.2m) surplus. This was possible primarily as a result of slippage in spend against the national risk pool for Continuing Health Care (CHC) retrospective claims (resulting in a return of £1.6m of contributions in January 2015) and lower than planned reductions to overall waiting lists, largely due to capacity issues at local trusts in the last quarter of the year. The CCG's preference was to carry forward this resource into 2015/16 to meet pressures identified for the new financial year, in particular to progress reductions to waiting times and developments in collaborative commissioning with Sheffield City Council. NHS England has agreed to this carry forward.

Our programme allocation, to commission health care services, was £711m and we underspent against this by £6.3m or 0.9%.

All CCGs were given an RCA of approximately £25 per head of population, which for Sheffield equated to £14m. This is used to fund the commissioning and governance costs and clinical engagement activities of the CCG and its Localities. As Sheffield CCG is a large CCG we benefit from economies of scale. In addition, NHS England had previously notified CCGs that RCAs would be cut by 10% in 2015/16 and we took a decision to remain within this lower level of funding also in 2014/15, allowing the balance to be spent on patient care. In 2014/15 our actual spend was £10.8 m (£18.50 per head of population).

For the first time, in 2014/15, we received additional funding, referred to as our 'Quality Premium' of £1.7m, based on our performance against agreed national criteria in 2013/14. Whilst the funding was added to our RCA, the funding was actually used to support commissioned spend - to support the emerging primary care development agenda of the CCG as well as initiatives seeking to reduce waiting times for certain services not specifically within Referral To Treatment targets including orthotics and child and adolescent mental health services. The total underspend of £5m against the RCA contributes to the overall surplus and will be carried forward into 2015/16.

The CCG has no allocation for capital expenditure. The CCG does not own any land or buildings, just limited IT and other office related equipment. Replacement of these assets is via revenue expenditure.

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 comparatives are shown for 2013-14.

Measure of compliance

	2014-15 Number	**2014-15 £000**	Prior Year Comparator 2013-14 Number	Prior Year Comparator 2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**13,945**	**94,388**	13,430	76,778
Total Non-NHS Trade Invoices Paid Within Target	**13,743**	**93,861**	13,177	76,105
Percentage of Non NHS Trade Invoices Paid Within Target	**98.55%**	**99.44%**	98.12%	99.12%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,527**	**570,694**	2,783	523,568
Total NHS Trade Invoices Paid Within Target	**3,505**	**570,654**	2,738	523,252
Percentage of NHS Trade Invoices Paid Within Target	**99.38%**	**99.99%**	98.38%	99.94%

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

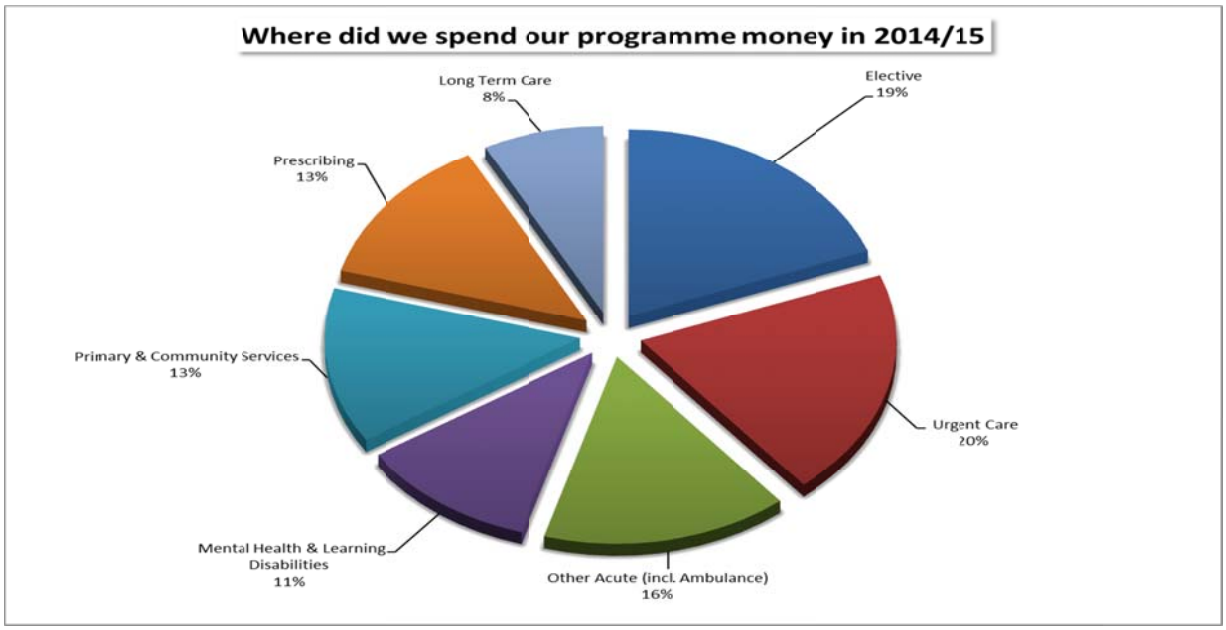
Overall, we spent an average of £1,203 per person on health care for the people of Sheffield. In 2013/14 spend was an average of £1,211 per person. The average has reduced slightly because our population has increased by around 23,000 or 4% and our funding has not increased at this same rate. The table below provides an analysis of how we invested our programme resources in 2014/15. The analysis includes spend against external income as well our revenue resources received from NHS England.

	2014/15	2013/14
	£m	£m
Primary & Community Care		
Primary & Community services	96	89
Prescribing	93	91
Acute Hospital Care		
Elective Care	136	132
Urgent Care	139	138
Other Acute *	88	87
Ambulance	22	21
Mental Health & Learning Difficulties	80	79
Long Term Conditions	55	51
Total	**710**	**688**

** The types of services included within Other Acute are cost per case, critical care, diagnostic testing and imaging and maternity pathway payments.*

The CCG, unlike Sheffield PCT, does not contract for core services provided by Primary Care Contractors such as GPs and Dentists, nor for specialised services. These are commissioned by NHS England.

The chart below presents similar information but shows expenditure, net of external income, as a percentage of the total programme spend.



Full sets of detailed Annual Accounts are available via the CCG's web site or in hard copy free of charge, from Margaret Saunders, NHS Sheffield CCG, 722 Prince of Wales Road, Sheffield, S9 4EU. Email: sheccg.foi@nhs.net. The Annual Accounts were prepared under a Direction issued by the NHS Commissioning Board (NHS England) under the National Health Service Act 2006 (as amended).

Looking ahead to future years

The CCG has a five year financial plan 2014/15 to 2018/19 which supports our overall strategy. The financial plan takes into account the expected very low real terms growth in our funding for the whole of the period due to the overall UK economic situation and that the CCG currently has an allocation which is above its "fair shares" target. This has meant that for 2015/16 we have received the minimum level of growth and it will bring significant challenges. It means that delivery of substantial QIPP productivity and efficiency savings will be required as we implement our local service transformation agenda. We will be working more closely with Sheffield City Council on a substantial integrated commissioning and service transformation programme. This will be supported by pooling funds through a formal Section 75 Better Care Fund arrangement. We intend to pool well in excess of the national requirement for 2015/16, at c£270m of which £165m will be CCG funding.

The CCG remains firmly committed to maintaining recurrent financial balance throughout the period of this strategic plan, and to building on our strong financial management ethos and partnership working to deliver sustainable health services within available resources. We are planning to deliver a small (1%) surplus in each year of the planning period. In addition, to ensure that we achieve maximum gain from the resources employed, we will continue to seek best value for money.

7. Relationships

Partners and Providers

Sheffield Teaching Hospitals NHS Foundation Trust
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
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
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.

Sheffield GP Provider Board
The 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 for residents of Sheffield.

Sheffield City Council
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. From 1 April 2015 NHS Sheffield CCG and Sheffield City Council will operate a £270 million pooled budget for all appropriate health and social care services across Sheffield. This pooled budget is one of the biggest in the country and will transform Sheffield's health and social care services to make care more coordinated and seamless.

Healthwatch
Established in 2013 as a statutory body under the Health and Social Care Act, Healthwatch has been the consumer champion to give adults, children and young people a powerful voice about health and social care services. Healthwatch Sheffield works with local people to improve health and social care services and help people to get the best out of those services. Sheffield CCG and Healthwatch Sheffield 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.

NHS England and Primary Care Providers (GPs, Dentists, Optometrists, Pharmacists)
From April 2013, NHS England took on many of the functions of the former primary care trusts (PCTs) 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. In Sheffield there are 87 general practices, operating from 114 surgeries across the city; there are 75 NHS dental practices and two salaried dental service clinics providing routine care, plus

four specialist orthodontic practices, and seven salaried dental clinics which provide specialist services for people with special care needs; there are 129 pharmacies in Sheffield; and 49 optometry contractors operating out of 57 practices in Sheffield.

The NHS England Area Team's regional role is to: Support and develop CCGs; Assess and assure performance; Undertake direct commissioning of primary care services (GPs, dental, pharmacy, optometry) and some public health services, for example, screening and immunisation programmes for children and adults; children's 0 – 5 year old health services; Commission specialised health services from Yorkshire and the Humber providers and from some specialised independent providers outside the area; Manage and cultivate local partnerships and stakeholder relationships, including membership of Local Health and Wellbeing Boards; Emergency planning, resilience and response; Ensure quality and safety; Provide configuration and system oversight; host the Clinical Senate for Yorkshire and the Humber and the Strategic Clinical Networks.

Other Providers
NHS Sheffield Clinical Commissioning Group 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: http://www.sheffieldccg.nhs.uk/about-us/spending-over-25k.htm.

Strategic Partnerships

Health and Wellbeing Board
The Health and Wellbeing Board is a strategic partnership primarily with Sheffield City Council, with NHS England and Healthwatch involved. Outputs of the partnership include the Joint Strategic Needs Assessment, the Joint Health and Wellbeing Strategy and proposals for integrated commissioning. The Joint Strategic Needs Assessment (or JSNA for short) is the means by which we assess the current and future health, care and wellbeing needs of the local population. Please visit: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA.html to read the report.

Right First Time
A partnership with Sheffield Health and Social Care NHS FT, Sheffield Teaching Hospitals NHS FT, Sheffield Children's NHS FT and Sheffield City Council. Outputs of the partnership include delivery of plans to help people stay healthy and at home, improvements in the NHS response to urgent care needs, reduction of hospital length of stay, and improved rehabilitation and long term care provision. The Right First Time partnership is where providers and commissioners discuss the integration of health and social care.

Future Shape Children's Health
A partnership with Sheffield City Council and Sheffield Children's NHS FT. Products of the partnership include delivery of plans to improve health and life chances for children in Sheffield.

CCGCOM and Yorkshire and Humber CCG Collaborative
A Collaborative working arrangement between CCG's across South Yorkshire and Bassetlaw (CCG Com) and Yorkshire and Humber CCGs, to identify and exploit benefits of work across a bigger geographic area and to coordinate the co-commissioning relationship with NHS England and to collaborate on contract negotiation and management with providers that we share.

Working Together
This is a programme of work developed by a collaborative approach across eight CCGs and NHS England, towards the end of 2013, as CCGs approached the end of their first year of establishment. The eight CCGs jointly developed a commissioner led programme of work to review and re-design a number of services across South Yorkshire, North Derbyshire and Wakefield health systems. A provider led 'Working Together' programme also exists, and the two programmes are closely aligned and work closely to improve services and improve the effectiveness of the CCGs' collective investment in health care.

Working Together has focused so far on four initial agreed areas, Children's Services, Cardiovascular, Smaller Surgical and Medical Specialties, and Urgent and Emergency Care. Good progress is being made, in partnership with local clinicians and other partners such as NHS England and Health and Wellbeing Boards. This programme is a major commitment and one that is necessary to deliver the significant changes that will deliver both improved patient outcomes and increased efficiencies in the way we deliver healthcare. As a result of work in phase one, changes to services will be made which will have a direct positive impact on the quality and experience of patient care. Phase two of the Working Together Programme will build on the commitments started in phase one, including improving the provision of children's services and stroke services. Sheffield, with the other seven CCGs involved, will be working with the King's Fund (a national health charity) to develop thinking and ambitions for new models of care and the opportunities of taking a collaborative approach to commissioning.

Additional partnership activity
In addition to the above, we are members of the Sheffield Executive Board and maintain relationships with individual organisations through regular Governing Body to Board meetings (including with voluntary, community and faith organisations) and we are members of a number of service or condition specific partnership boards and other planning groups. We also contribute to a number of Sheffield City Council groups and initiatives, for example we were involved in developing the multi-agency "Tackling Poverty Strategy".

In 2014/15 the CCG has worked with Sheffield City Council to look at how we can support the development of stronger and more engaged communities.

Public engagement

Patient and Public Voice Report
Sheffield CCG is committed to ensuring that the patient voice is at the heart of all our decisions. We believe that public and patient involvement leads to better service specifications, a better understanding of the quality of care, and a greater understanding of what the people of Sheffield need from healthcare.

During our first year (2013/14), we co-produced an Engagement Plan with the people of Sheffield. This led to the development of our patient, carer and public involvement network called 'Involve Me' and we have continued to develop this network in 2014/15.

Detail about the CCG's engagement activity for 2014/15 can be found within the Statement of Involvement Report (appendix Ai of the Strategic Report).

8. Quality

Quality assurance of the services that we commission is paramount. We assess performance against key local and national quality measures and this is an integral part of the monthly Quality and Outcomes Report to the Governing Body meeting held in public. This includes CCG and provider performance on patient experience – patient feedback and complaints, the prevention of infections resulting from medical care or treatment in hospital and serious incidents.

The Quality and Outcomes 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.

The monthly reports can be found on our website in the Governing Body Meetings section: http://www.sheffieldccg.nhs.uk/about-us/GB-meetings.htm.

Safeguarding

The CCG has a responsibility to protect vulnerable adults and children and we are committed to improving safeguarding processes in Sheffield. More information about safeguarding at the CCG can be found on our website http://www.sheffieldccg.nhs.uk/Your-Health/safeguarding-adults-and-children.htm.

As part of the CCG's commitment to transparency, quarterly reports on safeguarding are taken to the Governing Body. The latest report can be viewed below:

January 2015:
http://www.sheffieldccg.nhs.uk/Downloads/CCG%20Board%20Papers/January%2015%20Board%20Papers/Item%2014e%20Safeguarding%20update.pdf.

Serious Incidents

Monthly reports on Serious Incidents (SIs) are taken to the Governing Body. Please visit the Governing Body meeting pages on our website to find these reports:

http://www.sheffieldccg.nhs.uk/about-us/GB-meetings.htm

Compliments and Complaints

Quarterly reports on Compliments and Complaints are also made publically available as part of the Governing Body reports. The latest report can be viewed below:

January 2015:
http://www.sheffieldccg.nhs.uk/Downloads/CCG%20Board%20Papers/January%2015%20Board%20Papers/Item%2014f%20Compliments%20Complaints%20and%20MP%20Enquries%20report.pdf

The Compliments and Complaints Annual Report will be available in June 2015 on our website here: http://www.sheffieldccg.nhs.uk/our-information/strategies-and-policies.htm.

The CCG has fully adopted the Principles for Remedy which forma an integral part of the complaints handling and are incorporated into our Complaints Policy.

Infection Control

All Sheffield Foundation Trusts have plans to reduce Clostridium Difficile (C.Difficile) and other healthcare acquired infections. As part of ongoing work around infection control, there is a CCG C.Difficile report and an action plan – updated annually and monitored every quarter by our Quality Assurance Committee. The latest report and the action plan for 2014/15 can be found on our website:

http://www.sheffieldccg.nhs.uk/our-information/strategiesand-policies.htm.

The CCG produces an annual infection control report, which can also be found on our website:

http://www.sheffieldccg.nhs.uk/our-information/strategiesand-policies.htm.

Care Home Quality

An annual report into Care Home Quality is produced each year. The report for 2013/14 can be found on our website:

http://www.sheffieldccg.nhs.uk/our-information/strategies-and-policies.htm

Medicines Management

The management of medicines continues to be a priority for the CCG and work has been taken forward during the year to optimise the benefits that patients receive from their NHS provided medicines. This has included audits focussing on high risk medicines and the development of guidelines to support safe prescribing. In addition, given that medicines account for a considerable percentage of the CCG budget, the medicines management team work closely with practices to ensure that high quality, safe and cost effective prescribing is maintained. In 2014/15 this work has included making best use of community pharmacists working with their local practices to improve patient care.

Gender Equality Data

CCGs are required to publish certain data in their annual report. This can be found in section 6 of the Members' Report.

9. Managing Risk and Annual Governance Statement

NHS Sheffield CCG has developed strategic objectives and identified the principal risks to achieving these. The identified risks, controls and sources of assurance along with any identified gaps in controls are included in our Assurance Framework. We have also identified risks, controls, sources of assurance and gaps in controls in relation to the day-to-day operations of the organisation and these are entered onto the Operational Risk Register.

Trends and factors that the CCG consider likely to impact on future delivery are considered in our Commissioning Intentions plans for 2015/16 which can be found on our website here: http://www.sheffieldccg.nhs.uk/our-information/commissioning-intentions.htm.

The Assurance Framework and Risk Register are continuously monitored and provide both assurance to the Governing Body and documentary evidence to support the Annual Governance Statement. The CCG has adopted a proactive and systematic process of risk identification, analysis, treatment and evaluation of potential and actual risks. The primary purpose is to enable individuals and the CCG to deal competently with all key risks, thereby providing more confidence that we will achieve our objectives.

The NHS England CCG Assurance Framework requires clinical commissioning groups to report on their delivery of the duties laid down in the National Health Service Act 2006 (as amended). The report for how we have delivered on the duties in the Act can be found in the Annual Governance Statement

The Annual Governance Statement demonstrates NHS Sheffield CCG's ability to operate effectively and to a high standard of probity. It is designed to encompass all aspects of governance, risk management and internal control arrangements and how they operate in practice in the delivery of the organisation's objectives. It demonstrates the CCG's ability to achieve its aims and objectives in accordance with statutory and other requirements through the conduct of its business, its governance arrangements and the effective management of risks.

The Annual Governance Statement can be found at the end of this report.

Certification by the Accountable Officer

We certify that the clinical commissioning group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended)

Signed: Date:

Idris Griffiths

Idris Griffiths
Interim Accountable Officer

Appendices to the Strategic Report

Statement of Involvement 2014/15 Report

A report on engagement activity completed by the CCG and partners during 2014/15 can be found at appendix Ai

Sustainability Report

The CCG Sustainability report can be found attached to the annual report at appendix Aii

Equality and Diversity Report

The equality and diversity report can be found attached to the annual report at appendix Aiii

NHS Sheffield CCG Annual Report 2014/15
Appendix Ai) – Statement of Involvement Report 2014/15

Introduction

NHS Sheffield CCG has been working hard to ensure that we place patients at the heart of all our discussions with providers of healthcare and all our commissioning decisions. Extensive work has taken place throughout 2014/15, both internally and externally, to help us to achieve this as an organisation. This section highlights the breadth of work that we have done in order to make sure that we are a listening organisation and use the voice of the people of Sheffield to influence all that we do.

Internal CCG activity

Introduction of a phased approach to engagement

Sheffield CCG introduced a three phased approach to engagement with public, patient and carers which makes sure that we are getting the most of the feedback that we receive and use it in a systematic way.

Phase One – Collecting data

The first phase involves bringing together patient experience data that exists from provider and commissioner organisations as well as third sector partners both locally and nationally.

Phase Two – Talking to people

The second phase relates to engagement with people currently utilising the service or those with recent experience. Following phase two, we can then develop what we need to, whether that is a draft strategy or a service specification etc. alongside other data sources.

Phase Three – Testing our plans

Phase three involves talking to those who contributed in phase two to ensure their comments are visible in the general themes and trends of what we have produced. This makes sure that we are reflecting what people are telling us and enables people to feel heard and their contribution valued.

A second Engagement Summit is scheduled which will include further representation from the third sector and local authority to encourage a system-wide approach to public engagement.

Communications and Engagement Strategy Refresh

When the CCG was formed in April 2013, a Communications and Engagement Strategy was produced which provided a direction for how the CCG would engage with the public and patients. After 18 months of engaging with the public of Sheffield, and developing as an organisation, it was felt appropriate to refresh this strategy. Key outputs were added to the strategy including providing a quarterly report to Governing Body, undertaking a bi-annual satisfaction survey of Involve Me members and gaining assurance on our engagement activity through an audit.

The Communications and Engagement Strategy can be found at:
www.sheffieldccg.nhs.uk/Downloads/CCG%20Board%20Papers/October%202014%20board%20papers/PAPER%20H%20Comms%20and%20Engagement%20Strategy.pdf

Patient, Carer and Public Involvement Expenses Policy and Procedure
A Patient, Carer and Public Involvement Expenses Policy and Procedure has been developed in 2014/15 which details how the CCG plan to support people who choose to engage with the CCG. This will help us to be consistent in our offer to people when they are engaging with us in different ways. It will go to Governance Sub committee in August 2015.

Engagement Week
In November 2014, a week dedicated to engagement was held for all CCG staff. 'Engagement Week' was developed following conversations with staff across the organisation about how we can place patients at the heart of all our discussions and commissioning decisions. A timetable of activities was delivered giving staff the chance to hear what was happening within the organisation and why our leaders are passionate about embedding engagement within everything that we do. There were a variety of opportunities for all staff to hear, consider and act including sessions on community development, the voice of the third sector, Healthwatch Sheffield, involvement in procurement and learning lessons from previous successful engagement projects, along with many more.

Engagement Training
In July 2014, engagement training was delivered to CCG commissioning managers to upskill them on various aspects of public and patient engagement including their legal responsibilities to engage with the public, the commissioning cycle, types of engagement and future planning.

Patient Engagement and Experience Group
The Patient Engagement and Experience Group meet monthly to review engagement within the CCG. The group also provides a quarterly report to the Governing Body to highlight engagement activity and progress against the Patient and Public Involvement Plan, as well as providing a snapshot of feedback from local people based on specific engagement activity. These reports can be found in the Governing Body papers at www.sheffieldccg.nhs.uk/about-us/GB-meetings.htm

Programme Management Office
The Programme Management Office (PMO), launched in October 2014, supports the CCG to successfully deliver projects. Engagement with patients and the public is a key criterion in deciding whether new proposals are approved to carry on. If a proposal is deemed not to be based on sufficient enough public engagement, it can be paused until further engagement work is carried out, or stopped altogether.

Audit of PPI activity
In March 2015, 360 Assurance (a commercial company who act as the CCG's internal auditors) provided an audit of the CCG's patient and public engagement. The objective of the review was to provide independent assurance regarding the effectiveness of arrangements established by the CCG to ensure that patients and the public are being appropriately engaged in commissioning activities and examined the structure, strategy, plans and activities of the organisation relating to engagement. The Audit's opinion was that "significant assurance can be provided that there is a generally sound system of control designed to meet the system's objectives."

Engaging with our strategic partners in the city

Engagement Summit

Representatives from Sheffield Teaching Hospitals, Sheffield Health and Social Care Trust, Sheffield Children's Hospital, the CCG, Yorkshire Ambulance Service and Healthwatch Sheffield came together last year to discuss patient, carer and public engagement. The purpose of the event was to share our work on patient, carer and public engagement, and consider what more could be done to work collectively and cohesively to enable people to talk to the NHS as a whole and enable resources to go further. There was strong agreement that we should work together in communicating and engaging with the public – recognising that there are also separate responsibilities we each need to discharge. We agreed that there will be times when we should engage on a subject as one NHS, and, in addition, there are operational areas we can work on together. A key early outcome of the summit was to agree to regular meetings of our engagement teams to look at co-ordinating engagement activity across health and social care.

Healthwatch Sheffield and Young Healthwatch

We have continued to work in partnership with Healthwatch Sheffield and Young Healthwatch. Our partnership includes monthly meetings between our teams to discuss upcoming work and feedback received as well as Healthwatch providing an assurance on our engagement projects such as the musculoskeletal service review. A Healthwatch Sheffield representative also attends the Patient Engagement and Experience Group and Governing Body each month and provides an update for our quarterly Governing Body engagement paper. NHS Sheffield CCG and Healthwatch Sheffield also continue to raise the profile of engagement activities carried out by each other using their networks.

Health and Wellbeing Board

Through the Health and Wellbeing Board we have arranged with our partners, Sheffield City Council and Healthwatch Sheffield and Young Healthwatch, to promote each other's activities and events to our combined 1700 contacts across the city. It also gives an opportunity to share current and past activity with our partners with a view to coordinating our work and using learning more effectively.

Public Health

We have begun to make links with the Community Wellbeing Programme as part of the Sheffield public health team. We aim to keep each other informed on developments and progress of our engagement work as well as tapping into the community hubs to boost our reach into communities and hard to reach groups using already established networks.

Public, patient and carer activity

Involve me

'Involve Me' was launched in April 2014 and 704 people have joined to date. It was set up as a way of involving people who care about their local NHS and who would like to be kept updated, or get involved and have their say, on commissioning decisions for the benefit of Sheffield people.

We want to create a relationship with as many people as possible to give them the opportunity to hear what's really going on in the local NHS 'straight from the horse's

mouth' and to gather views on health and social care to inform the key decisions that we make.

We have recently sent the second edition of our Involve Me Insight magazine to all Involve Me members via e-mail and post. This edition included information on the NHS Five Year Forward View, Healthwatch Sheffield, Respiratory Services, Choose Well and the new Mental Health service for young people.

Recently we reviewed the network using a survey sent to all Involve Me members, both online and through the post. The survey asked about the readability, look, relevance, interest, frequency and benefits of the information that we send along with opportunities to suggest improvements. We will be taking the feedback to improve how we communicate with Involve Me members and the general public.

As part of the Involve Me network, we have a Readers' Panel who help us to review the materials we send out. They have recently reviewed leaflets from our Medicines Management Team. Comments received have resulted in amendments to the final documents based on the feedback. The team will also now be reviewing all their other leaflets with the Involve Me Readers' Panel.

You can sign up to our network online at www.sheffieldccg.nhs.uk/get-involved/involve-me.htm or by calling us on 0114 305 4609.

End of Life Care Strategy
An executive summary of the updated End of Life Care Strategy was sent to Involve Me and Healthwatch members who had expressed an interest in this area of our work. The comments that we received back helped to shape the Strategy for 2014-17, specifically around the support that carers receive.

Domiciliary Care Procurement
During the summer of 2014, the CCG advertised for a patient / carer representative to be involved in the procurement process for a new Domiciliary Care Provider for Sheffield. We recruited a local resident who kindly volunteered her valuable time to be involved in the procurement process as a carer representative, having had experience of these types of services within her family. The successful applicant also had extensive knowledge, understanding and experience of working within the NHS previously, which was of great benefit in understanding the procurement process and being able to actively take part in the discussions and decision making.

The lady we recruited attended a number of meetings and actively took part in the online scoring process and evaluating the tender documents offering a carer prospective to this process. Support was provided throughout the process from NHS Yorkshire and Humber Commissioning Support Unit (Y&H CSU)) Procurement Team, Head of Clinical Services for the CCG and members of the Engagement Team.

In conjunction with involvement directly within the procurement process, we also contacted people in receipt of current services directly via letter and invited their comments and feedback (both patients and carers) regarding their current experiences of domiciliary care across Sheffield via telephone, freepost or online survey. This was to try to ensure that the collective voice and feedback from the

people who use these type of services would help to shape and influence directly the outcome of the procurement process.

The engagement team sought feedback from those people involved regarding the pros and cons of the process that was undertaken as a whole from the initial recruitment of a patient /carer representative to the end of the process. This helped to inform a summary document which was compiled evaluating the process from the perspective of all involved, so that lessons can be learnt for the CCG, and the Engagement and Procurement Teams when involving patients and carers in procurement processes in the future.

Musculoskeletal services review - 'Moving Together'
Musculoskeletal services (MSK) support adults with over 200 different conditions affecting joints, bones, muscles and soft tissues and cover individual services like orthopaedics, rheumatology, chronic pain and physiotherapy. It is estimated that there are over 62,000 people with a chronic MSK condition living in Sheffield.

We are looking to build services around what patients need and value to make sure that the best care is offered. At the heart of Moving Together is recognising what matters most to patients, whether that is their outcomes, experiences or how their care is provided. This is a big change and needed patients and clinicians to work together to achieve. It was essential to include patients and healthcare professionals in a partnership to co-develop the outcomes that the provider would be measured against. To make sure that these outcomes were co-developed, a process of continuous feedback was adhered to. At regular occurrences throughout the six month engagement activity, a reflection of the feedback that had been received took place with patients, the public and providers checking and discussing the feedback in a process of refining the outcomes and shaping a new service. This reflection enabled us to identify key gaps in the diversity of our respondents, which gave us the opportunity to address this by targeting key groups that reflected the underrepresented communities.

Using various methods such as a survey, large co-production events, patient stories, the formation of a patient steering group and meeting with local patient and community groups, we were able to generate ideas and principles to base the new service on.

The full Musculoskeletal services engagement report can be found at:
www.sheffieldccg.nhs.uk/Downloads/CCG%20Board%20Papers/December%202014%20board%20papers/Item%2017j%20MSK%20Services%20Engagement%20Report%20and%20Appendices%20A-F.pdf

Commissioning Intentions
As we approach our third year of operation and the second year of our ambitious five year strategic plan we wanted to ask members of the public, staff and clinicians in the city what they think we should concentrate on as we look at refreshing our plans for 2015 onwards.

Using a mixture of general and focussed engagement activities we estimate that a total of 264,569 people across Sheffield will have received information regarding our Commissioning Intentions. General activities included using social and broadcast media and the Involve Me network, whilst a targeted approach was taken to engage

with children and young people by asking ChilyPEP (Children and Young People's Empowerment Project) to facilitate work on our behalf.

The full Commissioning Intentions engagement report can be found at: www.sheffieldccg.nhs.uk/Downloads/CCG%20Board%20Papers/April%202015/PAPER%20E%20Commissioning%20Intentions.pdf

Mental Health and Wellbeing Strategy refresh
The Mental Health Partnership Board (MHPB) for Sheffield, which is a multi-agency group consisting of representatives from across all of the key statutory health and care organisations working across Sheffield, wanted to update the strategy for the next five years (2014 – 19) to reflect recent mental health policy guidance and to recognise the views and wishes of service users and their carers.

NHS Sheffield CCG and Sheffield City Council are key members of the Mental Health Partnership Board and wanted to understand the experience of service users and carers who seek help when it is needed, and to understand what assists them in their journey of "recovery". In essence, they needed to find out what is working and what is not; what helps at those decisive moments and what does not.

From May to July 2014, Sheffield CCG co-ordinated engagement activity in relation to the above, on behalf of the Mental Health Partnership Board.

Respiratory Strategy
The CCG developed a strategy for respiratory care which defines what is commissioned in Sheffield up to 2019. The strategy helps to identify where access to services and patient treatments can be improved to help people living with respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD), asthma and pneumonia.

We wanted to hear from patients about their experience of respiratory care and services in Sheffield in the last two years. Our engagement involved using an innovative pilot to provide transparency to the process. Working in partnership with Patient Opinion, we encouraged people who had an experience of using services linked to respiratory conditions to comment online or over the telephone. All comments were included on the public Patient Opinion website. This was combined with the more traditional engagement method of visiting and talking to relevant patient groups such as Breathe Easy and Pulmonary Rehabilitation and semi-structured interviews with individuals. These methods were brought together using a regular online blog reflecting on the feedback received.

Healthy Living Champions
Sheffield now has nearly 50 Healthy Living Champions (HLCs) working in Healthy Living Pharmacies across the city. These Royal Society of Public Health qualified staff are trained in supporting patients in their general health and wellbeing. The impact of their interventions is rarely recorded and the engagement team is facilitating Medicines Management colleagues in gathering patient stories from HLCs and from patients first hand in the future. Some of these stories were recorded at a community pharmacy training event held in February 2015.

Feedback themes

General themes of the feedback we have received throughout the year

- Information, advice and awareness raising
- Mental health and wellbeing / emotional impact
- Integrated services / effective partnership working
- Being seen as a whole person and getting back to life
- Listened to and heard
- Effective care planning
- Understanding conditions and how to self-manage them
- Awareness of diversity and health inequalities
- Local services and knowing what they offer
- Choice over appointments
- Good care from skilled, caring staff

Current work

Urgent Care Service Review

Demand and pressure on urgent care services continues to increase in Sheffield, in common with the national picture. Local services are not uniform which can make it difficult for patients to navigate to the most appropriate place of care first time, and there is some duplication in use of resources. Our urgent care system increasingly struggles to meet demand and deliver clinically effective and safe services, which provide the best patient experience. In order to address these issues, it is proposed that a review of citywide urgent care services is undertaken via formal engagement with patients, public, clinicians and other key stakeholders, including existing service providers.

This review and engagement will seek to understand the outcomes required by local people when making use of urgent care services, test out a number of key principles and will seek to assess options for improvement within existing resources.

The importance of gathering the views of patients, public, service providers and other key stakeholders cannot be underestimated. In order to ensure that this review and resulting proposals are fully informed by local views, a full engagement and communication plan will be developed. At this stage, it is expected that this will follow a similar model to the recent successful work undertaken in musculoskeletal services and link closely with the ‘Involve Me’ network.

To find out more about this work, please visit www.sheffieldccg.nhs.uk/our-projects/Urgent-Care.htm.

NHS Sheffield CCG Annual Report 2014/15
Appendix Aii) – Sustainability Report

Sustainability and Carbon Management

The CCG is required to report its progress in delivering against sustainable development indicators. The CCG has undertaken risk assessments, and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this CCG's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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:

- Engaging with colleagues, providers and GP practices with sustainability and carbon management issues.
- Overseeing work in our offices and in practice premises including recycling (paper, pens, batteries, ink cartridges, glass, and cans), reducing waste, rules based printing, and reducing travel through the use of technology.
- Supporting business cases for service change that minimise patient and service user carbon impact by maximising the use of technology and providing care closer to home to reduce patient travel.
- Doing a public and practice campaign on waste.
- Working with our providers in terms of leading and supporting action by FTs and other providers, including contractual and partnership agreements.

The major piece of work which we have undertaken in 2014/15 is to work with Walker Resource Management Ltd (WRM) who recruited nine GP practices (listed below) across Sheffield to work on "Sustainability Health Checks" to reduce energy bills, improve environmental performance and engage local community groups.

Practices who took part in the GP Healthchecks

- Baslow Road
- Burncross Medical Centre
- Crookes Practice
- Crystal Peaks Medical Centre
- Duke Medical Centre
- Lowedges Surgery
- Pitsmoor Surgery
- Tramways Medical Centre
- White Lane Medical Centre

The practices were determined by size, type and age of premises, owned or leased and whether there are sustainability practices already in place.

The next steps

Each practice has now been supported to develop a two year action plan. The plan focuses on realistic and achievable goals to reduce emissions and costs.

Feedback from practices on the programme has been positive, with the majority of practices having implemented measures in the first few weeks after the reports were issued.

Complementary research
A research study has been conducted to support the development of local partnerships and understand how Sheffield CCG may support the role of GP practices as a social prescriber for health and environmental benefits by integrating health advice with wider social, wellbeing and environmental support and networks.

For example, the numbers of people falling into fuel poverty and fuel debt are rising, alongside the rapidly increasing prices of energy. There are large health implications when people cannot afford to heat their homes adequately. GPs can provide patients with advice and referrals that support the reduction of fuel poverty.

The research engaged community support organisations, local authorities, GP practices, and NHS/Public Health organisations. It showed that, while there were some great examples of this type of social prescribing occurring in Sheffield, these are fragmented and more can be done to widen the reach. Community sector providers are keen to work with GPs and CCGs, and wider public health organisations are equally keen to work in partnership.

Key recommendations included developing a business case tool for community providers to strengthen their social value evidence base, and developing a community provider ‘access point’ to drive integration.

Sheffield CCG will be working with Sheffield City Council to plan together how they can improve and support partnership working in local communities to help people stay well.

NHS Sheffield CCG Annual Report 2014-15
Appendix Aiii) – Equality and Diversity Report

Equality Act 2010

The Equality Act has two broad aspects:

1. To prohibit discrimination, harassment and victimisation against people with one or more protected characteristic. These characteristics are:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race (this includes ethnic or national origins, colour or nationality)
- Religion or belief (this includes lack of belief)
- Sex
- Sexual orientation
- Marriage or civil partnership (employment only)

2. The Public Sector Equality Duty (PSED) places an obligation on public bodies, including our CCG, to proactively improve equality for people with one or more protected characteristics. It aims to help public authorities avoid discriminatory practices and integrate equality into core business. It is made up of a general duty and specific duties. The general duty is the main part of the legislation, with the specific duties supporting public bodies to demonstrate performance and compliance.

The General Duty

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity
- Foster good relations

Specific Duties

- Equality objectives: The Act requires public bodies like the CCG to prepare and publish one or more specific and measurable equality objectives which they believe will support them to achieve the aims of the general duty.

- Publication of information: Annually, the CCG must publish information which describes the key inequalities experienced by people with protected characteristic(s) and which demonstrates the impact of its policies and practices on people with protected characteristics.

Our response to the Equality Act

We welcome the requirements of the Equality Act and are committed to making sure that equality and diversity is a priority when planning and commissioning local healthcare. To help us do this, we work closely with local communities to understand their needs and how best to commission the most appropriate services to meet those needs.

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 as appropriate.

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.

Equality Delivery System

We have been using the national **refreshed** Equality Delivery System **(EDS 2)**, a system designed to support our organisation in our commissioning role and our providers of services to deliver better outcomes for their local population and better working environments for staff which are personal, fair and diverse.

NHS Sheffield CCG Governing Body has approved our equality objectives that have been developed and supported by underpinning actions that are linked to the four Equality Delivery System (EDS 2) goals.

NHS Sheffield CCG objectives are:

- Ensure equality is core commissioning business
- Improve the range of activity information we have about patients in protected groups and how this is being used
- Improve our understanding of patient experience of services, regarding Equality and Diversity and act upon instances of potential discrimination
- Develop strong and consistent leadership on equality issues
- Improve access to services ie through the contracts we hold

We review our progress against our agreed actions and this is reported to the CCG Governing Body on a six monthly basis.

Equalities Information

Our CCG has gathered together information to show the key inequalities experienced by local people and that is published here http://www.sheffieldccg.nhs.uk/our-information/equality.htm.

Members' Report

1. 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
Tim is a Senior Partner at Oughtibridge Surgery. He was elected Chair of NHS Sheffield Clinical Commissioning Group (CCG) prior to authorisation in 2012 and has been Chair throughout the first year of the CCG's life as a formally constituted statutory body. This role includes chairing a number of meetings within the CCG, but also chairing the monthly meetings of the CCG Governing Body held in public, CCG membership meetings with the constituent practices held twice a year, and the CCG's annual public meeting. The role also includes chairing committees with other major partners in the city, such as co-chairing roles on the Health and Wellbeing Board (with the Local Authority) and Right First Time Project Board. Dr Moorhead is also a member of Sheffield Local Medical Committee (LMC) and is a shareholder in Rivelin Healthcare, a company set up with neighbouring practices in the West of the city to provide services to patients through collaboration between practices.

Ian Atkinson, Accountable Officer (to 31/3/15)
Ian was appointed as CCG Accountable Officer designate in July 2012 and his formal appointment confirmed by NHS England in January 2013 as part of the CCG's authorisation. He was appointed as NHS Sheffield's Director of Performance in April 2007. Prior to that, he was Director of Information Services at Barnsley Hospital NHS Foundation Trust. He has previously held senior management posts in Wakefield as well as within the private sector, where he worked for a large IT company which specialised in healthcare systems. Ian has a clinical background, having started his NHS career in Sheffield within mental health services. Ian has a national role as one of the Independent Panel members of Dame Fiona Caldicott's Information Governance Oversight Group.

Julia Newton, Director of Finance
Julia was appointed as Director of Finance for 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 Acting Director of Finance at South Yorkshire Strategic Health Authority and Director of Finance at NHS Sheffield from July 2007.

Kevin Clifford, Chief Nurse
Kevin 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 NHS Sheffield and then 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.

Tim Furness, Director of Business Planning and Partnerships
Tim was appointed to the Director of Business Planning and Partnerships post in September 2012, having previously been Deputy Director of Strategy for NHS Sheffield. He joined the NHS in 1990. Tim is responsible for leading business planning for the CCG, so that we have detailed operational plans to achieve our goals. He is also responsible for ensuring we have strong productive partnerships within Sheffield and across Yorkshire and the Humber, and is the lead Executive Director for developing integrated commissioning with Sheffield City Council. He is lead Executive Director for our work on patient and public engagement and sustainability, working with the lead Governing Body members for those areas, and for business continuity and emergency planning.

Idris Griffiths, Chief Operating Officer (Interim Accountable Officer from 1 April 2015)
Idris was appointed as the Chief Operating Officer for NHS Sheffield CCG in September 2012. 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 for a Trust covering three hospital sites. Idris holds an MBA and holds the recognised Chartered Institute of Personnel and Development qualification.

Dr Zak McMurray, Medical Director
After qualifying in Sheffield in 1988 and completing the Sheffield GP vocational training scheme, Zak became a partner in his practice in Woodhouse. 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. Zak became joint PEC chair with Dr Richard Oliver, on the creation of the Sheffield PCT, moving to Joint Clinical Director within Sheffield CCG. He left his practice in June 2014 to take up his current substantive post as Clinical Director (re-titled Medical Director from 1 April 2015). Zak is a member of the Quality Assurance 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.

Dr Amir Afzal, Locality Appointed Representative
Amir qualified from Nottingham Medical School in 1986 and is a GP at Duke Medical Centre in Sheffield. Amir is a member of the Remuneration and Terms of Service Committee, the Quality Assurance Committee, and the Sheffield Health and Wellbeing Board.

Dr Nikki Bates, Elected Member
Nikki has been a partner at Porter Brook Medical Centre for 25 years, having graduated from Nottingham University in 1985, and has been a member of the Executive Team for West Locality since 2009. Nikki is a member of the CCG's Remuneration and Terms of Service Committee and the Sheffield Health and Wellbeing Board. Nikki has a special interest in Young People's and Student Health. Nikki has been a Partner Governor at Sheffield Children's NHS Foundation Trust since 1 July 2014.

Dr Anil Gill, Elected Member
Anil graduated in 1995 at Sheffield Medical School having entered as a mature student. Anil spent six years as a GP in Rotherham and Chesterfield. This was

followed by a year as a locum before going back to general practice at Selborne Road, Sheffield.

Dr Andrew McGinty, Locality Appointed Representative (to 31/3/15)
Andrew has been a full time partner at the Woodhouse medical practice for the last 13 years. Andrew is a member of the Audit and Integrated Governance Committee and he specialises in research and education. Andrew is the CCG's Caldicott Guardian. Andrew has been appointed as the CCG's Clinical Director for the long term conditions portfolio with effect from 1 April 2015 and, as a result, was required to stand down from being a member of Governing Body on 31 March 2015.

Dr Marion Sloan, Elected Member
Marion has been a GP for 33 years and is a partner at the Sloan Medical Centre in Sheffield. Recent projects she has been involved in include sexual health, chlamydia screening and bowel cancer awareness.

Dr Leigh Sorsbie, Locality Appointed Representative
Leigh graduated from Sheffield Medical School in 1990 and has been a partner at Firth Park Surgery since 1997. Her interests include Mental Health, Elderly Medicine, Minor Surgery and Diabetes. Leigh is a member of the Audit and Integrated Governance Committee. Leigh was a Partner Governor at Sheffield Teaching Hospitals NHS Foundation Trust until 17 December 2014 and has been a Partner Governor at Sheffield Health and Social Care NHS Foundation Trust since 18 December 2014.

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 Richard Davidson, Secondary Care Doctor (to 2/4/2015)
Richard has been a Consultant in Intensive Care Medicine and Anaesthesia at Bradford Teaching Hospitals NHS Foundation Trust since January 2000. An educational enthusiast he has contributed at Trust level as Foundation Training Programme Director and at regional level as Deputy Regional Advisor in Intensive Care Medicine. Latterly he has taken up management roles, initially as Intensive Care Unit (ICU) Director and subsequently as Clinical Director for Anaesthesia, Intensive Care, Pain Management and Sleep Medicine and has deputised for the Divisional Director (Surgery and Anaesthesia). As Associate Medical Director he had a portfolio of RTT (18 week referral to treatment target) and more recently has been Clinical Lead for Transformation. For his current role he has been appointed in an operational capacity as Clinical Lead for Theatres and Critical Care. Richard has contributed to the NHS Sheffield CCG since November 2012.

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 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.

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. 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
Mark Gamsu is a visiting professor at Leeds Metropolitan University focusing on the relationship between Citizenship, Inequality and Wellbeing. He also works on a freelance basis supporting local commissioners and the voluntary sector to work together more effectively. Mark is a Trustee of Sheffield Citizens Advice and a board member of a number of voluntary organisations in Sheffield. Mark has worked in a range of local government departments - including Housing and Social Services and was the healthy city coordinator for Sheffield. Prior to moving to Sheffield he worked with neighbourhood based voluntary and community organisations in Lambeth and Lewisham. Mark has a specific remit around the public and patient engagement agenda. Mark is a member of the Remuneration and Terms of Service Committee.

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 2015 is attached as Appendix Biii to the Remuneration Report section of this Annual 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*

2. Audit and Integrated Governance Committee

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

John Boyington CBE, Lay Member (Chair)
Amanda Forrest, Lay Member (Deputy Chair)
Dr Andrew McGinty, CCG GP – to 31 March 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.

3. Additional Committees and Sub Committees

In addition to its Audit and Integrated Governance Committee, the CCG's Governing Body is supported by, and delegates specific functions to, a Quality and Assurance Committee and a Remuneration Committee. The Audit and Integrated Governance Committee is supported by a Governance Sub-Committee. Details on the functions and membership can be found in the Annual Governance Statement.

4. Research and Education

Sheffield CCG is committed to supporting research activity both within primary care and across the wider health community. The CCG Research leads are Dr Andrew McGinty, GP Member of the Governing Body and Kevin Clifford, Chief Nurse. In 2014/15 the CCG has become much more active in supporting the wider research agenda, developing relationships with the University of Sheffield and joining the local partnership Boards of several Research Bodies, representing CCGs and Primary Care. Utilising Research Capability Funding (RCF) the CCG has been able to appoint a part time research manager and support a number of projects via the School of Health and Related research(ScHARR) and the Academic Department of General Practice within the University of Sheffield/ The CCG also directly supports a small number of practice based projects.

The CCG is also an active contributor to Health Education England's Local Education and Training Board (LETB), working with other CCGs and NHSE in South Yorkshire and Bassetlaw to establish a workforce group for Primary Care to contribute to the national initiatives. In addition, the CCG has worked with its member practices to undertake an extensive workforce exercise, which improves our understanding of the local workforce challenges (for example demographic issues such as impending retirements, which necessitate succession planning).

5. The Member Practices

The following is a list of all of NHS Sheffield CCG's Member Practices by locality.

Locality	PRACTICE_NAME	PRACTICE ADDRESS	Town	PCode
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
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	Greenhill Health Centre	482 Lupton Road	Sheffield	S8 7NP
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	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 Meadowhead Group Practice	Old School Medical Centre, School Lane	Sheffield	S8 7RL
HAS	The Medical Centre Crystal Peaks	15 Peaks Mount	Sheffield	S20 7HZ

HAS	Totley Rise Medical Centre	96 Baslow Road	Sheffield	S17 4DQ
HAS	Upperthorpe Medical Centre	30 Addy Street, Upperthorpe	Sheffield	S6 3FT
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	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 Health Centre (REG)	Rockingham House, 75 Broad Lane	Sheffield	S1 3PB
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

6. Employment

Pensions Liabilities

Please see accounting policy note in the Financial Statements and Remuneration report of this annual report.

Sickness absence data

The sickness absence rate for the organisation is 2.3%. Sickness absence is managed in accordance with agreed policies and procedures which include employee wellbeing services of Occupational Health, counselling and physiotherapy. A table is included in the employee benefits note (note 4.3) to the Annual Accounts.

Employee consultation

Formal employee consultation is via the Joint Staff Consultative Forum (JSCF). This group was established in 2013 to ensure the following:

- Staff representatives are consulted on appropriate policy decisions, either local, regional or national, which have an impact upon staff
- Staff representatives are consulted on the development of employment policies and procedures, health and safety policies and procedures and any procedures, which have an impact upon staff
- Staff representatives are provided with a forum through which to express their collective views on issues affecting the employment of staff members including job security, health, wellbeing and safety
- a forum through which a joint review of commitments made to staff in either strategic or annual service direction documents can take place
- Promote the involvement of staff in the working of the organisation
- Refer agreed items concerning pay, conditions of employment or procedural agreements for detailed negotiation to sub-groups convened for this purpose, reporting to the JSCF for approval

Throughout 2014/2015 the group has met on a bi-monthly basis and has provided comment on a number of employee initiatives and employment policies.

The Joint Staff Consultative Forum (JSCF) Planning Group was established in 2013 as a Sub Group of the Joint Staff Consultative Forum. The membership of the JSCF Planning Group consists of management side, staff side and three volunteers from the workforce. The role of the JSCF Planning Group is to contribute to and formulate the agenda items and issues for consideration at the formal JSCF. This ensures that staff have a voice in influencing policies and decisions which affect them. The staff volunteers are encouraged to engage with the wider workforce in relation to this. The group met on a bi monthly basis throughout 2014/2015. In addition to the JSCF Planning Group there is a more informal staff engagement group which has contributed to work on organisational values; has helped to design and pilot training for staff; led team building activities and has provided another mechanism for staff to have their views heard.

Equality of Opportunity

The organisation is committed to equality of opportunity for all employees and potential employees. It views diversity positively and, in recognising that everyone is different, the unique contribution that each individual's experience, knowledge and skills can make, is valued equally. The promotion of equality and diversity will be actively pursued through policies and procedures which will ensure that employees and potential employees are not subject to direct or indirect discrimination.
NHS Sheffield Clinical Commissioning Group has been re-awarded the 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

Equality data is available on the internet as follows;
http://www.sheffieldccg.nhs.uk/Downloads/Equality%20and%20diversity/PSED%20Documents/NHS%20Sheffield%20CCG%20Workforce%20Summary.pdf.
http://www.sheffieldccg.nhs.uk/about-us/equal-opportunities.htm.

Gender Equality Data

	Female	Male
Governing Body	**5**	**13**
Very Senior Managers (VSM)	**1**	**1**
All employees	**121**	**43**

7. External Audit

NHS Sheffield's external auditor for 2014/15 is KPMG LLP. The total cost for their services for the year was £114,000 including VAT. This cost covers the audit of the statutory financial statements. No other services were provided.

8. Serious Incidents

Details about CCG serious incidents can be found in the Annual Governance Statement that follows this annual report.

Details about provider serious incidents can be found in the Quality Section in the Strategic Report section of this annual report.

9. Cost allocation and setting of charges for information

We certify that the CCG has complied with HM Treasury's guidance on setting charges for information.

10. Principles for Remedy

The CCG has fully adopted the Principles for Remedy which form an integral part of complaints handling and have been incorporated into the Complaints Policy.

11. Emergency Preparedness, resilience and response

I certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS England Core Standards for Emergency Preparedness, Resilience and Response which were revised in July 2014. The CCG regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

Signed: Date:

Idris Griffiths
Idris Griffiths
Interim Accountable Officer

Remuneration Report

1. Remuneration Committee

Details of the membership of the Remuneration Committee can be found within the Annual Governance Statement (page 61-84). 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 the Governing Body as set out in the CCG's Constitution. Profiles of each Governing Body member can be found in the Members' Report section of this Annual Report.

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

Senior Managers' remuneration for 2014/15 was determined by the Remuneration Committee and took account of national guidance, the prevailing economic climate, local market conditions and the requirement to obtain best possible value for money. The costs of posts are met from the notified Clinical Commissioning Group running cost allowance.

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

- The Agenda for Change guidance from NHS Employers including the staffing body pay and employment conditions in relation to senior managers' remuneration to ensure parity as far as reasonably practicable. The zero per cent cost of living rise for staff subject to Agenda for Change was mirrored for senior managers / Governing Body members.
- The Very Senior Manager (VSM) framework determined by the Department of Health.
- Recommendations made in 2012 by HM Treasury and HMRC regarding tax arrangements in relation to Governing Body members and senior officials.
- National guidance set out in "*Clinical commissioning group governing body members: Role outlines, attributes and skills"* (October 2012).

- NHS England guidance regarding the remuneration of clinical commissioning group Chief Officers (Accountable Officers) and Chief Finance Officers (Directors of Finance). This covers basic salary, recruitment and retention premia where deemed applicable and additional payments for additional duties.

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

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

The CCG's Accountable Officer and Director of Finance are engaged on Very Senior Manager contracts which include a requirement for an annual review.
The Remuneration Committee sets the framework within which the terms and conditions of the Very Senior Managers are developed and agreed. It also receives reports on performance against standards set in relation to local and national targets from the CCGs strategic and operational plans for the Accountable Officer and Director of Finance. The remuneration is set through a process that is based on a consistent framework and independent decision of performance measures against an individual's performance with due consideration to comparative salary data, the labour market, the financial circumstances of the organisation plus any national guidance. No cost of living award was applied in 2014/15. Performance related pay was paid to the Accountable Officer and Director of Finance of 3% of basic salary following assessment of individual performance in 2013/14 and a subsequent recommendation by the Remuneration Committee.

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 on can be found in the CCG's Standing Orders which are available on our website as part of our constitution:

http://www.sheffieldccg.nhs.uk/Downloads/NHS%20constitution/Constitution.pdf

The table below provides, for each senior manager who has served on the Governing Body in 2014/15, further information on their service contract.

Name	Title	Contract Commencement *	Contract expiration
Dr Tim Moorhead	As Chair	1st April 2013	1st October 2015
	As Locality Appointed GP	1st November 2014	31st October 2017
Ian Atkinson	Accountable Officer	1st April 2013	Substantive post
Kevin Clifford	Chief Nurse	1st April 2013	Substantive post
Tim Furness	Director of Business Planning and Partnerships	1st April 2013	Substantive post
Idris Griffiths	Chief Operating Officer	1st April 2013	Substantive post
Julia Newton	Director of Finance	1st April 2013	Substantive post
Dr Zak McMurray	Clinical Director	1st April 2013	Substantive post
Dr Nikki Bates	GP Elected Member	1st January 2014	1st October 2016
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 Andrew McGinty	Locality Appointed GP	1st November 2014	Resigned wef 1 April 2015
Dr Leigh Sorsbie	Locality Appointed GP	1st November 2014	31st October 2017
Dr Richard Davidson	Secondary Care Doctor	1st April 2013	Resigned wef 1 April 2015
John Boyington	Lay member	1st July 2013	31st March 2018
Amanda Forrest	Lay member	1st July 2013	31st March 2017
Mark Gamsu	Lay member	1st July 2013	30th June 2016

* 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 table at Appendix Bi details 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 Bii details their pension entitlements. It is important to note that the pension values for the clinical members of the Governing Body relate to their Non Practitioner employment only as provided by the Business Services Authority. Whilst this will include, from 1st April 2014, the work undertaken in their capacity as a senior manager of the CCG, it might also include other, non-practitioner work. These pension values will also include contributions made in previous employments in a non-practitioner role. Prior year comparators are shown for 2013/14.

7. Pay Multiples (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 the 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 Clinical Commissioning Group in the financial year 2014/15 was £162,500 (£162,500 in 2013/14). This was 4.10 (4.0 times in 2013/14) times the median remuneration of the workforce which was £39,953 (£40,558 in 2013/14).

There has been no material change year-on year to either the remuneration of the highest paid member of the CCG or the median remuneration of all CCG staff. There was an increase in the size of the workforce from 102 employees in 2013/14 to 163 employees in 2014/15 which was mainly due to the Medicines Management Team and the Primary Care Development Nurses transferring to the CCG from the Commissioning Support Unit. This increase in staff had no material impact on the median ratio calculation.

In 2014/15 no employees received remuneration in excess of the highest paid member of the Governing Body.

Remuneration for CCG employees ranged from £5,442 to £163,800.

8. 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 2015 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 2015	40
The number that have existed:	
• For less than one year at the time of reporting	13
• For between one and two years at the time of reporting	27
• For between two and three years at the time of reporting	0
• 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 2014 and 31 March 2015.	13
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.	13
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.	5
Number of individuals that have been deemed Governing Body members during the financial year (this figure includes both off-payroll and on-payroll engagements).	18

Signed: Date:

Idris Griffiths

Idris Griffiths
Interim Accountable Officer

Appendices to the Remuneration Report

Bi) Senior Managers- Salaries and Allowances (including prior year comparators)

Bii) Senior Managers – Pension Benefits (including prior year comparators)

Biii) Declarations of Interest Register

Appendix Bi Senior Managers: Salaries & Allowances for 2014-15

Remuneration Report: Senior Managers: Salaries and Allowances — Appendix Bi

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

	2014-15					
Name and Title	**Salary**	**Expense Payments (taxable)**	**Performance pay and bonuses**	**Long term Performance pay and bonuses**	**All Pension Related Benefits**	**TOTAL**
	(bands of £5k)	**(rounded to the nearest £100)**	**(bands of £5k)**	**(bands of £5k)**	**(bands of £2.5k)**	**(bands of £5k)**
	£000	**£00**	**£000**	**£000**	**£000**	**£000**
T Moorhead Chair of the Governing Body	**95- 100**	**0**	**0**	**0**	**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**	**10 - 15**
A McGinty (up to 31 March 2015) Locality appointed GP	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
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 £100.

Pension related benefits is the increase/(decrease) 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). This does not, therefore, represent income in the current financial year to the individual.

*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.

Appendix Bi Senior Managers: Salaries & Allowances: Prior Year Comparators 2013-14

Remuneration Report: Senior Managers: Salaries and Allowances — Appendix Bi

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

	2013-14					
Name and Title	**Salary & Fees** (bands of £5k) £000	**Taxable Benefits** (rounded to the nearest £00) £000	**Annual Performance Related Bonuses** (bands of £5k) £000	**Long term Performance Related Bonuses** £000	**All Pension Related Benefits** (bands of £5k) £000	**Total** (bands of £5k) £000
T Moorhead Chair of the Governing Body (and Locality appointed GP)	95 - 100	0	0	0	385 - 390	480 - 485
I Atkinson Accountable Officer	135 - 140	0	0	0	40 - 45	180 - 185
K Clifford Chief Nurse	95 - 100	0.4	0	0	30 - 35	130 - 135
T Furness Director of Business Planning and Partnerships	90 - 95	0.2	0	0	105 - 110	195 - 200
I Griffiths Chief Operating Officer	90 - 95	0	0	0	35 - 40	130 - 135
J Newton Director of Finance	105 - 110	0.2	0	0	35 - 40	140 - 145
Z McMurray Joint Clinical Director	15 - 20	0	0	0	0	15 - 20
R Oliver Joint Clinical Director	50 - 55	0	0	0	5 - 10	60 - 65
M Ainger (1 April to 18 October 2013) GP Elected Member	5 - 10	0	0	0	150 - 155	160 - 165
N Bates (From 1 January 2014) GP Elected Member	0 - 5	0	0	0	150 - 155	150 - 155
A Gill GP Elected Member	10 - 15	0	0	0	130 - 135	140 - 145
M Sloan GP Elected Member	10 - 15	0	0	0	0	10 - 15
T Turner GP Elected Member	10 - 15	0	0	0	135 - 140	150 - 155
A Afzal Locality appointed GP	10 - 15	0	0	0	230 - 235	245 - 250
A McGinty Locality appointed GP	10 - 15	0	0	0	225 - 230	235 - 240
L Sorsbie Locality appointed GP	10 - 15	0	0	0	155 - 160	165 - 170
R Davidson * Secondary Care Doctor	5 - 10	0	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	0.1	0	0	0	10 - 15
M Gamsu (From 1 July 2013) Lay Member	5 - 10	0	0	0	0	5 - 10

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). This does not, therefore, represent income in the current financial year to the individual.

*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

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.

Appendix Bii Senior Managers – Pension Benefits 2014-15

Pension Benefits - 2014-15 **Appendix Bii**

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

Name and Title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer Value at 1 April 2014 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £'00
Tim Moorhead, Chair of the Governing Body	0 - 2.5	0 - 2.5	15 - 20	50 - 55	330	299	23	0
I Atkinson, Accountable Officer (up to 31 March 2015) $	0 - 2.5	0 - 2.5	45 - 50	145 - 150	0	856	0	0
K Clifford, Chief Nurse	0 - 2.5	0 - 2.5	40 - 45	130 - 135	864	816	26	0
T Furness, Chief of Business Planning and Partnerships	0 - 2.5	5.0 - 7.5	30 - 35	95 - 100	637	568	54	0
I Griffiths, Chief Operating Officer	0 - 2.5	5.0 - 7.5	30 - 35	90 - 95	561	500	48	0
J Newton, Director of Finance	0 - 2.5	0 - 2.5	30 - 35	90 - 95	556	522	20	0
Z McMurray, Clinical Director	0	0	0	0	0	0	0	0
N Bates, GP Elected Member	0	0	5 - 10	20 - 25	132	125	3	0
A Gill, GP Elected Member	0 - 2.5	2.5 - 5.0	10 - 15	35 - 40	261	230	25	0
M Sloan, GP Elected Member	0	0	0	0	0	0	0	0
T Turner, GP Elected Member	0	0	5 - 10	25 - 30	188	180	3	0
A Afzal, Locality appointed GP	0	0	10 - 15	30 - 35	229	221	2	0
A McGinty, Locality appointed GP (up to 31 March 2015)	0	0	10 - 15	35 - 40	196	188	4	0
L Sorsbie, Locality appointed GP	0 - 2.5	0 - 2.5	5 - 10	25 - 30	172	156	12	0
R Davidson, Secondary Care Doctor * (up to 2 April 2015)	0	0	0	0	0	0	0	0

$ Ian Atkinson will claim benefits from the NHS Pension Scheme from 31 March 2015 and hence there is no information on the Cash Equivalent Transfer Value as at 31 March 2015

*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.
Dr McMurray and Dr Sloan ceased to make contributions prior to 1st April 2014 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.

Real Increase in accrued pension and lump sum

The values in the table are calculated by comparing the accrued pension/lump sum as at 31 March 15 against the accrued pension/lump sum at 31 March 14 which is then adjusted by a a factor of 2.7% to account for inflation (2.7% 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 2015.

Appendix Bii Senior Managers – Pension Benefits: Prior Year Comparators 2013-14

Pension Benefits: 2013-14 Comparators **Appendix Bii**

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

Name and Title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £'00
I Atkinson, Accountable Officer	0 - 2.5	5 - 7.5	45 - 50	140 - 145	856	784	55	0
K Clifford, Chief Nurse	0 - 2.5	2.5 - 5	40 - 45	125 - 130	816	750	49	0
T Furness, Chief of Business Planning and Partnerships	2.5 - 5	12.5 - 15	25 - 30	85 - 90	568	458	100	0
I Griffiths, Chief Operating Officer	0 - 2.5	5 - 7.5	25 - 30	85 - 90	500	446	44	0
J Newton, Director of Finance	0 - 2.5	2.5 - 5	25 - 30	85 - 90	522	470	42	0
Tim Moorhead, Chair of the Governing Body	15 - 17.5	50 - 52.5	15 - 20	50 - 55	299	7	292	0
Z McMurray, Joint Clinical Director #	0	0	0	0	0	0	0	0
R Oliver, Joint Clinical Director	0 - 2.5	0 - 2.5	10 - 15	30 - 35	219	200	14	0
M Ainger, GP Elected Member (1 April to 18 October 2013)	5 - 7.5	20 - 22.5	5 - 10	20 - 25	142	26	115	0
N Bates, GP Elected Member (From 1 January 2014)	5 - 7.5	17.5 - 20	5 - 10	20 - 25	125	12	112	0
A Gill, GP Elected Member	5 - 7.5	15 - 17.5	10 - 15	35 - 40	230	112	116	0
M Sloan, GP Elected Member #	0	0	0	0	0	0	0	0
T Turner, GP Elected Member	5 - 7.5	17.5 - 20	5 - 10	25 - 30	180	88	89	0
A Afzal, Locality appointed GP	10 - 12.5	30 - 32.5	10 - 15	30 - 35	221	41	179	0
A McGinty, Locality appointed GP	7.5 - 10	27.5 - 30	10 - 15	35 - 40	188	35	152	0
L Sorsbie, Locality appointed GP	5 - 7.5	20 - 22.5	5 - 10	25 - 30	156	60	95	0
R Davidson, Secondary Care Doctor *	-	-	-	-	-	-	-	-

*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.

Dr McMurray and Dr Sloan have ceased to 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.

This reflects the increase in 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.

Appendix Biii
NHS Sheffield Clinical Commissioning Group Governing Body Register of Interest
(1 April 2014 to 31 March 2015)

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)
Ian Atkinson	Accountable Officer	• Non Executive Director, South Yorkshire Housing Association (unpaid) (until 3 September 2014) • Independent Panel Member of the Dame Fiona Caldicott's Information Governance Oversight Panel (unpaid) • Director, AtkinsonWalker Ltd, a healthcare and commercial consultancy business (currently does not have any contracts with the NHS) (from 1 March 2015)
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 (from 1 July 2014)

John Boyington CBE	Lay Member	• Chairman and Trustee (unpaid), Croft House Settlement a registered charity providing premises and facilities for voluntary groups to meet in Sheffield city centre • Non Executive Director (2 days per month paid), Bury GP Practices Ltd, a Company Limited by shares which is a provider of health services (until 30 June 2014) • Chairman (2 days per week paid), Bury GP Practices Ltd, a Company Limited by shares which is a provider of health services (from 1 July 2014) • Trustee of the Royal Masonic Benevolent Institution, a charity 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 • Chairman of Masonic Care Ltd, a charitable Company providing residential care to 12 people with a learning disability in Thorne, South Yorkshire
Kevin Clifford	Chief Nurse	• Chair of Corporation, Longley Park 6th Form College • Honorary Lecturer, Faculty of Medicine, Dentistry & Health, University of Sheffield
Richard Davidson	Secondary Care Doctor	• Consultant in Intensive Care Medicine & Anaesthesia / Associate Medical Director, RTT, Anaesthetic Department, Bradford Teaching Hospitals NHS Foundation Trust (until 31 August 2014) • Consultant in Intensive Care Medicine & Anaesthesia / Clinical Lead for Transformation, Bradford Teaching Hospitals NHS Foundation Trust (from 1 September 2014) • Director, Yorkshire Medical Logistics Ltd (from 1 September 2014)
Amanda Forrest	Lay Member	• Director, Sheffield Cubed (voluntary sector organisation (until 31 July 2014)

Tim Furness	Director of Business Planning and Partnerships	• Nil return
Mark Gamsu	Lay Member	• Director, Local Democracy and Health Ltd (public health consultancy) • Trustee, Sheffield Citizens Advice Bureau • Committee Member, Darnall Wellbeing • Trustee, Citizens Advice • Trustee, INVOLVE Yorkshire and Humber • Committee Member, Chance to Dance
Anil Gill	CCG GP Elected City-wide Representative	• GP appraiser (ad hoc basis) • GP Principal, Selborne Road Medical Centre
Idris Griffiths	Chief Operating Officer	• Nil return
Andrew McGinty	CCG GP Locality representative	• GP Partner, Woodhouse Health Centre • Director, Woodhouse Health Services Ltd • Partner in a shareholding practice, Primary Provider Ltd
Zak McMurray	Clinical Director	• GP Partner, Woodhouse Health Centre (until 30 June 2014) • Director, Woodhouse Health Care Services Ltd (until 30 June 2014) • Shareholder Primary Provider Ltd (until 30 June 2014) • Shareholder, Woodhouse Health Care Services Ltd (from 1 July 2014) • Trustee, Talbot Trusts
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	Director of Finance	• 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, Sheffield Teaching Hospitals NHS Foundation Trust (STHFT (until 17 December 2014) • Partner, Sheffield SHSCFT (from 18 December 2014)
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

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 Ian Atkinson 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, the CCG's Accountable Officer for the 2014/15 financial year discharged his responsibilities set out in his Clinical Commissioning Group Accountable Officer Appointment Letter and that from 1 April 2015, I have discharged the responsibilities set out in my appointment letter as interim Accountable Officer.

Signed: Date:

Idris Griffiths

Idris Griffiths
Interim Accountable Officer

Annual Governance Statement

1 Introduction

Sheffield Clinical Commissioning Group was created a whole city CCG (with four localities) and a geography coterminous with our Local Authority, Sheffield City Council and licensed to operate without conditions by NHS England from 1st April 2013. Previously, there had been a whole city Primary Care Trust for Sheffield. We were fortunate in retaining our senior team to lead us through the period of transition in 2012/13 and onto full authorisation in April 2013, and to build on this solid foundation subsequently, with robust business systems and governance processes in place.

During 2014/15 the Clinical Commissioning Group has continued to refine its governance arrangements. The CCG has retained adherence to the principles of good governance as a principal risk on our Assurance Framework and will continue be so during 2015/16 so that we keep a continual focus on ensuring our processes are robust.

2 Scope of responsibility

The Accountable Officer, has responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which the Accountable Officer is personally responsible, in accordance with the responsibilities assigned to the post in *Managing Public Money*. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group interim 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.

i) Principle Leadership

NHS Sheffield CCG is governed and led by an effective unitary Governing Body comprised of Clinical Leads, Executive Directors and Lay Members, each with clear understanding of their 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 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 value their constructive

challenge and their contributions to the development of our strategies. All committees are chaired by a Lay Member.

The Governing Body sets the Clinical Commissioning Group's strategic aims and, with a revenue resource limit of £711.8m for programme spend and £15.8m for running costs for 2014/15, ensures that the necessary financial and human resources are in place for the organisation to meet its objectives.

ii) 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 the time commitment of members is appraised, as well as a formal assessment and appraisal process.

A comprehensive Organisational Development programme is in place for the whole organisation, and which includes a strand of activities designed to support Governing Body members in discharging their statutory responsibilities, for example training on prevention of fraud, media skills, risk management and legal duties as employers.

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 (paper or electronic). All papers presented at Governing Body and Committee meetings follow a recommended format including a standard front sheet, this has three important functions:

- It quickly draws members' attention to the key issues and recommendations.
- The sheet clearly states how the main body of the paper provides assurance that identified risks are being controlled.
- It provides evidence of the CCG's compliance with the requirements of the Equality Act 2010 and our 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 our public facing meetings.

iii) 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, (eg Finance, Quality and Delivery reports)
- The development and publication of an Annual Plan
- The development and 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.

iv) 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.

v) 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 87 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.

Our 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

We reviewed and updated our Constitution in July 2014 when the following changes were proposed and agreed by NHS England:

- Changes to reflect the Clinical Director role – ie previously two post holders now one Clinical Director

- Strengthening of Committee and Sub-committee Terms of Reference

- Amendments throughout with regard to reference to NHS Commissioning Board now NHS England

- Changes to reflect number of GP practices from 88 to 87

- Removal of terms of reference for both the four Locality Executive Groups and the Commissioning Executive Team – these will instead be posted onto the CCG website to enable more frequent review and allow them to be adapted quickly to respond to emerging needs at speed.

- General formatting throughout the document including slight changes to the NHS Sheffield CCG logo

A second review of the Constitution was undertaken in January 2015 and the following changes were also accepted by NHS England:

- Inclusion of model wording to allow for Joint Commissioning arrangements following the issue of the Legislative Reform Order allowing CCGs and NHS England to form joint committees from 1 October 2014.

- References to the CCG Company Secretary amended to read Head of Governance and Planning.

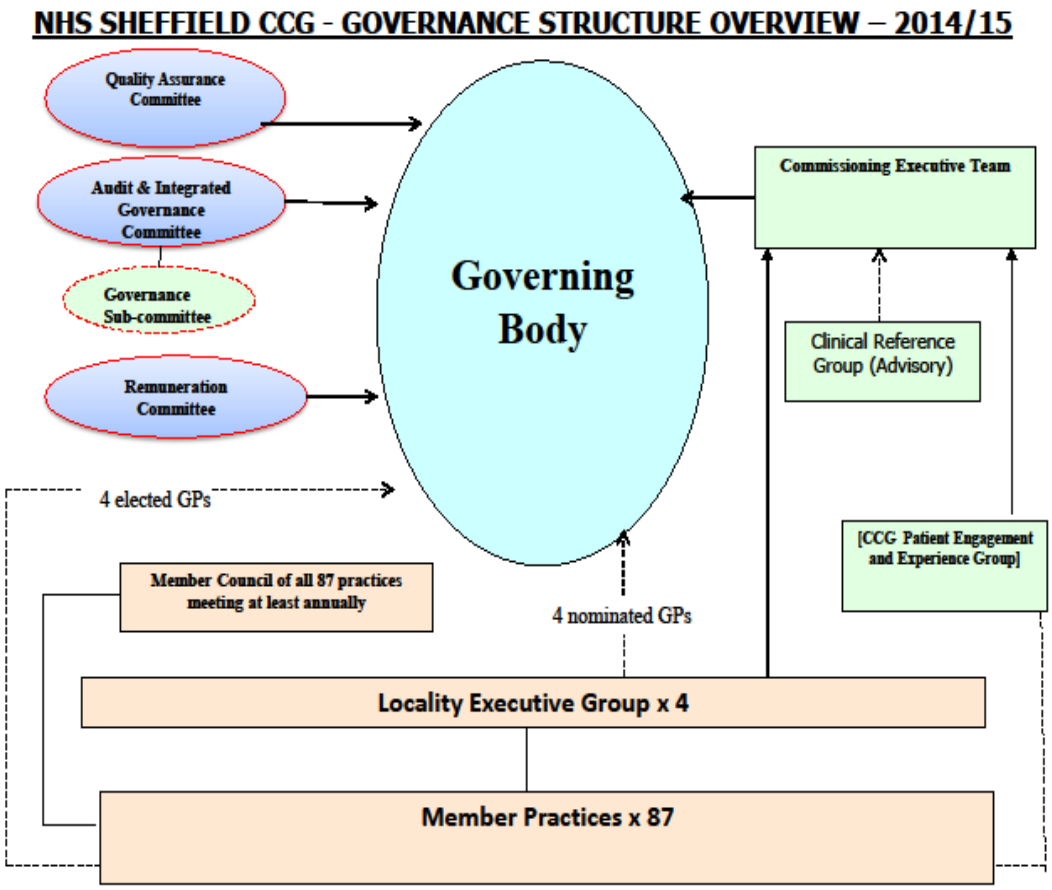
- Change of name of Meersbrook Medical Centre to 'Veritas'.

- General changes to the Terms of Reference of each of the high level committees, these included changes to membership, as well as quoracy, and have been proposed in order to strengthen the current arrangements.

Our Constitution, particularly through our Scheme of Reservation and Delegation, makes clear the respective responsibilities of our Members' Council (membership body) and our 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 enable us to achieve our strategic objectives and create the right environment to help ensure that services are commissioned in an appropriate and cost effective way.

Fig 1



NHS Sheffield CCG Governance Structure

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 2014 to 31 March 2015 with the exception of August (no meeting took place) and January (when it was held on the second Thursday) and was quorate at each meeting. Attendance is monitored as part of our monitoring systems and details of attendance are available on all Governing Body minutes which are published on the CCG webpage http://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
- Accountable Officer
- 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)
- Secondary Care Doctor
- Chief Operating Officer
- Director of Finance
- Chief Nurse
- Director of Business Planning and Partnerships

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 an effective and innovative 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 local Foundation Trusts
- Executive to Executive meetings with the Locality 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 (core cities are those which are of a similar size to Sheffield, and share many common characteristics and challenges, for example, Manchester and Newcastle).
- A joint arrangement with the Clinical Commissioning Groups from South Yorkshire and Bassetlaw, Hardwick and North Derbyshire for the CCG Collaborative Commissioning Arrangement (known as CCGCOM)
- Joint working with the Sheffield Universities for the delivery of education and development;
- 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 2014/15 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 has been a priority area for 2014/15 and is an area which is kept under continuous review and enhancement.

Following a review of Governing Body meetings, a number of improvements have been implemented. These included a new format for meetings, intended to offer a more disciplined approach, which included a change to the timing of meetings held in public to commence at 4.00 pm. An audit was undertaken of 11 meetings which found that 49% of papers required a decision and 51% of papers were for noting. Therefore, papers for noting (ie not requiring discussion and decision) are now distributed by email separate to meeting papers, and are also available on the internet. These papers are listed as "previously circulated for noting" on the agenda and recorded as such on all minutes of meetings.

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 2014/15 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

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 July 2014 and January 2015, 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 2014/15 included:

- Approval of the annual programme of work to be undertaken by Internal Audit and Counter Fraud services and in year monitoring of delivery against the plan, ensuring officers followed up on recommendations within finalised reports;
- Receipt of update reports from External Audit as the CCG prepared to produce its Annual Accounts for 2014/15. Committee also approved the CCG's accounting policies;
- Ongoing review of various aspects of internal control, including updates on key quality and performance issues from the Quality Assurance Committee;
- Review of the Governing Body Assurance Framework with particular focus on ongoing identified gaps in control and/or assurance;
- Annual review of the CCG's Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies. In line with its delegated responsibilities approval of changes to detailed financial policies.
- All members and key attendees at the Committee completed a second self-assessment questionnaire to assess the effectiveness of the Committee in January 2015 and how views had changed after a second year of operation. The positive results were considered at the March 2015 meeting.

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 exception 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:

Following a review of its functions and membership in December 2013, QAC has continued to develop and deliver its responsibilities. Specifically, the committee has:

- Systematically reviewed providers' performance in relation to all areas of quality, with a focus during the year of new initiatives introduced following the Francis Public Inquiry. These include the Friends and Family Test and staffing levels.

- 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 Incidents, 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.

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.

Performance / Highlights of Remuneration Committee:

During 2014/15 key areas considered by the Committee included:

- Review of Remuneration Committee Terms of Reference
- Review of remuneration for all Governing Body members
- Recommendations to Governing Body re the remuneration arrangements for other clinicians working for the CCG on commissioning issues and re the remuneration and appointments process for the five Clinical Directors.
- Managing the Accountable Officer recruitment process
- Managing the Governing Body Nominated Locality GP Representative process
- Outcomes of relevant performance reviews

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	4	4
	Amanda Forrest	Lay Member and Vice Chair	4	4
	Andrew McGinty	CCG GP Governing Body Member	3	4
	Leigh Sorsbie	CCG GP Governing Body Member	4	4
Quality Assurance	Amanda Forrest	Lay Member and Chair	4	4
	Kevin Clifford	Chief Nurse and Vice Chair	3	4
	Amir Afzal	CCG GP Lead for Quality	2	4
	Jane Harriman	Deputy Chief Nurse	4	4
	Peter Magirr	Head of Medicines Management (ceased to be a core member from December 2014)	1	3
	Zak McMurray	Clinical Director	3	4
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	3	4
	Nikki Bates	CCG GP Governing Body Member	3	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. 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 2014/15 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.
- Policy management system introduced 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 for the CCG Collaborative Commissioning Arrangements (known as CCGCOM) which works under agreed terms of reference to collaboratively commission services where the CCGs agree that will be beneficial. 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.

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's Risk Management Framework

The CCG's Risk Management Strategy and Action Plan, together with its policies and procedures, has been in place throughout 2014/15, and is 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 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 the activity undertaken by the Local Counter Fraud Specialist (LCFS). The content of the report is formatted to comply with the requirements of the NHS Counter Fraud Manual, outlining where relevant activity has taken place across the seven generic areas of the work of the Local Security Management Service (LSMS):

- Anti-fraud culture
- Deterrence
- Prevention
- Detection
- Investigations
- Sanctions
- Redress

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.

6 The Clinical Commissioning Group Internal Control Framework

A system of internal control is the set of processes and procedures in place in the Clinical Commissioning Group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised, 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 ie ensuring the risk does not occur and includes for example the Scheme of Delegation and Reservation and financial authorisation and authorisation levels. In addition, the CCG produces a range of detection controls ie performance monitoring and quality reports. 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 2014/15 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 2014/15.

The CCG continues to work locally and nationally to secure a sustainable model for information governance that provides adequate restrictions and safeguards for the use of patient identifiable data, whilst allowing the smooth delivery of our commissioning responsibilities in areas such as out of area referrals and individualised commissioning (eg CHC). The CCG now effectively operates with pseudonymised data and is no longer pursuing either Accredited Safe Haven (ASH) or Commissioning Environment for Finance (CEfF) status.

In recognition of the many changes associated with the flow of information upon the introduction of the 2012 Health and Social Care Act, the Accountable Officer in post throughout 2014/15 took a representative view nationally on the Information Governance Board to improve information flows across commissioning and was an independent member of Dame Fiona Caldicott's Information Governance Oversight panel.

6.2 Incident Reporting

There is a process in place for the reporting of all incidents and investigation of serious incidents supported by an Incident Reporting Policy. The policy was reviewed to provide further clarity with regard to information governance incidents and to ensure that processes reflect Health and Social Care Information Centre

(HSCIC) Serious Incident Reporting and Learning (SIRL) guidance. The revised policy was approved by the Governance Sub-committee at its meeting in February 2015. Staff are encouraged to report all incidents via the on-line incident reporting system. Incident reporting training is mandatory and all staff are encouraged to attend.

Of fundamental importance is the CCG's commitment to the ongoing development of a 'culture of openness' where incident reporting is openly and actively encouraged and to achieving a progressively 'risk aware' workforce.

6.3 Public stakeholders' involvement in managing risks

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.

6.4 Pensions Obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

6.5 Equality, Diversity & Human Rights Obligations

Control measures are in place to ensure that all the clinical commissioning group's obligations under equality, diversity and human rights legislation are complied with.

6.6 Sustainable Development Obligations

The CCG is required to report its progress in delivering against sustainable development indicators. The CCG has undertaken risk assessments, and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this CCG's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

7 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 1 May 2014 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. The Governing Body was provided with details of the refreshed GBAF at its meeting in June 2014 which included details of the changes to be taken forward for 2014/15. 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.

7.1 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 2014/15 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.

7.2 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 Business Planning and Partnerships, 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 17 strategic risks on the GBAF since it was approved in June 2014. Initially one risk was categorised as very high (score of 16); a further six categorised as high (scores of 12); five risks categorised as medium (score of 9); one risk categorised as 6 (medium). At the end of quarter 4 (31 March 2015), I am pleased to report that primarily through the actions we have taken to manage these key risks, our assessment is that none should be categorised as high. The final year end position is as follows:

Risk Score	Number	Category of Rating
9	6	Medium
6	3	Medium
2	3	Low

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

7.3 Operational Risk Register

Current Risks

At 31 March 2015 there were 43 risks identified and added to the Operational Risk Register. Of these, 17 risks were classified as high and 2 risks identified as Very High; 19 risks were rated moderate and 5 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 12 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.

8 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 scrutinise in detail the CCG's financial statements for 2014/15 at its meeting on 20 May 2015, together with the report from external audit, before these are presented to Governing Body on 21 May 2015 for adoption.

9 Review of the effectiveness of Governance, Risk Management and Internal Control

The Accountable Officer has responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group.

9.1 Capacity to Handle Risk

All staff are offered, and are expected to attend, 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.

9.2 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 itself 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 2014/15 and have managed risks assigned to them:

Committee	Chair
Governing Body	Dr Tim Moorhead
Audit and Integrated Governance Committee (AIGC)	Mr John Boyington, CBE
Quality Assurance Committee (QAC)	Ms Amanda Forrest
Remuneration 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 2014/15 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.

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
- 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.

Sheffield CCG commissions a range of services from Yorkshire and Humber Commissioning Support (YHCS). As part of the establishment of CSU's in 2012/13 NHS England decided that it would use Service Auditor Reporting (SAR) as the main assurance tool in assessing the robustness and effectiveness of CSU control procedures. Sheffield CCG has received a Service Auditor Report, produced by Deloittes (Y&HCS's internal auditors) for the first six months of 2014/15, together with a rectification plan. The report relates to the totality of the relevant services provided by Y&HCS, not just those services commissioned by NHS Sheffield CCG. The CCG has reviewed the report and relevant rectification plan for areas provided to NHS Sheffield CCG, and is satisfied that the reported actions and the supporting controls within the CCG are sufficient to provide assurance on overall controls. A further Service Auditor Report is expected, covering the last six months of the financial year. At the time of writing, this report has yet to be received by the CCG.

The Yorkshire and Humber Commissioning Support organisation was unsuccessful in its bid to be on the national Commissioning Support Unit Lead Provider Framework and as a result will not be able to be a provider of commissioning support from April 2016. The CSU will still be able to provide services in 2015/16 and the CCG will continue to use services during next year until such time as they are brought in house to the CCG or moved to another provider. A transition board has been established across the Yorkshire and Humber CCGs and NHS England to enable a smooth transition of services during 2015/16. The CCG has identified a lead for each service who will lead the transition on behalf of the CCG.

At 31 March 2015, the Governing Body Assurance Framework identified the following outstanding gaps in control within the GBAF:

- 4.5 Inability to secure partnerships with our main providers that help us to deliver our commissioning plans, including savings and service improvements to be delivered under the Quality, Innovation, Productivity and Prevention (QIPP) initiative.

- 4.6 Contractual restraints facing member practices resulting in an inability of practices to deliver and expand service provision - this gap remains due to this remaining national policy and therefore the responsibility of NHSE.

The above gaps in control have robust action plans and have been built into the 2015/16 framework. There were no significant gaps in control identified.

9.3 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 clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

I am pleased to report that we are providing the CCG with **Significant Assurance** as there is a generally sound system of internal control, designed to meet objectives, and that controls are generally being applied consistently. This opinion is determined through our review of your Governing Body Assurance Framework (GBAF) and associated processes and the work that we have undertaken throughout the year.

The full Head of Internal Audit Opinion report is attached as appendix C to this AGS.

During the year Internal audit has issued no reports with a conclusion of limited assurance and no reports with a conclusion of no assurance.

9.4 Data Quality

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

9.5 Business Critical Models

An appropriate framework and environment is in place to provide quality assurance of business critical models – inputs, methodology and outputs.

9.6 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 2014/15.

9.7 Discharge of Statutory Functions

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

In light of the Harris Review, the Clinical Commissioning Group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the Clinical Commissioning Group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

We have quarterly assurance reviews with the Local Area Team of NHS England, which also cover discharge of our statutory functions, and these reviews have resulted in positive outcomes in 2014/15.

10 Conclusion

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

Signed: Date:

Idris Griffiths *22 May 2015*

Idris Griffiths
Interim Accountable Officer

All links in this document are available in hard copy upon request from the CCG: sheccg.comms@nhs.net
0114 305 1398

360 ASSURANCE

NHS Sheffield CCG

2014/15 Final Head of Internal Audit Opinion and Annual Report

Contents

1. Executive Summary

This report is provided in support of your accounts and Annual Governance Statement and details my final Head of Internal Audit Opinion and a summary of the delivery of your internal audit service for the 2014/15 financial year.

2014/15 has continued to be a year of significant change for the NHS and commissioning organisations in particular, with, amongst other areas, the applications for the devolvement of functions as part of co-commissioning and the challenges around developing joint working relationships with Local Authorities as part of the establishment of the Better Care Funds. Commissioning organisations face on-going issues around working with their providers in support of the transformation agenda and the development of quality services for the populations that they serve, all within reducing management costs. Commissioning organisations continue to seek independent assurances across an ever-increasing range of services and the delivery of these assurances is reflected within our Internal Audit Plans.

The completion of individual assignments within our agreed Audit Plan and our assessment of your overall governance and assurance arrangements has enabled us to form an opinion on your arrangements for internal control as follows:

Overall Opinion

I am pleased to report that we are providing the CCG with **Significant Assurance** as there is a generally sound system of internal control, designed to meet objectives, and that controls are generally being applied consistently. This opinion is determined through our review of your Governing Body Assurance Framework (GBAF) and associated processes and the work that we have undertaken throughout the year.

Your Internal Audit Plan for 2014/15

Your Internal Audit Plan was developed in line with the mandatory requirements of the Public Sector Internal Audit Standards (PSIAS), and was aligned to your Governing Body's Assurance Framework and strategic objectives. We also engaged with the Executive Team and the Audit Committee to identify priority areas for audit review. As such, the plan was designed to enable us to satisfy our statutory responsibility to provide a balanced annual Head of Internal Audit Opinion. Our work, as always, was discussed with External Audit and Counter Fraud to ensure effective use of resources.

Progress in relation to the delivery of your Internal Audit Plan has been reported to each Audit Committee meeting.

Performance Against Service Level Agreement

Our audit work has been delivered in line with our SLA with the CCG. Section 3 of this report demonstrates our performance against the SLA, including adherence to the mandatory Public Sector Internal Audit Standards. We have provided a breakdown of our delivery of your plan and evidence our achievement against the Key Performance Indicators included within our SLA (see Appendix B). In addition we have provided

analysis of the feedback from the Client Satisfaction Questionnaires completed across the service delivered by our Commissioner Services Team for 2014/15.

360 Assurance

This has also been a year of change for our organisation as we have built upon the foundations of our merger in July 2013.

Our focus has been on continuing to develop the strength of our audit team, specifically we have been able to significantly develop our Clinical Quality and Performance and Information Teams. This has allowed us to consolidate our position as one of the leading UK providers of internal audit, assurance and counter fraud services to the NHS.

We look forward to building on these successes, with the support of our clients.

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

2. Head of Internal Audit Opinion

In accordance with Public Sector Internal Audit Standards, I am required to provide an annual opinion, based upon work performed by Internal Audit to assess the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. This is achieved through the completion of an annual internal audit plan (Appendix A), which is based on the organisation's key risks.

The purpose of my annual Head of Internal Audit Opinion 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 Annual Governance Statement (AGS).

The opinion does not imply that Internal Audit has reviewed all risks and assurances related to the organisation.

HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL FOR THE YEAR ENDED 31ST MARCH 2015.

My opinion is set out as follows:

2.1 Overall opinion;

2.2 Basis for the opinion; and

2.3 Commentary.

2.1 Overall Opinion

From my review of your systems of internal control, primarily through the operation of your Governing Body Assurance Framework and the individual assignments 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 for the Opinion

The basis for forming my opinion is as follows:

a) An assessment of the design and operation of the underpinning Assurance Framework and supporting processes. *(Guidance requires that I weight the opinion towards the suitability of the Governing Body 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. 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 and other third party assurances should also be considered. In addition the Organisation should take account of other independent assurances that are considered relevant.

2.3 Commentary

The commentary below provides the context for my opinion and, together with the opinion, should be read in its entirety. The issues highlighted in this commentary should be considered by the Organisation when completing its AGS.

2.3.1 The Design and Operation of the Governing Body Assurance Framework (GBAF) and Associated Processes

The GBAF and Risk register are regularly reviewed in the CCG.

The GBAF and Risk Register were presented quarterly to the Governing Body, with an accompanying Exception report which set out the key issues arising.

Prior to the submission to the GB, the GBAF is discussed at the Governance Sub Committee, and then at the Audit and Integrated Governance Committee.

The Executive Lead for Governance is the Director of Business Planning and Partnerships, who chairs the Governance Sub Committee. Principal risks within the GBAF are assigned to lead directors, all of whom are members of the Governance Sub.

The process of compiling and maintaining the GBAF is the responsibility of the Senior Associate Risk and Governance within the CSU.

The GBAF is refreshed at the start of each year, in order to ensure the principal risks remain relevant, that new risks are added where necessary, and to take stock of the risk ratings. This takes place in 'challenge meetings' of the lead directors, where the content of the GBAF is constructively challenged, and a consensus reached on articulation of risks, risk scoring, and the evaluation of controls and assurances. A final version of the GBAF from these meetings is presented to the GB in April or May.

Observation throughout the year, and sample testing of the GBAF at year end, confirm that the process is generally working well, with a clear understanding of the process and a thoughtful approach to the scrutiny of risks, controls and assurances.

2.3.2 The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year.

2014/15 Audit Assignments

In line with Public Sector Internal Audit Standards, the 2014/15 Internal Audit Plan was produced using a risk-based approach. The audit plan was developed following a review of the organisation's principal level risks to the achievement of its strategic objectives, as detailed within its Assurance Framework, and following consultation with the organisation's Executive Team and Audit Committee members.

At the time of producing this Annual Report, we have issued four reports and two draft reports, of which:

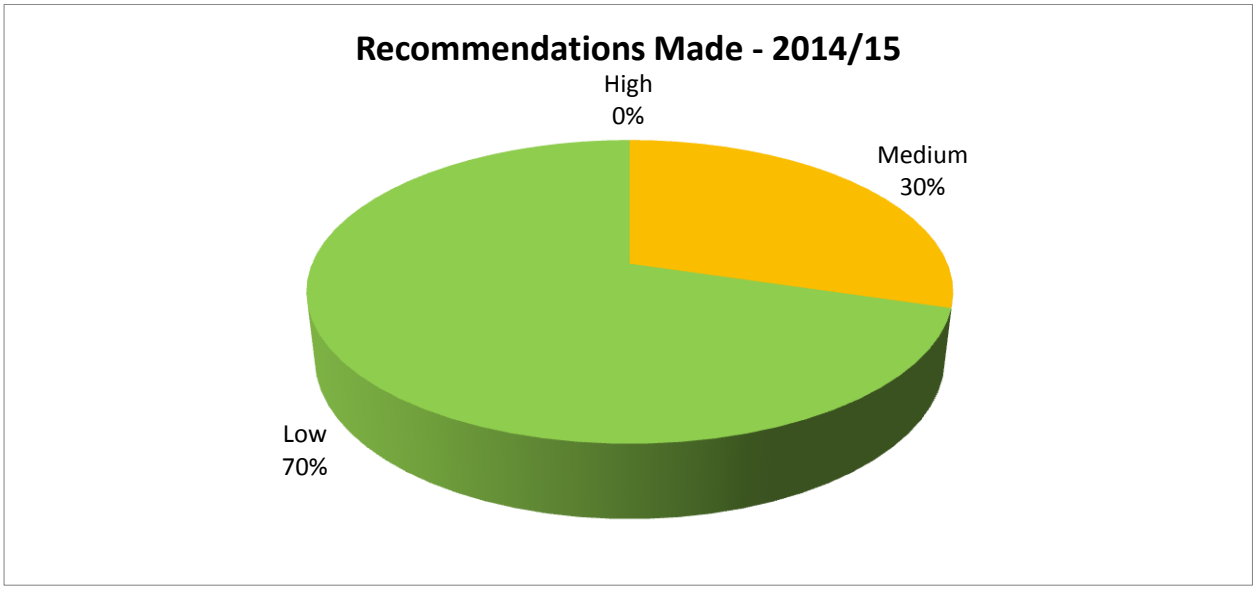
- Full assurance was provided in relation to one review;
- Five reports were issued with Significant Assurance;

At the time of writing, there remains one report which we still need to issue to the CCG, which details our involvement in the Better Care Fund Finance and Governance Work Group throughout 2014/15. This report will not include a formal opinion as it summarises advice we provided throughout the year.

Details of all assignments contained within the 2014/15 Internal Audit work programme are attached at **Appendix A**.

At the time of writing, no high risk issues have been formally reported as a result of our 2014/15 work to date.

Appendix A provides details of all work completed within the 2014/15 plan. In total, this work resulted in 27 recommendations. The chart below provides a breakdown of the risk ratings of these recommendations for the year.



2.3.3 The Organisation's response to Internal Audit recommendations and the extent to which they have been implemented

As part of PSIAS, I am required to consider the appropriateness of the organisation's response to Internal Audit recommendations made and action subsequently implemented.

As part of our follow-up process, we seek to assess whether management has taken appropriate action to address risks identified during our original review and the extent to which action taken has had the desired impact on outcomes.

All high risk recommendations are subject of a specific follow up review, As part of our year end process, we seek evidence of implementation of any medium risk

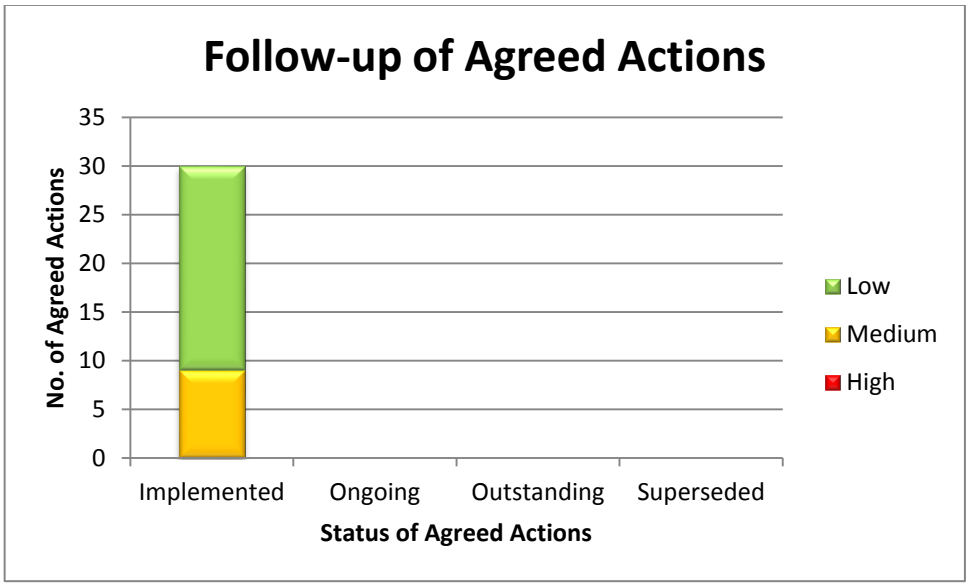
recommendations that have not already been subject to follow up, for example as part of a cyclical audit.

The CCG has a well-established process for ensuring the completion of Internal Audit recommendations.

During 2014/15, the Finance Lead- Financial Governance maintained a log of all agreed Internal Audit recommendations, and periodically, obtained confirmation from responsible officers that implementation had taken place.

Progress on implementation of recommendations rated high or medium risk was reported as a standing item to the Audit and Integrated Governance Committee, which is a strong advocate for ensuring progress is made with outstanding recommendations.

Follow-up work completed has confirmed that the organisation is proactively ensuring that appropriate actions are being taken to address internal audit recommendations in line with agreed timescales. The graph below demonstrates progress against agreed actions in relation to all follow-up work reported to the Audit Committee during 2014/15:



3. 360 Assurance Performance

3.1 Compliance with Public Sector Internal Audit Standards

As Internal Auditors we are required to comply with the mandatory Public Sector Internal Audit Standards. The delivery of our service adheres to these standards and our working processes are clearly documented in our Internal Audit Manual, which is aligned to the requirements of the standards. These are reviewed on a regular basis and all staff are required to formally acknowledge receipt and adherence.

During 2014/15 we engaged with BHP Chartered Accountants who have undertaken an external assessment of our compliance with PSIAS. This review confirmed our compliance with the standards and a copy of the resulting report and actions agreed in order to enhance our processes has been shared with the Chief Finance Officer.

3.2 Achievement of the Plan

The 2014/15 Internal Audit Plan for 135 days was approved at the Audit Committee meeting on 27th of March 2014.

One adjustment was made to the Plan in-year: The allocation for Collaborative Commissioning was reassigned to the resource in the Plan for Internal Audit's involvement in the Better Care Fund Finance & Governance Work Group. This amendment was discussed and agreed with the Chief Finance Officer.

At the conclusion of the year there were 8 days which had not been used and which have been carried forward into 2015/16.

During 2014/15 we have had discussions with representatives from your External Audit provider to ensure that our work programmes did not overlap and that our reviews could be referenced by External Audit, where appropriate.

3.3 Staffing

As the Director of 360 Assurance, I have a strategic responsibility for overseeing the effective delivery of the audit services to the organisation. The contract is delivered by a team of staff led by your nominated Assistant Director, Kevin Watkins.

Throughout 2014/15 we have been sufficiently staffed to meet the requirements of the audit plan.

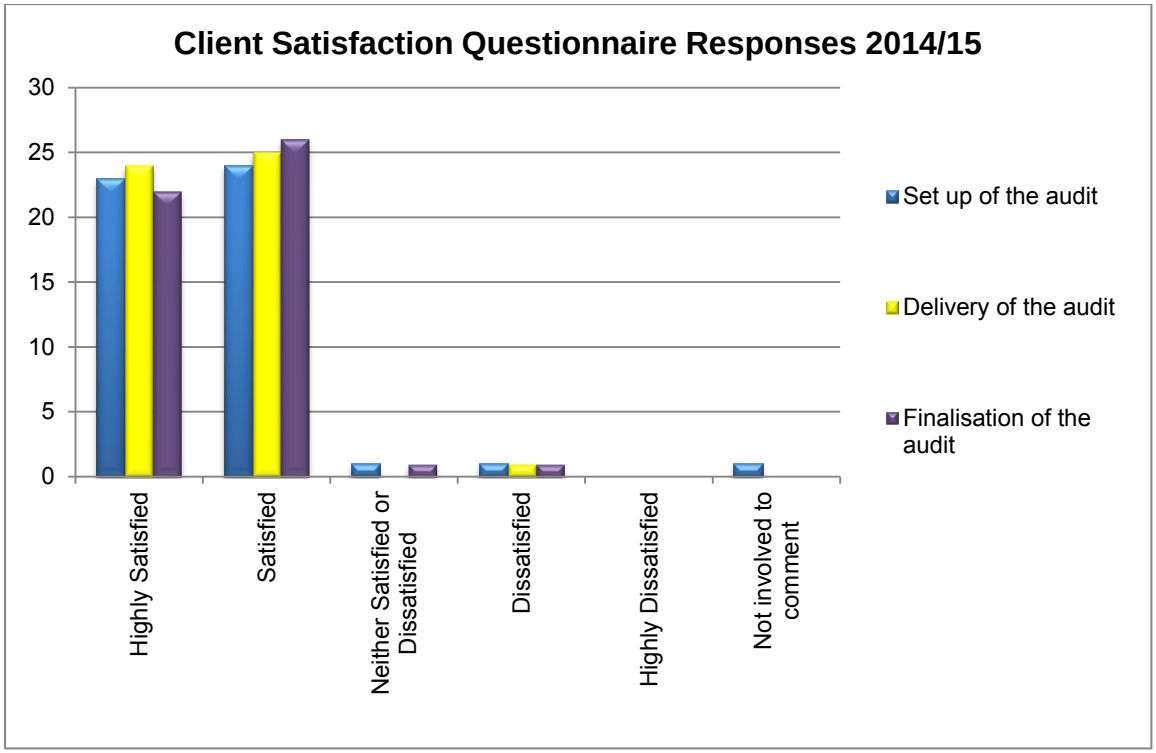
3.4 Key Performance Indicators (KPIs)

Appendix B sets out the KPIs that have been agreed as part of our SLA with the Organisation. We have demonstrated our achievement against each of the indicators within the Appendix.

3.5 Client Satisfaction Questionnaires

As part of our drive to improve quality, we have continued to issue Client Satisfaction Questionnaires following the conclusion of all audit reviews. The questionnaire seeks to

confirm that the auditee was appropriately engaged in the planning and reporting process and that our approach to the review and subsequent report provided added value to the Organisation. Responses received during 2014/15 are summarised in the graph below:



Where we have received comments on specific areas of service, these are reviewed and action taken, as appropriate, by the Assistant Director. Feedback is provided to the Lead Officer where required.

Appendix A – Internal Audit Outturn for 2014/15

Audit Assignment	Report Ref.	Status	Assurance Level/Comment
Patient & Public Engagement	1415/SCCG/01/R	Significant	Complete
MSK Project Management Review	1415/SCCG/02/R	Significant	Complete
Budgetary Control & Key Financial Systems	1415/SCCG/03/R	Full	Complete
Information Governance Toolkit	1415/SCCG/04/R	Significant	Complete
111 Service Quality Monitoring	1415/SCCG/05/R	Significant	Complete
Medicines Management	1415/SCCG/06/R	Significant	Complete
BCF Finance & Governance Work Group Involvement	1415/SCCG/07/R	N/A	Draft Report Being Prepared

Appendix B – Performance Indicators

Key Performance Indicator (From the SLA)	360 Assurance Performance 2014/15
Strategic and Operational Internal Audit Plans will be produced for client agreement by 31st March annually.	The 2014/15 Operational Plan was agreed at the Audit Committee meeting in March 2014.
All high-risk issues and any significant issues which could result in a no assurance opinion identified during the course of Internal Audit work will be brought to the immediate attention of the Chief Finance Officer and other senior officers as appropriate).	No high risk issues were identified during the course of our audit work for 2014/15.
A final draft audit report will be issued within three weeks of the exit meeting. Exceptions resulting from extenuating circumstances will be agreed with the Chief Finance Officer	Final draft reports have been issued within the timescales outlined in this performance measure and the progress of each audit, including the reporting information, is contained within the report issued.
The Assistant Director will meet with the nominated Audit Lead at the client organisation at an agreed frequency at the request of the client (minimum quarterly).	Meetings were held with the Chief Finance Officer to discuss progress of the audit plan.
A report will be presented to the Audit Committee for each meeting, which details progress made towards the completion of the Internal Audit Operational Plan.	A progress report was presented by the Director, 360 Assurance or Associate Director at all Audit Committee meetings in the financial year.
General enquiries will be responded to within two working days.	All requests for ad hoc advice have been responded to within the required timeframe.
As far as possible and reasonable, a consistent team will be provided.	The client has a dedicated team of professionally qualified auditors which has been consistent through-out the year. The client has been provided with details of nominated senior staff leads.
All work undertaken will be made available to the clients' External Auditors in order that they can place reliance upon Internal Audit activity, thereby avoiding unnecessary overlapping of work.	We have provided final reports to External Audit leads as a matter of routine. Completed audit files and other relevant documentary evidence are available to the External Auditors as required.
Internal Audit work is undertaken in compliance with the requirements of Public Sector Internal Audit Standards (PSIAS).	Our working practices and protocols have been reviewed and updated to ensure compliance to PSIAS.
An Annual Report and Head of Internal Audit Opinion Statement will be provided in line with DH reporting timeframes.	This is provided on an annual basis and is in line with DH reporting timeframes.

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

We have audited the financial statements of NHS Sheffield CCG for the year ended 31 March 2015, comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related notes. These financial statements have been prepared under applicable law and the accounting polices directed by NHS England 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 Report that is subject to audit.

This report is made solely to the Members of NHS Sheffield CCG, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Members 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 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. 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.

Scope of the audit of the financial statements

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

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

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 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 2015 and of its net operating expenditure for the year then ended; and

- have been properly prepared in accordance with the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting polices directed by the NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and

- the information given in the Strategic Report and Members' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with NHS England's Guidance;

- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or

- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

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

Respective responsibilities of the CCG and auditor

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

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

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

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the CCG has proper arrangements for:

- securing financial resilience; and

- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

We planned and performed our work in accordance with the Code of Audit Practice 2010 for local NHS bodies. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all material respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that, in all material respects, NHS Sheffield CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate

We certify that we have completed the audit of the accounts of NHS Sheffield CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

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

Chartered Accountants
1 The Embankment
Leeds
LS1 4DW

22 May 2015

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2014-15

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

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	4.1.1	7,125	4,572
Operating Expenses	5	714,966	694,554
Other operating revenue	2	(6,310)	(7,571)
Net operating expenditure before interest		**715,781**	**691,555**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	0
Net operating expenditure for the financial year		**715,781**	**691,555**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**715,781**	**691,555**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	5,588	4,572
Operating Expenses	5	6,743	6,443
Other operating revenue	2	(1,493)	(1,350)
Net administration costs before interest		**10,838**	**9,665**
Programme Income and Expenditure			
Employee benefits	4.1.1	1,537	0
Operating Expenses	5	708,223	688,111
Other operating revenue	2	(4,817)	(6,221)
Net programme expenditure before interest		**704,943**	**681,890**

Other Comprehensive Net Expenditure		2014-15 £000	2013-14 £000
Impairments and reversals	22	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		0	0
On disposal of available for sale financial assets		0	0
Total comprehensive net expenditure for the year		**715,781**	**691,555**

The notes on pages 5 to 34 form part of this statement.

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	13	0	0
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		**0**	0
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	6,710	7,621
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	121	73
Total current assets		**6,831**	7,694
Non-current assets held for sale	21	0	0
Total current assets		**6,831**	7,694
Total assets		**6,831**	7,694
Current liabilities			
Trade and other payables	23	(30,833)	(33,734)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total current liabilities		**(30,833)**	(33,734)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(24,002)**	(26,040)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(24,002)**	(26,040)
Financed by Taxpayers' Equity			
General fund		(24,002)	(26,040)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(24,002)**	(26,040)

The notes on pages 5 to 34 form part of this statement.

The financial statements on pages 1 to 4 were approved by the Governing Body on 21st May 2015 and signed on its behalf by:

Interim Chief Officer
Idris Griffiths

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

	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 between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted Clinical Commissioning Group balance at 1 April 2014	**(26,040)**	**0**	**0**	**(26,040)**
Changes in Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating expenditure for the financial year	(715,781)	0	0	(715,781)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	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 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)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2013-14				
Balance at 1 April 2013	**0**	**0**	**0**	**0**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**192**	**0**	**0**	**192**
Adjusted Clinical Commissioning Group balance at 1 April 2013	**192**	**0**	**0**	**192**
Changes in Clinical Commissioning Group taxpayers' equity for 2013-14				
Net operating costs for the financial year	(691,555)	0	0	(691,555)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	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 Clinical Commissioning Group Expenditure for the Financial Year (Restated)	**(691,555)**	**0**	**0**	**(691,555)**
Net funding	665,323	0	0	665,323
Balance at 31 March 2014	**(26,040)**	**0**	**0**	**(26,040)**

The notes on pages 5 to 34 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(715,781)	(691,555)
Depreciation and amortisation	5	0	205
Impairments and reversals	5	0	(13)
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	17	911	(7,621)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(2,901)	33,734
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	0	0
Net Cash Inflow (Outflow) from Operating Activities		**(717,771)**	(665,250)
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		**(717,771)**	(665,250)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		717,819	665,323
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		**717,819**	665,323
Net Increase (Decrease) in Cash & Cash Equivalents	20	**48**	73
Cash & Cash Equivalents at the Beginning of the Financial Year		**73**	0
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		**121**	73

The notes on pages 5 to 34 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2014-15 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.

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 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 Charitable Funds

From 2014-15, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

1.6 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.

1.7 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.

1.7.1 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.

1.7.2 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 - Sheffield 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 Audit & Integrated Governance Group. The key areas requiring estimation were healthcare contracts and prescribing expenditure.

Notes to the financial statements

1.8 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.

1.9 Employee Benefits

1.9.1 Short-term Employee Benefits

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

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

1.9.2 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.

1.10 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.

1.11 Property, Plant & Equipment

1.11.1 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.

1.11.2 Valuation

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

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

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

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

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

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

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

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

1.11.3 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.

1.12 Intangible Assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Clinical Commissioning Group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the Clinical Commissioning Group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the Clinical Commissioning Group and may be shorter than the physical 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 or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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

1.14 Donated Assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government Grants

The value of assets received by means of a government grant is credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Non-current Assets Held For Sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

. The sale is highly probable;

· The asset is available for immediate sale in its present condition; and,

· Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses. The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve. Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 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.

1.17.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.17.2 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.

1.18 Private Finance Initiative Transactions

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Clinical Commissioning Group therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.18.1 Services Received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.18.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Clinical Commissioning Group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.18.4 Lifecycle Replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Clinical Commissioning Group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18.5 Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Clinical Commissioning Group's Statement of Financial Position.

1.18.6 Other Assets Contributed by the Clinical Commissioning Group to the Operator

Assets contributed (e.g. cash payments, surplus property) by the Clinical Commissioning Group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Clinical Commissioning Group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.19 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.20 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.

1.21 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 1.50%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.05%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.30%

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.

Notes to the financial statements

1.22 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.

1.23 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.

1.24 Continuing healthcare risk pooling

In 2014-15 a risk pool scheme has 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.

1.25 Carbon Reduction Commitment Scheme

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the Clinical Commissioning Group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.26 Contingencies

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

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

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

1.27 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.

1.27.1 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.

1.27.2 Held to Maturity Assets

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

1.27.3 Available For Sale Financial Assets

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

1.27.4 Loans & Receivables

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

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

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

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

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

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

1.28 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.

1.28.1 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.

1.28.2 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.

1.28.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the 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.

1.29 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.

1.30 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.

1.31 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Clinical Commissioning Group has no beneficial interest in them.

1.32 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).

1.33 Subsidiaries

Material entities over which the Clinical Commissioning Group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Clinical Commissioning Group or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 Associates

Material entities over which the Clinical Commissioning Group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Clinical Commissioning Group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Clinical Commissioning Group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Clinical Commissioning Group from the entity.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 Joint Ventures

Material entities over which the Clinical Commissioning Group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method. Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.36 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.

1.37 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.

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2014-15, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 13: Fair Value Measurement
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

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

2 Other Operating Revenue

	2014-15 Admin £000	2014-15 Programme £000	2014-15 Total £000	2013-14 Total £000
Recoveries in respect of employee benefits	341	2	343	0
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	303	0	303	313
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	261	4	265	129
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	499	346	845	324
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*	89	4,465	4,554	6,805
Total other operating revenue	**1,493**	**4,817**	**6,310**	**7,571**

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

* For 2014/15, for 'Other revenue' shown, £2.9m relates to income received from Sheffield City Council (SCC) for the following : the recharge of care costs for care where SCC have funding responsibility (£1m); the recharge of prescribing costs for services that SCC commission (£1m); and the SCC contribution to the Community Equipment Service Pooled Budget hosted by Sheffield CCG (£0.9m). Of the remaining £1.7m income, £0.9m relates to income from other CCGs as Sheffield CCG 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.

In 2013/14, 'Other revenue' related to the following: £0.6m shown under Admin revenue relates to income from West and South Yorkshire and Bassetlaw CSU in relation to shared costs for occupation of a joint building. For the other revenue shown under Programme, £3.1m relates to the recharge of care costs to Sheffield City Council for care where they have funding responsibility; £1m relates to income from Sheffield City Council in relation to their contribution to the pooled budget arrangements, £0.9m relates to lead commissioner arrangements for patient transport services; £0.4m relates to recharge of costs for detained patients, for which Sheffield Health and Social Care NHS Foundation Trust took responsibility for in 2013/14; £0.1m relates to recharge of prescribing costs to Sheffield City Council in relation to services for which they have commissioning responsibility.

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.

3 Revenue

	2014-15 Admin £000	2014-15 Programme £000	2014-15 Total £000	2013-14 Total £000
From rendering of services	1,493	4,817	6,310	7,571
From sale of goods	0	0	0	0
Total	**1,493**	**4,817**	**6,310**	**7,571**

Revenue is totally from the supply of services. Sheffield Clinical Commissioning Group receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2014-15	Total			Admin			Programme		
	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**

Prior Year	2013-14	Total			Admin			Programme	
	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	3,685	3,560	125	3,685	3,560	125	0	0	0
Social security costs	370	370	0	370	370	0	0	0	0
Employer Contributions to NHS Pension scheme	517	517	0	517	517	0	0	0	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	**4,572**	**4,447**	**125**	**4,572**	**4,447**	**125**	**0**	**0**	**0**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**4,572**	**4,447**	**125**	**4,572**	**4,447**	**125**	**0**	**0**	**0**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**4,572**	**4,447**	**125**	**4,572**	**4,447**	**125**	**0**	**0**	**0**

4.1.2 Recoveries in respect of employee benefits

	2014-15			2013-14		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£000	£000	£000	£000	£000	£000
Employee Benefits - Revenue						
Salaries and wages	(281)	(281)	0	0	0	0
Social security costs	(26)	(26)	0	0	0	0
Employer contributions to the NHS Pension Scheme	(36)	(36)	0	0	0	0
Other pension costs	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0
Total recoveries in respect of employee benefits	**(343)**	**(343)**	**0**	**0**	**0**	**0**

4.2 Average number of people employed

	2014-15 Total Number	2014-15 Permanently employed Number	2014-15 Other Number	2013-14 Total Number
Total	**123**	**119**	**4**	75
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

	2014-15 Number	2013-14 Number
Total Days Lost	495	184
Total Staff Years	111	77
Average working Days Lost	**4**	**2**

	2014-15 Number	2013-14 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 Exit packages agreed in the financial year

	2014-15 Compulsory redundancies		2014-15 Other agreed departures		2014-15 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	Departures where special payments have been made	
	Number	£
Less than £10,000	0	0
£10,001 to £25,000	0	0
£25,001 to £50,000	0	0
£50,001 to £100,000	0	0
£100,001 to £150,000	0	0
£150,001 to £200,000	0	0
Over £200,001	0	0
Total	**0**	**0**

Analysis of Other Agreed Departures

	Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval*	0	0
Total	**0**	**0**

* As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.
These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

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

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, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables. The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

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

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

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

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

4.5.1 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for the financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data at 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

4.5.3 Scheme Provisions

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

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

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

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

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

• For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

5. Operating expenses

	2014-15 Admin £000	2014-15 Programme £000	2014-15 Total £000	2013-14 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	4,805	1,537	6,342	3,813
Executive governing body members	783	0	783	759
Total gross employee benefits	**5,588**	**1,537**	**7,125**	**4,572**
Other costs				
Services from other CCGs and NHS England	3,018	1,652	4,670	7,348
Services from foundation trusts	10	503,425	503,435	483,461
Services from other NHS trusts	0	22,784	22,784	22,475
Services from other NHS bodies	0	0	0	2
Purchase of healthcare from non-NHS bodies	0	77,533	77,533	82,616
Chair and Non Executive Members	373	0	373	259
Supplies and services – clinical	0	0	0	0
Supplies and services – general	1,843	457	2,300	2,007
Consultancy services*	230	19	249	172
Establishment	204	125	329	222
Transport	23	0	23	14
Premises	346	1,799	2,145	1,808
Impairments and reversals of receivables	0	0	0	0
Inventories written down	0	0	0	0
Depreciation	0	0	0	205
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	(13)
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets	0	0	0	0
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	114	0	114	126
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	0	90,740	90,740	87,793
Pharmaceutical services	0	373	373	362
General ophthalmic services	0	235	235	253
GPMS/APMS and PCTMS	0	7,851	7,851	4,774
Other professional fees excl. audit	178	2	180	214
Grants to other public bodies	0	200	200	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	278	0	278	377
Education and training	74	9	83	44
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
CHC Risk Pool contributions	0	1,019	1,019	0
Other expenditure	52	0	52	35
Total other costs	**6,743**	**708,223**	**714,966**	**694,554**
Total operating expenses	**12,331**	**709,760**	**722,091**	**699,126**

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

* In 2014/15, Sheffield CCG commissioned some consultancy work in partnership with Sheffield City Council. The council's contribution to consultancy costs (£70k) is reflected in income (see Note 2).

6.1 Better Payment Practice Code

Measure of compliance	2014-15 Number	2014-15 £000	2013-14 Number	2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	13,945	94,388	13,430	76,778
Total Non-NHS Trade Invoices paid within target	13,743	93,861	13,177	76,105
Percentage of Non-NHS Trade invoices paid within target	**98.55%**	**99.44%**	**98.12%**	**99.12%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,527	570,694	2,783	523,568
Total NHS Trade Invoices Paid within target	3,505	570,655	2,738	523,252
Percentage of NHS Trade Invoices paid within target	**99.38%**	**99.99%**	**98.38%**	**99.94%**

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	2014-15 £000	2013-14 £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**

7 Income Generation Activities

Sheffield Clinical Commissioning Group does not undertake any income generation activities.

8. Investment revenue

	2014-15 £000	2013-14 £000
Rental Revenue		
PFI finance lease revenue (planned)	0	0
PFI finance lease revenue (contingent)	0	0
Other finance lease revenue	0	0
Total rental revenue	**0**	**0**
Interest Revenue		
LIFT: equity dividends receivable	0	0
LIFT: loan interest receivable	0	0
Bank interest	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Total interest revenue	**0**	**0**
Total investment revenue	**0**	**0**

9. Other gains and losses

	2014-15 £000	2013-14 £000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	0	0
Gain/(loss) on disposal of intangible assets other than by sale	0	0
Gain/(loss) on disposal of financial assets other than held for sale	0	0
Gain/(loss) on disposal of assets held for sale	0	0
Gain/(loss) on foreign exchange	0	0
Change in fair value of financial assets carried at fair value through the statement of comprehensive net expenditure	0	0
Change in fair value of financial liabilities carried at fair value through the statement of comprehensive net expenditure	0	0
Change in fair value of investment property	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	**0**	**0**

10. Finance costs

	2014-15 £000	2013-14 £000
Interest		
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under PFI contracts:		
· Main finance cost	0	0
· Contingent finance cost	0	0
Interest on obligations under LIFT contracts:		
· Main finance cost	0	0
· Contingent finance cost	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest	**0**	**0**
Other finance costs	0	0
Provisions: unwinding of discount	0	0
Total finance costs	**0**	**0**

11. Net gain/(loss) on transfer by absorption

Sheffield Clinical Commissioning Group had no transfers by absorption during the year ended 31 March 2015 (as at 31 March 2014 nil).

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	2014-15				2013-14
	Land	**Buildings**	**Other**	**Total**	Total
	£000	**£000**	**£000**	**£000**	£000
Payments recognised as an expense					
Minimum lease payments	0	554	0	**554**	838
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**554**	**0**	**554**	**838**

Whilst Sheffield Clinical Commissioning Group has arrangements with Community Health Partnerships Limited and NHS Property Services Limited which fall within the definition of operating leases, the rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for these arrangements. The financial value included in the Statement of Comprehensive Net Expenditure for 2014-15 is £254k (2013-14 is £607k).

Sheffield Clinical Commissioning Group has entered into a financial arrangement involving the use of Walk In Centre premises. Under: IAS 17 Leases, SIC 27 'Evaluating the substance of transactions involving the legal form of a lease' and IFRIC 4 'Determining whether an arrangement contains a lease', the clinical commissioning group has determined that this operating lease must be recognised, but, as there is no formal contract in place for the arrangement entered into, it is not possible to analyse the arrangement over future financial years. The financial value included in the Statement of Comprehensive Net Expenditure for 2014-15 is £300k (2013-14 is £231k).

12.1.2 Future minimum lease payments

	2014-15				2013-14
	Land	**Buildings**	**Other**	**Total**	Total
	£000	**£000**	**£000**	**£000**	£000
Payable:					
No later than one year	0	0	0	**0**	0
Between one and five years	0	0	0	**0**	0
After five years	0	0	0	**0**	0
Total	**0**	**0**	**0**	**0**	**0**

12.2 As lessor

12.2.1 Rental revenue

	2014-15	2013-14
	£000	£000
Recognised as income		
Rent	0	0
Contingent rents	0	0
Total	**0**	**0**

12.2.2 Future minimum rental value

	2014-15	2013-14
	£000	£000
Receivable:		
No later than one year	0	0
Between one and five years	0	0
After five years	0	0
Total	**0**	**0**

13 Property, plant and equipment

2014-15	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2014	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 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**205**	**205**
Depreciation 1 April 2014	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 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**205**	**205**
Net Book Value at 31 March 2015	**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 2015	**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 2015	**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 1 April 2014	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 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

	2014-15 £000	2013-14 £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	0	0
Total	**0**	**0**

13.2 Donated assets

Sheffield Clinical Commissioning Group did not receive any donated assets in 2014/15 (2013/14 none).

13.3 Government granted assets

Sheffield Clinical Commissioning Group did not receive any government granted assets in 2014/15 (2013/14 none).

13.4 Property revaluation

Sheffield Clinical Commissioning Group does not own any non current property assets. As a result, no revaluation of assets has occurred in 2014/15 (2013/14 none).

13.5 Compensation from third parties

Sheffield Clinical Commissioning Group did not impair any assets in 2014/15 (2013/14 none). As a result, no amounts are included in the Statement of Comprehensive Net Expenditure for compensation from Third parties.

13.6 Write downs to recoverable amount

No assets were written down to recoverable amounts in 2014/15 (2013/14 none). There were no reversals of previous write downs in 2014/15 (2013/14 none).

13.7 Temporarily idle assets

Sheffield Clinical Commissioning Group had no temporarily idle assets as at 31 March 2015 (2013/14 none).

13.8 Cost or valuation of fully depreciated assets

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

	2014-15 £000	2013-14 £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**

13.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	-	-
Transport equipment	-	-
Information technology	-	-
Furniture & fittings	0	10

14 Intangible non-current assets

2014-15	Computer Software: Purchased £000	Computer Software: Internally Generated £000	Licences & Trademarks £000	Patents £000	Development Expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2014	0	0	0	0	0	0
Additions purchased	0	0	0	0	0	0
Additions internally generated	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	0
Cost / Valuation At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation 1 April 2014	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	0
Amortisation At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**
Purchased	0	0	0	0	0	0
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**

Revaluation Reserve Balance for intangible assets

	Computer Software: Purchased £000's	Computer Software: Internally Generated £000's	Licences & Trademarks £000's	Patents £000's	Development Expenditure (internally generated) £000's	Total £000's
Balance at 1 April 2014	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0
Other movements	0	0	0	0	0	0
At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**

14 Intangible non-current assets cont'd

14.1 Donated assets
Sheffield Clinical Commissioning Group did not receive any donated intangible assets in 2014/15 (2013/14 none).

14.2 Government granted assets
Sheffield Clinical Commissioning Group did not receive any government granted intangible assets in 2014/15 (2013/14 none).

14.3 Revaluation
Sheffield Clinical Commissioning Group does not own any intangible non current assets. As a result, no revaluation of assets has occurred in 2014/15 (2013/14 none).

14.4 Compensation from third parties
Sheffield Clinical Commissioning Group did not impair any assets in 2014/15 (2013/14 none). As a result, no amounts are included in the Statement of Comprehensive Net Expenditure for compensation from Third parties.

14.5 Write downs to recoverable amount
No assets were written down to recoverable amounts in 2014/15 (2013/14 none). There were no reversals of previous write downs in 2014/15 (2013/14 none).

14.6 Non-capitalised assets
Sheffield Clinical Commissioning Group does not control any significant intangible assets not recognised as assets because they didn't meet the recognition criteria.

14.7 Temporarily idle assets
Sheffield Clinical Commissioning Group had no temporarily idle assets as at 31 March 2015 (2013/14 none).

14.8 Cost or valuation of fully amortised assets
Sheffield Clinical Commissioning Group had no fully depreciated intangible assets still in use as at 31 March 2015 (2013/14 none).

14.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	-	-
Computer software: internally generated	-	-
Licences & trademarks	-	-
Patents	-	-
Development expenditure (internally generated)	-	-

15 Investment property
Sheffield Clinical Commissioning Group had no investment property as at 31 March 2015 (as at 31 March 2014 nil).

16 Inventories
Sheffield Clinical Commissioning Group had no inventories as at 31 March 2015 (as at 31 March 2014 nil).

17 Trade and other receivables	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	619	0	2,463	0
NHS receivables: Capital	0	0	0	0
NHS prepayments and accrued income	3,343	0	3,367	0
Non-NHS receivables: Revenue	449	0	431	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments and accrued income	2,293	0	1,345	0
Provision for the impairment of receivables	0	0	0	0
VAT	6	0	15	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	0	0	0	0
Total Trade & other receivables	**6,710**	**0**	**7,621**	**0**
Total current and non current	**6,710**		**7,621**	
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.

17.1 Receivables past their due date but not impaired	2014-15 £000	2013-14 £000
By up to three months	569	343
By three to six months	7	0
By more than six months	49	0
Total	**625**	**343**

£489k of the amount above has subsequently been recovered post 31 March 2015.

Sheffield Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2015.

17.2 Provision for impairment of receivables	2014-15 £000	2013-14 £000
Balance at 1 April 2014	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	0	0
Transfer (to) from other public sector body	0	0
Balance at 31 March 2015	**0**	**0**

Sheffield Clinical Commissioning Group has not impaired any receivables during the year ended 31 March 2015 (2013/14 nil).

	2014-15 %	2013-14 %
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 90 and 120 days old	0	0
All other non-NHS debt over 120 days old	0	0

18 Other financial assets

Sheffield Clinical Commissioning Group had no other financial assets as at 31 March 2015 (as at 31 March 2014 nil).

19 Other current assets

Sheffield Clinical Commissioning Group had no other current assets as at 31 March 2015 (as at 31 March 2014 nil).

20 Cash and cash equivalents

	2014-15	2013-14
	£000	£000
Balance at 1 April 2014	73	0
Net change in year	48	73
Balance at 31 March 2015	**121**	**73**
Made up of:		
Cash with the Government Banking Service	121	73
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	**121**	**73**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2015	**121**	**73**
Patients' money held by the clinical commissioning group, not included above	0	0

21 Non-current assets held for sale

Sheffield Clinical Commissioning Group had no non-current assets held for sale as at 31 March 2015 (as at 31 March 2014 nil).

22 Analysis of impairments and reversals

Sheffield Clinical Commissioning Group had no impairments or reversals of impairments recognised in expenditure during 2014-15 (2013/14 nil).

23 Trade and other payables	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	0	0	0	0
NHS payables: revenue	1,681	0	967	0
NHS payables: capital	0	0	0	0
NHS accruals and deferred income	5,266	0	8,275	0
Non-NHS payables: revenue	1,569	0	720	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals and deferred income	21,811	0	23,141	0
Social security costs	83	0	57	0
VAT	0	0	0	0
Tax	87	0	62	0
Payments received on account	0	0	0	0
Other payables	336	0	512	0
Total Trade & Other Payables	**30,833**	**0**	**33,734**	**0**
Total current and non-current	**30,833**		**33,734**	

Included above are liabilities of £nil due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2014: £nil).

Non-NHS accruals and deferred income includes £15,722k Prescribing accrual and £6,089k relating to Continuing Healthcare and Non NHS Contract accruals (31 March 2014: £14,275k Prescribing accrual and £8,866k Continuing Healthcare and Non NHS Contract accruals).

Other payables include £127k outstanding pension contributions at 31 March 2015 (31 March 2014: £84k).

24 Other financial liabilities

Sheffield Clinical Commissioning Group had no other financial liabilities as at 31 March 2015 (as at 31 March 2014 nil).

25 Other liabilities

Sheffield Clinical Commissioning Group had no other liabilities as at 31 March 2015 (as at 31 March 2014 nil).

26 Borrowings

Sheffield Clinical Commissioning Group had no borrowings as at 31 March 2015 (as at 31 March 2014 nil).

27 Private finance initiative, LIFT and other service concession arrangements

27.1 Off-Statement of Financial Position private finance initiative and other service concession

Sheffield Clinical Commissioning Group had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31 March 2015 (as at 31 March 2014 nil).

27.2 On-Statement of Financial Position Private Finance Initiative, LIFT & Other Service Concession Arrangements

Sheffield Clinical Commissioning Group had no private finance initiative, LIFT or other service concession arrangements that were included in the Statement of Financial Position as at 31 March 2015 (as at 31 March 2014 nil).

28 Finance lease obligations

Sheffield Clinical Commissioning Group had no finance lease obligations as at 31 March 2015 (as at 31 March 2014 nil).

29 Finance lease receivables

Sheffield Clinical Commissioning Group had no finance lease receivables as at 31 March 2015 (as at 31 March 2014 nil).

30 Provisions

Sheffield Clinical Commissioning Group had no provisions as at 31 March 2015 (as at 31 March 2014 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 CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2015 is £3,677k (31 March 2014: £6,829k).

£175,089 is included in the provisions of NHS Litigation Authority as at 31 March 2015 in respect of clinical negligence liabilities of the clinical commissioning group.

31 Contingencies

Sheffield Clinical Commissioning Group had no contingent assets or liabilities as at 31 March 2015 (as at 31 March 2014 nil).

32 Commitments

32.1 Capital commitments

Sheffield Clinical Commissioning Group had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2015 (as at 31 March 2014 nil).

32.2 Other financial commitments

Sheffield Clinical Commissioning Group has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2014-15	2013-14
	£000	£000
In not more than one year	23	0
In more than one year but not more than five years	0	0
In more than five years	0	0
Total	**23**	**0**

33 Financial instruments

33.1 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 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 Clinical Commissioning Group's Prime Financial Policies and other policies agreed by the Governing Body. Treasury activity is subject to review by the Clinical Commissioning Group and internal auditors.

33.1.1 Currency risk

The 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 Clinical Commissioning Group has no overseas operations. The Clinical Commissioning Group therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

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

33.1.3 Credit risk

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

33.1.3 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	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	450
Cash at bank and in hand	0	121	0	121
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**1,189**	**0**	**1,189**

	At 'fair value through profit and loss' 2013-14 £000	Loans and Receivables 2013-14 £000	Available for Sale 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	2,463	0	2,463
· Non-NHS	0	431	0	431
Cash at bank and in hand	0	73	0	73
Other financial assets	0	0	0	0
Total at 31 March 2014	0	2,967	0	2,967

33.3 Financial liabilities

	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 2015	**0**	**30,663**	**30,663**

	At 'fair value through profit and loss' 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	9,243	9,243
· Non-NHS	0	23,861	23,861
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 2014	0	33,104	33,104

33.4 Maturity of financial liabilities

	Payable to DH	Payable to Other bodies
	£'000	£'000
In one year or less	0	30,663
In more than one year but not more than two years	0	0
In more than two years but not more than five years	0	0
In more than five years	0	0
Total CCG at 31 March 2015	**0**	**30,663**

34 Operating segments

Sheffield Clinical Commissioning Group considers that it has only one 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	722,091	(6,310)	**715,781**	6,831	(30,833)	**(24,002)**

During the year Sheffield Clinical Commissioning Group paid £375,158k, approx. 52% of total expenditure, (2013-14: £361,196k approx. 52%) to Sheffield Teaching Hospitals NHS Foundation Trust for the purchase of healthcare and other services provided.

During the year Sheffield Clinical Commissioning Group paid £83,387K, approx. 12% of total expenditure (2013-14: £81,641 approx. 12%) to Sheffield Health and Social Care NHS Foundation Trust for the purchase of healthcare and other services provided.

35 Pooled budgets

The Clinical Commissioning Group had entered into a pooled budget arrangement with Sheffield City Council. The pool is hosted by Sheffield City Council. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for **Learning Disabilities Services**. The memorandum account for the pooled budget is:

	31 March 2015	31 March 2014
	£'000	£'000
Income	1,765	1,777
Expenditure	-1,765	-1,777

Financial contribution of each of the partners.

	£000	£000
NHS Sheffield Clinical Commissioning Group	665	677
Sheffield City Council	1,100	1,100
	1,765	**1,777**

Allocation of Expenditure.

	£000	£000
Learning Disabilities Respite Services	-1,765	-1,777
	-1,765	**-1,777**

The Clinical Commissioning Group's share of the income and expenditure handled by the pooled budget in the financial year were:

	31 March 2015	31 March 2014
	£'000	£'000
Income	665	677
Expenditure	-665	-677

The Clinical Commissioning Group had entered into a pooled budget arrangement with Sheffield City Council. The pool is hosted by NHS Sheffield CCG. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for **Community Equipment Services**. The memorandum account for the pooled budget is:

	31 March 2015	31 March 2014
	£'000	£'000
Income	2,993	2,750
Expenditure	-2,993	-2,750

Financial contribution of each of the partners.

	£000	£000
NHS Sheffield Clinical Commissioning Group	2,133	1,814
Sheffield City Council	860	936
	2,993	**2,750**

Allocation of Expenditure

	£000	£000
Staffing Costs	-944	-923
Medical & Surgical Equipment	-1,213	-785
Running Costs	-836	-1,042
	-2,993	**-2,750**

The Clinical Commissioning Group's share of the income and expenditure handled by the pooled budget in the financial year were:

	31 March 2015	31 March 2014
	£'000	£'000
Income	2,133	1,814
Expenditure	-2,133	-1,814

36 NHS Lift investments

	Loan 2014-15 £000	**Share Capital 2014-15 £000**	**Total 2014-15 £000**
Balance at 1 April 2014	0	0	**0**
Additions	0	0	**0**
Disposals	0	0	**0**
Loan repayments	0	0	**0**
Revaluations	0	0	**0**
Loans repayable within 12 months	0	0	**0**
Balance at 31 March 2015	**0**	**0**	**0**

	Loan 2013-14 £000	Share Capital 2013-14 £000	Total 2013-14 £000
Balance at 1 April 2013	0	0	0
Transfer of investments from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0
Adjusted Balance at 1 April 2013	0	0	0
Additions	0	0	0
Disposals	0	0	0
Loan repayments	0	0	0
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2014	0	0	0

37 Intra-government and other balances

	Current Receivables 2014-15 £000	**Non-current Receivables 2014-15 £000**	**Current Payables 2014-15 £000**	**Non-current Payables 2014-15 £000**
Balances with:				
· Other Central Government bodies	6	0	473	0
· Local Authorities	2,412	0	1,869	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	435	0	185	0
· NHS Trusts and Foundation Trusts	3,527	0	6,762	0
Total of balances with NHS bodies:	**3,962**	**0**	**6,947**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	330	0	21,544	0
Total balances at 31 March 2015	**6,710**	**0**	**30,833**	**0**

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	61	0	209	0
· Local Authorities	1,114	0	4,018	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	649	0	106	0
· NHS Trusts and Foundation Trusts	5,181	0	9,137	0
Total of balances with NHS bodies:	5,830	0	9,243	0
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	616	0	20,264	0
Total balances at 31 March 2014	7,621	0	33,734	0

38 Related party transactions

Details of related party transactions with individuals are as follows:

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

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

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the
• NHS England;
• NHS Foundation Trusts;
• NHS Trusts;
• NHS Litigation Authority; and,
• NHS Business Services Authority.
In addition, 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 2013-14*

Name	Title	Related Parties for which transactions made	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Dr Amir Afzal	Locality Appointed GP	Duke Medical Centre	82	0	3	0
Ian Atkinson	Accountable Officer	South Yorkshire Housing Association	2,558	0	0	0
Dr Nikki Bates	GP Elected Member	Porterbrook Medical Centre	135	0	4	0
		Rivelin Healthcare Ltd	95	0	8	0
Mark Gamsu	Lay Member	Voluntary Action Sheffield	2	0	0	0
		Sheffield Mental Health CAB	64	0	0	0
		Community Legal Advice Service South Yorkshire	25	0	25	0
		Darnall Wellbeing	38	0	0	0
Dr Anil Gill	GP Elected Member	Selborne Road Medical Centre	28	0	0	0
Dr Andrew McGinty	Locality Appointed GP	Woodhouse Health Centre	194	0	11	0
		Woodhouse Health Services Ltd	12	0	0	0
		Primary Provider Ltd	176	0	19	0
Dr Zak McMurray	Joint Clinical Director	Woodhouse Health Centre	see above	0	see above	0
		Woodhouse Health Services Ltd	see above	0	see above	0
		Primary Provider Ltd	see above	0	see above	0
Dr Tim Moorhead	Chair of the Governing Body	Oughtibridge Surgery	299	0	3	0
		Rivelin Healthcare Ltd	see above	0	see above	0
Dr Richard Oliver	Joint Clinical Director	Ecclesfield Group Practice	203	0	0	0
Dr Marion Sloan	GP Elected Member	Sloan Medical Centre	152	0	9	0
Dr Leigh Sorsbie	Locality Appointed GP	Firth Park Surgery	97	0	7	0
Dr Ted Turner	GP Elected Member	Southey & Owlerton Area Regeneration	12	0	0	0
		Shiregreen Medical Centre	90	0	4	0

Prior year comparators have been re-stated in a format that is consistent with that reported in 2014-15.

39 Events after the end of the reporting period

NHS England recently announced details of the Clinical Commissioning Groups approved to take on greater delegated responsibility or to jointly commission GP services from 1st April 2015. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View to deliver a new deal for primary care and another step towards plans set out by NHS England early last year to give patients, communities and clinicians more involvement in deciding local health services.

40 Losses and special payments

40.1 Losses

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

	Total Number of Cases 2014-15 Number	**Total Value of Cases 2014-15 £'000**	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £'000
Administrative write-offs	0	0	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	**0**	**0**	0	0

There were no cases over £300k which require additional disclosure.

40.2 Special payments

	Total Number of Cases 2014-15 Number	**Total Value of Cases 2014-15 £'000**	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	2	1	1	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**2**	**1**	1	0

41 Third party assets

Sheffield Clinical Commissioning Group held no third party assets as at 31 March 2015 (as at 31 March 2014 nil).

42 Financial performance targets

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

NHS Act Section	Duty	2014-15 Target £'000	2014-15 Performance £'000	2014-15 Variance £'000	Duty Achieved?	2013-14 Target £'000	2013-14 Performance £'000	2013-14 Variance £'000
223H(1)*	Expenditure not to exceed income	733,406	722,091	11,315	Yes	706,046	699,126	6,920
223I(2)	Capital resource use does not exceed the amount specified in Directions	0	0	0	Yes	0	0	0
223I(3)	Revenue resource use does not exceed the amount specified in Directions	733,406	722,091	11,315	Yes	706,046	699,126	6,920
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Yes	0	0	0
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	716,097	709,760	6,337	Yes	690,626	688,111	2,515
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	17,309	12,331	4,978	Yes	15,420	11,015	4,405

* For the purposes of 223H(1); 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 received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

43 Impact of IFRS

	2014-15 £'000	2013-14 £'000
Depreciation charges	0	0
Interest expense	0	0
Impairment charge: Annually Managed Expenditure	0	0
Impairment charge: Departmental Expenditure Limit	0	0
Other Expenditure	0	0
Revenue receivable from subleasing	0	0
Total IFRS Expenditure (IFRIC 12)	**0**	**0**
Revenue consequences of private finance initiative/LIFT schemes under UK GAAP/ESA95 (net of any sublease revenue)	0	0
Net IFRS Change (IFRIC 12)	**0**	**0**
Capital Consequences of IFRS: private finance initiative/LIFT and other service concession arrangements under IFRIC 12		
Capital expenditure 2014-15	0	0
UK GAAP capital expenditure 2014-15 (reversionary interest)	0	0

44 Analysis of charitable reserves

Sheffield Clinical Commissioning Group does not produce consolidated accounts involving a charity.