NHS
Sheffield
Clinical Commissioning Group

# NHS Sheffield Clinical Commissioning Group

## Annual Report 2020/21

# Contents

# PERFORMANCE REPORT

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**Lesley Smith**

Accountable Officer

20 May 2021

# Performance Overview

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

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

It has been an unprecedented and challenging year, not only for the CCG but for the wider NHS and indeed the world, as we continue to respond to the COVID-19 pandemic.

The pandemic has touched us all. It has had an impact on the way we work, how we relate to each other, where we can go and how we communicate. It has also had a wider impact on family, friends, and communities, as well as the ways in which we engage with health and care services. Responding to the pandemic reshaped the way we work and redefined our priorities, to focus on managing the crisis as it unfolded, and on directly supporting the delivery of front line services through volunteering in GP practices and other services across the city.

During this uncertain and difficult time our staff, and staff working in GP practices in the city, came together in extraordinary circumstances to protect our city's most vulnerable people. We want to publicly acknowledge all your hard work and thank each and every one of you for how you have made a positive impact over the past year. We are proud of everyone's resilience in the face of uncertainty and how you have collectively supported one another.

Against this background we want to give you a small insight into some of the great work that has taken place over the past year in the response to COVID-19.

As cases of COVID-19 began to rise in Sheffield last year, we saw the impact on our NHS services as hospital admissions increased. The pandemic also had a real impact on primary care in the city.

GP practices in Sheffield responded rapidly to the pandemic threat and transformed how they work to ensure that they could remain open, continue to treat patients, and keep their staff and patients safe from the virus. Our practices quickly adopted telephone, online and video consultations for a wide variety of appointments. Face-to-face appointments have always remained available to those who needed to see a clinician, for example people who need to have a vaccination, cervical screening appointment or those who need physical examinations.

In April 2020 the CCG, in partnership with Primary Care Sheffield and Sheffield City Council, set up and managed a COVID-19 testing service for health, social care and voluntary sector staff, and members of their households, to reduce the spread of the virus. The service also offered testing for staff and residents in care homes to reduce the risk of outbreaks. The service complemented the national testing service.

A team of nurses from both organisations also provided support and training to staff within care and nursing homes to help them test their own residents and staff. Our CCG infection prevention and control teams worked jointly with Sheffield City Council to provide further training and support for care homes and provided mutual aid to ensure PPE was available.

Once COVID-19 vaccinations were approved in the UK, teams from GP practices and CCG staff worked around the clock to deliver the vaccine to people most at risk from COVID-19.

In Sheffield, groups of GP practices are working together in their primary care networks (PCNs) to administer the vaccine to their local communities and care homes via 15 community vaccination centres. All but one of these centres are based at GP practices in the city with the remaining one being at a church.

PCNs have also shown innovation in setting up pop up clinics in community buildings, such as mosques, in their local areas to target specific groups of patients. As well as vaccinating patients in local vaccination sites, primary care networks have worked hard to get out to all care homes for elderly residents in the city and deliver the COVID-19 vaccination to this extremely vulnerable group of people.

Our CCG teams are working with 26 community organisations in the city to encourage uptake of COVID-19 vaccinations, particularly in seldom heard communities. The organisations are developing appropriate activity to engage with their communities and share key messages, working in collaboration with smaller organisations in their communities to achieve maximum reach.

This is the biggest vaccination programme ever and we are so proud of how we have worked as a whole system in Sheffield to ensure our most vulnerable residents are vaccinated quickly. In the four months from starting in December 2020 to March 2021 we had delivered vaccinations to over 250,000 citizens in Sheffield.

We want to thank our Sheffield GPs, nurses, pharmacists, as well as many other support staff, including our own team from the CCG, who have all been working long hours and weekends to ensure some of the most vulnerable people are vaccinated and protected from this awful virus.

Aside from the CCG's response to the pandemic, our teams have worked with partners to continue to transform and improve services for Sheffield people. Over the past 12 months we have worked with partners to improve discharge from hospital by joining up the support people receive in their homes, we have supported improvements in end of life care and our city is rolling out an innovative mental health service in primary care. Children and adolescents now have round-the-clock mental health crisis support. Our medicines optimisation team have continued to support safe and effective prescribing across our practices.

Looking ahead, 2021/22 will be a year of managing the next phases of COVID-19 and striking a balance between managing current and future peaks in cases. Our focus will be on restoring our health services whilst remaining steadfast to our commitment to reducing health inequalities, working with voluntary and community organisations and involving Sheffield people in how we design and improve health and care services in the future.

As we move into the next year and beyond, we will be working with partners in Sheffield and across South Yorkshire and Bassetlaw to develop an integrated health and care system to improve the lives of Sheffield people.

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

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|---|---|
| Lesley Smith | Dr Terry Hudsen |
| Accountable Officer | Chair |

# About us: NHS Sheffield CCG at a glance

## Who is Sheffield Clinical Commissioning Group (CCG)?

We are a membership organisation made up of 77 GP practices. The CCG uses the clinical expertise of local doctors and nurses, supported by experienced managers and lay members, to commission (plan, monitor, and fund) health services.

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

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

During 2020/21 we reviewed the CCG's overarching strategy to ensure that it remained fit for purpose and reflected the new challenges and requirements of the COVID-19 pandemic.

## Our vision

Our vision is: "working with you to make Sheffield healthier".

## Our organisational objectives

Our five objectives are:

1. Reduce the impact of health inequalities on peoples' health and wellbeing through working with Sheffield City Council and partners
2. Lead the improvement of quality of care and standards
3. Bring care closer to home
4. Improve health care sustainability and affordability
5. Be a caring employer that values diversity and maximises the potential of our people.

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

We need to**:**

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

## Commissioning principles

We identified a number of principles in our Operational Plan, which was approved by our Governing Body in November 2020:

- We will live by our values when working with our staff, public and partners and when making decisions
- We will tackle health inequalities by designing and investing in services to support those people most in need
- We will involve people of Sheffield in our decisions, especially target those with the greatest health inequalities and in the poorest health
- Our work will focus on delivering value for money
- Our decisions will have a positive, long term impact on the people of Sheffield and the environment

## Our 2020/21 priorities

**Engagement in prevention**

- People will be better informed and will choose/be supported to make healthier lifestyle choices for themselves and their families

**Timely evidence based diagnosis and supporting personalised care/self-care/ management**

- Children have the best possible start in life and will grow into happy, healthy adults
- Staff feel confident in knowing how and where to signpost patients to have their needs effectively met
- Everybody will feel confident that they and their families' health and related needs will be identified, understood and addressed as early as possible

**Prevention and optimal management approach to the integration of all age physical and mental, primary and community services**

- People feel supported and empowered to manage their health in the most appropriate setting/community
- People feel confident that they are able to access the right service first time
- Staff will feel confident they are able to meet the needs of the whole population

Our other priorities:

- Continuing to respond to COVID-19
- Addressing health inequalities
- Ensuring resilient primary care
- Restoring secondary care services in the context of the ongoing pandemic (including services for mental health, learning disabilities, autism and dementia)
- Protecting the most vulnerable people

Our operational plan (November 2020) identified detailed priorities for each service area in order to respond to the Government's interim planning guidance, which asked the NHS to restore services and build future resilience. You can see our full operational plan for last year here: Re-prioritisation process for recalibrated commissioning intentions (sheffieldccg.nhs.uk)

## Key issues and risks

The CCG continually reviews all its services to ensure that they provide high quality services whilst being good value for money. This ensures that we work with providers so that patients receive the most benefit from the available monies and in 2020/21 this was reflected in our Quality, Innovation, Productivity and Prevention (QIPP) programme.

We have assessed our key risks and uncertainties throughout the year using the CCG's Governing Body Assurance Framework (GBAF) and our local corporate risk register. The GBAF sets out the risks to delivering our strategic objectives and how these risks are managed.

The GBAF is presented to the Governing Body quarterly at its meetings in public so that members can review the risks and mitigations and receive assurances that the risks are being managed. It is also considered by our Audit and Integrated Governance Committee (AIGC) prior to Governing Body meetings.

Further details on risk are included in the annual governance statement set out later in this document and can be found at page 85.

The highest scoring risk categories (Areas of Focus) at 31 March 2021 were:

**Strategic Objective 2 – Lead the improvement of quality of care and standards**

Risk 2.1 There is a risk that organisations fail to meet quality standards, resulting in reduced quality of services, increased patient safety risks and a lack of satisfaction in commissioned services. (Risk score 4 x 4)

Risk 2.2 There is a risk that system wide or specific provider capacity problems emerge in secondary and/or primary care to prevent delivery of statutory requirements of the NHS Constitution, Long Term Plan and 2020/2021 Operational Plan expectations. (Risk score 5 x 3)

Risk 2.3 There is a risk that we fail to effectively communicate with the public and involve patients in CCG and system priorities and service developments, leading to loss of confidence in CCG decisions and potential legal challenge or referral to the Secretary of State. (Risk score 4 x 4)

Risk 2.5 There is a risk that insufficient preparedness to deal with significant emergency events mean that if those events occur local health services may be overwhelmed distorting delivery of our priorities. (Risk score 5 x 3)

**Strategic Objective 3 – Bring Care Closer to Home**

Risk 3.2 There is a risk that there is insufficient resilience in primary and community care, in particular GP practices but also in the community pharmacy, care providers

and the voluntary sector, that we are unable to expand capacity in primary and community care. (Risk score 4 x 4).

**Strategic Objective 4 – Improve Healthcare sustainability and affordability**

Risk 4.4 There is a risk that the digital infrastructure that we have to deliver safe, efficient and high quality services is inadequately maintained / developed. (Risk score 4 x 4)

Risk 4.8 There is a risk that our collective risk appetite is insufficient to realise the potential of our plans. (Risk score 4 x 4)

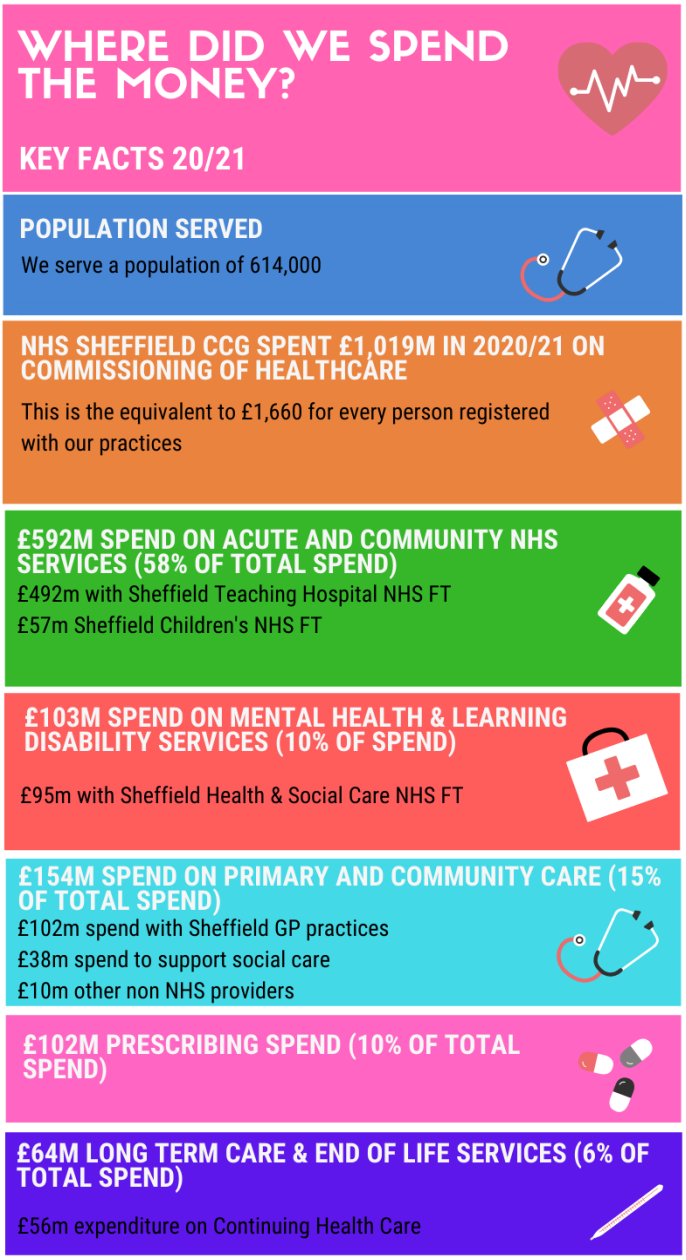
## Finance at a glance

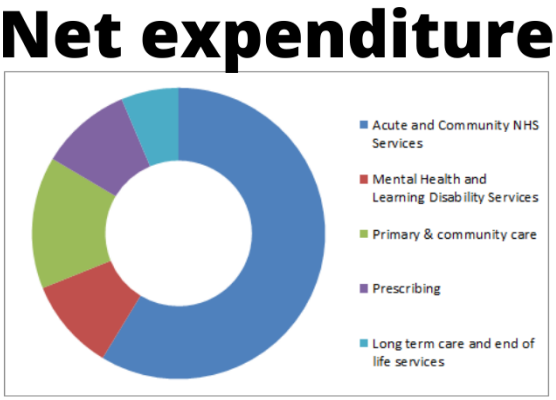
The response to the COVID-19 pandemic during 2020/21 has brought with it a number of financial challenges over and above that faced by the CCG in previous years. In March 2020, NHS England and Improvement confirmed the suspension of the normal financial framework; with previously published CCG allocations replaced by revised allocations based on historic spend, adjusted for the expected impact of the COVID-19 response. NHS Sheffield CCG has worked with partners to commission additional services to support the pandemic response e.g. additional in hours GP 'hot hubs' to review patients with potential COVID-19 symptoms and additional mental health support services. In addition, the CCG was able to draw down funding, based on actual spend, to support patients to be discharged from hospital on a timely basis, ensuring that hospital capacity could be protected to support treatment of the sickest patients. In total the CCG incurred costs of £22.3m directly in relation to the CCG's COVID response, of which £17.1m was drawn from the national Hospital Discharge Programme funding. A breakdown of this funding is shown below:

| Spending on COVID Support Activity | Actual Expenditure £000's |
|---|---|
| Community and social care packages to support discharges from hospital | 16,710 |
| Capacity and Additional Support for specific patient groups in primary care | 4,409 |
| Voluntary sector and hospice wrap-around support for care homes and patient discharges | 707 |
| Schemes to support additional mental health needs | 135 |
| Additional staff capacity to support the response | 192 |
| Other | 154 |
| **Total** | **22,307** |

In addition to expenditure directly incurred, the CCG transferred funding of £62.9m in 2020/21 to Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Children's NHS Foundation Trust and Sheffield Health and Social Care NHS Foundation Trust that related to additional funding to support the response to the COVID-19 pandemic, as well as system top up funding calculated to meet the expected expenditure of those providers.

Despite the changing financial circumstances, the CCG retains a statutory duty to contain expenditure within the funding allocation issued by NHS England. The CCG is pleased to report that we achieved our statutory financial duties as an NHS commissioning organisation. Our financial accounts, appended to this Annual Report, demonstrate delivery of a small in-year surplus of £3,032k, of which £32k relates to CCG activities and £3,000k relates to the surplus of the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) for which Sheffield CCG is the host organisation.




## Financial Performance 2020/21

We spent £1,019m to commission health care services for the people of Sheffield and a further £14.5m on behalf of the South Yorkshire and Bassetlaw ICS.

Overall, we spent an average of £1,660 per person on health care for the people of Sheffield (compared to £1,479 in 2019/20). The table at the side provides a summary of where the money was spent. It includes spending against external income as well as our revenue resources received from NHS England.

£22.2m was spent directly on services to manage COVID-19 (as described in the previous section)

Our running cost allowance was £12.1m. This is used to fund the commissioning, governance costs and clinical engagement activities of the CCG and its localities. In 2020/21, our actual spend was £11.5m (an underspend of £0.6m). This equates to £18.73 per head of population (compared to £18.20 in 2019/20). We used this underspend to support our commissioning of health services.

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

# A look back over our year

Over the past year, we've done lots of work at the CCG and with our partners and stakeholders across the city, particularly in the response to COVID-19. It's impossible to capture all this work into one document but we want to give you a flavour – here's a quick look back at some of the achievements of 2020/21.

## NHS Sheffield CCG invests over £25,000 into cancer information hub

In March 2020 the Sheffield Cancer Information Hub in the city centre expanded its service, thanks to an additional investment of almost £26,000 from NHS Sheffield Clinical Commissioning Group.

The hub, which opened in October 2017, is based in the Moor Market and provides shoppers with cancer information and support in an informal, non-medical setting.

The hub is run by the Cavendish Centre and from March its services were extended to provide information, advice and sign posting for a range of other long term health conditions such as Chronic Obstructive Pulmonary Disease (COPD), a long term lung condition; diabetes; mental health conditions, as well as living with, and beyond, cancer. Other organisations and services will run the stand on a pop up basis offering information and support on other long term conditions.

Some people find going to their GP daunting but the hub at Moor Market offers a relaxed, informal place for people to get information and support and to find out about some of the fantastic services available to them across the city. During the pandemic the hub opened as allowed in line with social distancing and lockdown guidance.

An evaluation of the hub from 2018/19 found that 12% of people were repeat visitors to the service, highlighting that it's working really well as a support network for people, which is one of the many benefits of the hub.

## Sheffield COVID-19 testing service helps fight the spread of the virus

The Sheffield COVID-19 testing service was set up with the aim to reduce the spread of the virus in care and residential homes by testing staff and residents, and in the wider community by providing access to testing for NHS and Council staff.

The COVID-19 testing service for health, social care and voluntary sector staff, and members of their households, was set up in April by NHS Sheffield Clinical Commissioning Group (CCG), Primary Care Sheffield Ltd (PCS) and Sheffield City Council.

The service complemented the national testing service for care homes, by ensuring when residents had symptoms the tests were completed and results confirmed quickly to patients and staff protected.

Testing staff without symptoms helped us to gather evidence on the number of infections in care home staff. Early detection helped with reducing the spread of infection.

A team of nurses from the CCG and PCS provided support and training to staff within care and nursing homes to help them test residents and their staff.

As well as providing testing to care homes, the Sheffield service also offered testing to primary care health staff, social care staff and voluntary sector staff who had symptoms, as well as members of their households who had symptoms.

When the service was set up it had the capacity to test up to 100 people a day in drive through centres.

There were three testing centres across the city offering appointments as early as the day after a referral. The service was provided by nurses and health care assistants who offered help and support for people taking the test in a safe environment.

## Sheffield sets out its commitments to children and young people with special educational needs and disabilities

In June, NHS Sheffield CCG and Sheffield City Council set out their commitments to children and young people with Special Educational Needs and Disabilities (SEND) in a strategy document.

The inclusion strategy sets out Sheffield's plans to provide more high quality provision to meet the growing demand for services; reduce waiting times for specialist support; provide training to schools and nurseries so that they have the knowledge and skills to identify needs early and provide key workers for the most vulnerable children.

Feedback from children, young people and their families made it clear that we can do better in making sure they are at the centre of all decision making and that services meet their needs in a timely and co-ordinated manner. Based on all the research, consultation activity and feedback we have received we have developed a number of commitments in partnership with Sheffield City Council to change the way we work.

Our vision is that we are able to act early to identify, assess and meet needs, work in partnership and establish integrated and locally based processes and services that make Sheffield a more inclusive city.

Following a local area inspection in November 2018, we have been working hard across the city to improve the services and expectations of children with SEND. We know that there is still much to do. The strategy, written with young people, parents, front line professionals and leaders, is our plan to make sure everyone has confidence in our ability to meet the needs of young people and their families.

## Vulnerable benefit from new home visiting service

Over 700 vulnerable people in Sheffield have so far benefitted from a new service set up by a group of GP practices and funded by NHS Sheffield CCG.

The Sheffield GP practices who make up the Sevenhills Primary Care Network set up the new home visiting service in response to the COVID-19 pandemic so that vulnerable and frail

people who may not be seeking help as they normally would can be seen and don't have to come into the GP practice.

Sevenhills Primary Care Network is made up of a group of five GP practices covering Darnall, Tinsley and Handsworth including two practices managed by Primary Care Sheffield, and during COVID-19 has been joined by Primary Care Sheffield's five additional practices across the city. They cover a total patient population of 47,000 people.

By working together the practices can provide more personalised and coordinated health and social care, supporting people to gain control of their health and wellbeing, helping them to live well and independently as well as reducing ill health and unnecessary hospital admissions. As part of the visits, patients with long term conditions such as diabetes, heart disease and chronic obstructive pulmonary disease can be safely seen at home by a healthcare assistant for their review and check-up rather than having to come into the practice like they usually would before COVID-19. The visits are also helping to tackle isolation and vulnerability.

Patients will have tests depending on their condition, such as bloods, urine, blood pressure, heart rate, weight and foot checks. They are also asked what their biggest worry is to identify any unknown clinical and social issues that they could receive help with.

After the visits, the results are reviewed by a GP and they have a remote consultation with a practice nurse over the phone to talk through the results. The practice nurse can then refer them to the relevant people such as a pharmacist for a medicine review, a GP, physiotherapist or link worker depending on their needs.

The home visiting service is making a massive difference to patients in the area. Just some of the examples of people they've been able to help are a 90 year old diabetic who thought they was okay but actually turned out to need an urgent GP appointment due to some worrying symptoms and an 80 year old diabetic whose blood sugar has drastically improved since being seen.

They have also seen and been able to help people who are struggling to buy food, people worried about their memory, weight gain, and people dealing with pain or not able to get around the house.

The CCG gave the Sevenhills Primary Care Network £32,000 of funding to support their response to COVID-19.

This project won the Health Service Journal (HSJ) Primary Care Innovation award in March 2021, a great accomplishment for all involved.

## Sheffield CCG nurse co-authors national COVID-19 training

A nurse from NHS Sheffield CCG has co-written national training to support care homes during COVID-19, which has been published by the Infection Prevention Society.

Lisa Renshaw, an infection prevention and control nurse, co-wrote the COVID-19 infection prevention and control training package for care homes, alongside Professor Jennie Wilson, vice president of the Infection Prevention Society.

The Infection Prevention Society is an independent charity with a 2,000 strong member network. Their vision is that no person is harmed by a preventable infection and they support members through educational opportunities and associated resources.

The care home training package is being used by care homes nationwide to support the roll-out of infection prevention and control training and includes information about managing COVID-19 outbreaks. It also has instructions on taking swabs to test residents for the virus – with the aim of reducing the impact of the virus.

Lisa's role at the CCG involves assisting GP practices to comply with national legislation around social care provision by providing advice and support as and when necessary, as well as supporting Sheffield care homes to comply with infection prevention and control national requirements.

Donna Pierpoint, Manager of Broomgrove Nursing Home in Sheffield which received the care home training package, said: "The training package has been an invaluable resource for all of our staff during the pandemic. It's enabled us to have clear and precise information and guidance that can be accessed and referred to at any time, which has helped to keep our residents and staff safe."

## New Sheffield service supports people to access mental health support

In June a new specialist mental health service was set up in Sheffield in order to meet the needs of a group of people who have not been able to access this kind of treatment before.

The service, which is being delivered from GP practices, tests different ways of delivering support for patients with serious mental illness, who have not previously been supported by specialist services.

Sheffield is one of 12 national sites selected by NHS England to test new ways of delivering how primary and community mental health services are provided.

As a result of being selected to test the new service, Sheffield has been able to invest an additional £2.4m per year into mental health services. This has increased the number of staff available and the range of support that can be offered in general practice.

A new team was set up during the COVID-19 pandemic and includes the health and voluntary sector. The team is based in GP practices and is working with adults who have serious mental illnesses and complex needs which local Improving Access to Psychological Therapies (IAPT) services can't help, but are not complex enough to require a specialist mental health team's help. Some of the conditions seen by the service include anxiety and panic, mood problems, personality disorder, trauma and post-traumatic stress disorder.

Patients are seen close to their home and access to services is quick as GPs can book patients directly in to the specialist team without having to wait for a referral. Patients are still able to access other mental health services where required.

The service is being delivered in partnership by NHS Sheffield CCG, Primary Care Sheffield, Sheffield Health and Social Care NHS Foundation Trust, Sheffield Mind and other voluntary sector partners, in collaboration with the South Yorkshire and Bassetlaw Integrated Care System.

Poor mental health is one of the biggest health challenges in our society with one in four people suffering from mental health issues. It has a significant impact on life expectancy and wellbeing. It is hoped that this programme will enable more people to access mental health support appropriate for their condition.

The service launched in June 2020 despite COVID-19 and, in the first month alone, 195 patients who were previously unable to get existing mental health support, were seen. This is a very necessary service which has been welcomed by patients and GPs alike.

## CCG funded home blood testing service for housebound and home restricted patients

A new home blood testing service was set up for patients who are housebound, home restricted, or struggle to come into a practice because of mobility or social reasons.

A group of Sheffield GP practices, known as HeeleyPlus Primary Care Network, set up the phlebotomy service with funds from NHS Sheffield CCG during the pandemic.

HeeleyPlus is made up of nine GP practices covering 50,000 patients in the South East of the city.

Due to the pandemic, the numbers of home restricted patients increased dramatically as people needed to isolate and shield to protect their own health and that of others. Patients were also unable to access practices due to public transport restrictions and practices saw increased numbers of patients struggling to attend due to social situations or anxiety around the pandemic.

People who are housebound or home restricted often require more medical support due to their health and social situation. Alongside blood tests the new service offers long term condition checks, medication reviews and investigations, with the aim of preventing them becoming unwell. The service sees around 70 people a week.

The service is making a real difference to patients and has become more than just a blood testing service.

During visits, staff have been able to identify where patients are struggling socially, with isolation, mental health or with care needs and have made referrals for them to see a GP or

community service for additional support. A phlebotomist also built up such a positive relationship with a needle phobic patient that they were able to get a successful sample first time and increase the confidence of the patient for further visits.

## Keeping patients safe during COVID-19

During the ongoing COVID-19 pandemic, GP practices in Sheffield have remained open and made changes to the way they work to keep their staff and patients safe. During the first six months of the pandemic, over 19,000 items of Personal Protective Equipment (PPE) were delivered to GP practices from the CCG, these included items such as face masks, visors, gloves, disposable aprons and specialist cleaning equipment.

At the start of the pandemic, practices changed the way they offered appointments and moved to online triage and telephone/video consultations for those patients who don't need face to face appointments. In the first six months of the pandemic there were 4,975 online triage sessions.

Face to face appointments continued to still be available to those who need to see a doctor or nurse - for example people who need to have a vaccination, cervical screening appointment or those who need physical examinations.

In these cases, staff wear PPE and processes are in place in practices to reduce the risk of spreading the virus including asking patients to wait in their vehicle or outside until their appointment and wearing a face covering when inside, apart from in exceptional circumstances.

The pandemic has highlighted the huge challenges and risks health workers face including health care associated infections, violence, stigma, psychological and emotional trauma, illness and even death in some cases.

It's really important that we keep our staff safe from the virus, if our practice staff are healthy and protected from the virus as much as possible, it means they can continue to be available to offer appointments to their patients. It also means that they can provide safe care to their patients and minimise the risk of passing the virus on.

## COVID vaccination centres up and running

In December we started the roll out of the vaccination programme at GP practices in Sheffield. Three GP surgeries in the city kick started the mass roll out of community vaccine on behalf of 18 neighbouring practices.

Freda France, a 90 year old from Sheffield, was the first person to be given the Pfizer vaccine at a GP practice in the city.

By January all 15 local vaccination centres in Sheffield were set up. Groups of GP practices are working together in their primary care networks (PCNs) to administer the vaccine to their

local communities and care homes via 15 community vaccination centres. All but one of these centres are based at GP practices in the city with the remaining one being at a church.

Practice staff also visited care homes in their areas to vaccinate residents and staff in the homes.

Some local vaccination centres have taken innovative steps to reach more people by setting up pop up clinics in community settings such as mosques.

GPs, pharmacists, nurses, admin staff and volunteers have all been working incredibly hard to deliver the vaccine programme to their patients and in care homes, at the same time as continuing to provide care to all those who need it. It's a great achievement to vaccinate so many people, thereby saving lives.

A team from the CCG have co-ordinated the vaccination programme, supporting local vaccination sites in setting up the centres, co-ordinating delivery of vaccines from NHS England and ensuring sites have all the latest guidance.

## Supporting CCG staff

### Staff health and wellbeing

In August 2020 the CCG began reporting on a number of indicators relating to our workforce and to their experiences of working through the COVID-19 pandemic, and how the CCG was supporting staff to remain healthy and to work effectively. A key aspect of this was supporting staff to adapt to remote working and video conferencing, which has had many positive aspects, not least reduced travel time for staff and reduced carbon footprint for the CCG.

The majority of our staff were working from home throughout 2020/21 and the CCG actively worked to support staff to manage the negative impacts of this.  Our staff reported many advantages to working at home, but also told us about problems such as; isolation, psychological stress, musculo-skeletal problems due to not having ergonomic working spaces at home, and balancing work with caring responsibilities and home schooling. We have established a staff-led forum for parents to provide mutual support around managing child care with work and supporting children with their anxieties around the pandemic.

The CCG has sought feedback from staff about their experience of working remotely and their physical and mental health through a regular 'temperature check' survey. The feedback received helped the CCG to design interventions to support staff, for example, creating opportunities for staff to remain socially connected and to boost team work and morale.

The CCG ensured that staff have access to one to one physiotherapy advice to support them with any problems caused by working at home in less than ideal conditions, as well as virtual drop in advice sessions and support to keep active, such as online Pilates sessions. All staff had confidential discussions with their line manager and risk assessments undertaken around any factors which are affecting their physical and/or mental wellbeing and action plans to support them to maintain good health. We ran a winter wellness campaign to support staff to

cope with the impacts of the ongoing lockdown, changed working patterns and potential isolation; this included encouraging and empowering staff to take regular breaks and to get outside and away from their computer during the working day.

We encouraged staff to receive the influenza vaccine, we offered some vaccination sessions at our headquarters and gave vouchers to receive the vaccine in pharmacies. This was part of ensuring that our workforce remained well and is a normal part of our winter resilience planning. Seventy nine per cent of our staff were vaccinated against flu in 2020/21.

**Developing the skills of our staff**

There is a wealth of expertise amongst our staff and during 2020/21 we harnessed this to deliver personal and professional development sessions for colleagues on topics such as time management, developing positive habits and tackling negative self-talk. Coaching continues to be available to staff as well as group supervision for people who are line managers. A range of mental health support opportunities are in place, both in-house, such as our trained Mental Health First Aiders, ‘time to talk’ sessions and suicide prevention awareness, and external services such as our Employee Assistance programme. We have held in-house sessions on coping with change, developing resilience, managing and preventing back pain, and using mindfulness techniques to manage stress.

We continued to offer development opportunities to line managers through online supervision sessions and coaching and support managers to identify staff who were struggling, offering support and signposting to further help. Our in-house course Management and Leadership Training in Sheffield (MALTS) ran again this year, but was delivered online. This course is delivered by our own staff and continues to be well evaluated by those who participate.

**Equality and diversity in the workplace**

Our commitment to equality, diversity and inclusion has been reflected in a number of initiatives led by our equality, diversity and inclusion group, a group of staff who meet regularly to discuss and plan how we as an organisation can become more inclusive.

Through the planning of this group we have held a number of virtual events for our staff, see the section below on our duties on diversity and inclusion. We acknowledge and recognise religious festivals and celebrations in our staff communications and have delivered learning lunches on topics such as health issues facing different groups including young carers and transgender people and the experiences of young LGBT people. These activities reflect our desire to be an inclusive employer and also to develop a workforce which has the knowledge and awareness to commission services for all our diverse population.

The CCG has many women in senior roles, but more needs to be done to increase the number of staff members from Black, Asian and Minority Ethnic (BAME) backgrounds and to address the imbalance in BAME staff in senior roles. We want to be an organisation that truly reflects and represents all our communities. We are working with our staff, particularly our BAME staff, to look at how we can address inequalities at the CCG. This includes setting up a BAME staff network that we hope will offer peer support and networking to our BAME staff, inform our policy around equality issues, and raise awareness of issues facing our BAME colleagues. We

want to listen to the lived experiences of our staff and use these experiences to learn and develop and make our work place more inclusive, as well as helping us to reflect on our role as a commissioner for the whole population of Sheffield.

## Developing our culture and fulfilling the potential of our staff

### Our duties around diversity and inclusion

In previous years we have invested in staff training to raise awareness of the organisation's legal duties around public involvement and equality. This training has helped our organisation to be more aware of the requirements and benefits of involving people in our work.

We have built upon this by continuing a series of learning sessions for our staff based on the protected characteristics of the Equality Act 2010. Through these sessions, we invite a member of the public or staff member with a protected characteristic to discuss their experience of receiving services and the challenges and barriers they have faced.

The CCG Equality Group was originally set up to look at promoting equality and diversity within the CCG. The group has since extended, welcoming a varied and diverse membership including individuals with an interest in equality and diversity issues, and representation from teams across the organisation. This group has been involved in coordinating many extra sessions for staff to learn and discuss a wide variety of topics such as:

- Black Lives Matter
- Black History month
- LGBT+ History month
- Eating Disorder Awareness week
- Rainbow badge accreditation scheme

This is bringing a great insight into the communities we serve and how we can work towards reducing the health inequalities that exist.

### COVID learning group

The CCG established a COVID learning group to capture the ideas and experiences of our staff, to support a culture of innovation, and to ensure that our senior team understood the impacts of COVID, lockdown and remote working on our staff. This included developing how the organisation would make the most of the positive aspects of working from home, how we could maintain good communication, and suggestions about how to stay healthy and be effective during this challenging time. Staff were encouraged to contribute their views to shape the CCG's strategy around how we should conduct our business during the pandemic, and planning for the future. This included contributing to policies around home based and flexible working, differing ways of working in and across teams, maximising the use of IT, and ensuring that the good things and positive changes which had come about would continue. Staff generously shared their experiences, the highs and lows, and tips on what had helped them to cope.

## Improvement plan

NHS Sheffield CCG underwent an external review in 2018/19 commissioned by our regulatory body, NHS England, which looked at a number of issues around our leadership, culture, staff involvement and how we developed and communicated our strategy. An improvement plan was developed with our staff to address these issues. The plan was endorsed in July 2019 by our Governing Body and our staff were involved in progressing the actions and feeding back their views on the impact of the improvement plan.

Progress on implementation of the 76 actions was monitored and reported to our Governing Body each month. A steering group, chaired by one of our Governing Body lay members, and attended by our accountable officer and a cross section of staff, had oversight of the plan, with a particular remit to ensure that we were developing a culture where staff felt valued and empowered.

Our final update on the improvement plan was reviewed at a public Governing Body meeting in June 2020 and the plan was signed off as having achieved its aims. It was considered that the actions from the improvement plan had enabled improved communication, particularly around our aims and strategy, that our senior leadership was more visible, and that our staff felt better supported. This progress had laid a vital foundation for the CCG as we adapted to deal with the challenges created by the COVID-19 pandemic.

The CCG's auditors, 360 Assurance, undertook a review of the improvement plan on their chosen theme, which was staff engagement. The auditors looked in detail at 10 selected actions to consider evidence to support implementation and to what extent the changes had been embedded as business as usual. The auditor's opinion was that there was significant assurance that staff engagement was a core part of our organisation's culture and practice.

## Cultural change

Many of the initiatives for staff development and wellbeing which are reported on in this annual report were started as part of implementing the improvement plan, but we have gone much further in terms of development of a supportive culture whereby the fantastic energy and talents of our staff can thrive.

The CCG commissioned a well-established consultancy, The Pacific Institute, to deliver a bespoke development programme for all our staff, including governing body members. The Pacific Institute was founded in 1971 and has international experience of working with both public and private sector organisations. Sheffield CCG's programme was called "Onwards and Upwards" and was designed to empower staff to contribute to our collective culture and to enrich us with new skills, including leadership and problem solving skills. There was a strong emphasis in the programme around looking at how values shape behaviours, how staff can learn to address barriers which stifle their ability to innovate; developing a positive mind set to free up individual and team potential, and how to create the conditions for creative thinking. A small cohort of staff have trained to be trainers and facilitators and are delivering a modified version of the training to other staff, this has continued into 2021/22. Some of the key elements of the programme have been included in refresher sessions for staff, led by our learning and development team.

### Openness and transparency

When the pandemic started, we moved our staff briefing, a regular meeting with the senior management team and staff, to a virtual meeting and increased the frequency from monthly to every two weeks. The virtual sessions are recorded for any staff that are not able to attend live.

Our senior leadership team have provided a regular update on the situation regarding the pandemic, clarity around the CCG's key priorities, and have showcased the work of different teams. This format allowed greater staff participation, raised the profile of members of the governing body amongst staff and provided reassurance for staff and a way of connecting whilst most of us were working away from our headquarters. We have also offered virtual drop in sessions with directors so that staff can talk to our executive team members in confidence to feedback ideas, ask questions and share their experiences of the new ways of working we have adopted.

Our chair and accountable officer used virtual staff briefings to keep staff informed regarding the ongoing conversations about the NHS white paper and the journey of integrating care in neighbourhoods, places and across the system that we have been on in Sheffield for many years. The CCG has made a commitment to embark on a collaborative approach to the transition with our staff. The aim is to co-create the future with our staff underpinned by the national commitment to minimising uncertainty, offering stability while the transition to the expected new working arrangements take place.

## Looking ahead to 2021/22

### Joint health and social care plan for 2021/22

Looking ahead to the medium term, NHS Sheffield CCG and Sheffield City Council agreed a joint health and social care plan for 2021/22. This is an exciting development of our joint working, which was endorsed by our Governing Body in March 2021. This plan includes 18 joint commissioning intentions for the CCG and City Council; reducing the impact of health inequalities which runs through all these intentions, as well as supporting thriving communities and better health and wellbeing.

The 18 joint intentions cover a number of themes, with a sample of some of our intentions as follows:

- Communities and voluntary sector – for example, improving access to care and health outcomes for people from the most vulnerable groups
- Ongoing care – for example, developing personalised approaches to long term condition reviews, so that people can be better supported to manage their own health whilst living with a long term condition
- Children and families – for example, improving services that help children who have experienced adverse childhood events
- Mental health and learning disability – for example, improving access to crisis services throughout the week, for both adults and children; and delivering all the recommendations in our city wide dementia strategy
- Frailty – develop a service that can assess people's ongoing support needs in their own home setting.

Our vision for 2021/22 will be delivered by closer working with the City Council, the voluntary sector and by continuing to seek the views of our citizens and patients, and working with them to design the care they need.

The CCG has a number of priorities for 2021/22 which are not joint priorities with the Council as they are more clinically focussed and these include redesigning community phlebotomy (obtaining blood samples from patients), supporting the recovery of elective services post pandemic, ensuring that we have resilient primary care, and improving care at the end of life.

**Future plans for South Yorkshire and Bassetlaw Integrated Care System**
With the February 2021 publication of the government's white paper, 'Integration and innovation: working together to improve health and social care for all', the South Yorkshire and Bassetlaw Integrated Care System is set to evolve into a statutory body by April 2022. Sheffield CCG, along with all other CCGs in England, will be abolished and the functions and staff from the five CCGs in SYB will transfer into the new SYB ICS NHS body.

There will still remains a strong Sheffield place-based commissioning presence and Sheffield CCG continues to work in collaboration with the other SYB health and social care organisations to ensure that we take advantage of these system changes to further integrate care and improve the health outcomes for our local populations.

Organisational change can be unsettling for staff and, as described in the section above on openness and transparency, the CCG has made a commitment to undertake a collaborative approach to the transition with our staff.

# Performance analysis

## Delivery of NHS Constitutional Standards and secondary care performance overview

This section of the report provides an overview of the impact of COVID-19 on key standards in the NHS Constitution and other key performance measures. It also briefly describes some of the ways that the service adapted to continue providing safe care.

There were significant changes to the healthcare system in Sheffield as a number of measures were put in place to respond to the COVID-19 pandemic.  Additional hospital capacity needed to be created to treat very sick patients which meant that providers needed to deploy their staff and facilities differently. Additional infection control measures and the need for physical distancing meant that there was reduced outpatient and theatre capacity available, and fewer inpatient beds available at times of peak COVID-19 infections.  Staff sickness absence was also a factor; all these issues combined to affect performance in every area of health care.

In order to reduce the burden of reporting, and to free up resources for managing the pandemic, many of our regular reporting requirements were temporarily suspended at the start of the pandemic by NHS England and Improvement (our regulatory body). This included the

reporting of cancelled operations, delayed transfers of care, mixed sex accommodation and patient experience surveys. Most of these remained suspended at the end of the year.

At the start of the pandemic, national guidance was issued to NHS hospitals and community services to prioritise responding to the pandemic so that maximum capacity and flexibility could be freed up for patients who were very sick with COVID-19. At this stage, the NHS was in a new situation and the level of need or the duration of high numbers of infections could not be predicted. This meant that all 'non-essential' services were stood down as capacity was moved to support critical care and the high numbers of very ill patients being admitted to hospitals. This continued to be evident particularly during the second / third waves from November 2020 to March 2021.

Significantly fewer people attended accident and emergency (A&E) services during the first months of the pandemic, which led to an improvement in the four hour waiting standard in the earlier part of the year, which then worsened as numbers attending increased, including people presenting with mental health crises. A significant number of people who were transported to A&E by ambulance were acutely ill, and this translated to longer ambulance handover times, resulting in deterioration in performance against this standard.

As the pandemic progressed it became clear that there was also a pressing need to ensure that services were in place for regular non–COVID illness, and that some capacity needed to be made available for urgent elective surgery, and cancer diagnostics and treatments. All services, including general practice, sought to balance bringing services fully back on line, with the need for safety and the need to respond to patients presenting with COVID-19.

Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Children's NHS Foundation Trust strove to reinstate their elective activity in line with national COVID-19 planning guidance although progress was hampered during the second surge of cases over the winter. This meant that patients were waiting longer than usual. Providers sought to manage this situation by undertaking clinically-led assessments on patients to make sure that those who were at most risk were treated more urgently.

In line with national guidance our provider partners developed alternatives to physical, face to face services where possible, for example outpatient appointments via telephone or online. Some mental health services also transferred online (e.g. talking treatments such as Improving Access to Psychological Therapies, or IAPT). The IAPT service ran some new services as online groups, for example the "Coping with COVID" course which helped people to discover self- management tools for stress, anxiety and sleep disturbance.

COVID-19 was classed as an ongoing national critical incident throughout 2020/21, at various times the level of national alert was escalated and de-escalated. Collaborative working with the wider health care system across South Yorkshire and Bassetlaw was an important feature of how we responded to the pandemic. All the CCGs and NHS Trusts across the patch worked together, facilitated by the locality team at NHS England, via daily conference calls (later reduced to three times a week and then weekly). The system was able to provide mutual aid to ease pressure points, sometimes re-deploying specialised staff into other settings, accepting

transfers of patients from out of area to ease bed shortages, and assisting with equipment and supplies where there were temporary supply issues.

The focus at the end of the year was on the impact that COVID-19 had made on the overall delivery of services, and the subsequent backlogs and additional waits, with national concern about the medical and psychological impact of this on patients in need of treatment. There was understandable concern about cancer waiting time standards across England, however, as the year closed there were signs that the position against the three 62 day waiting time standards was improving, the size of the priority list was stable and the overall number of long waiters continued to fall.

In the last three months of the year it had become clear that there was significantly increased demand for mental health services. This encompassed people who had been living with mental ill health for some time and were known to services, and who had become more unwell due to the stresses associated with COVID-19 and lockdown, and people who were experiencing mental ill health for the first time. There were significant pressures on mental health inpatient beds and specialist services and this was expected to be an ongoing challenge into 2021/22.

The CCG would like to acknowledge the extraordinary efforts of our provider partners in responding to the COVID-19 pandemic, whilst continuing to offer the usual services which our citizens need to access. As the commissioner for Sheffield patients we are aware that many people have not been able to access services in the timely way that we would all like to see and we will continue to work with system partners to address this is as a priority.

## Emergency Preparedness, Resilience and Response (EPRR)

**Overview**
Emergency Preparedness, Resilience and Response (EPRR) is defined by a series of statutory responsibilities under the Civil Contingencies Act (CCA) 2004 and the Health and Social Care Act 2012. This legislation requires NHS organisations to maintain a robust capability to plan for, and respond to, incidents or emergencies that could impact on their communities. The CCA specifies that CCGs are classed as category two responders. We work with local agencies such as Sheffield City Council, South Yorkshire Police and South Yorkshire Fire and Rescue Service.

The CCG has policies and procedures in place which enable us to respond to incidents such as severe weather, to ensure that we can continue to deliver our critical business operations, as well as to support our partners in the event of a major incident or emergency such as the COVID-19 pandemic.

The EPRR assurance process was streamlined by NHS England and Improvement in September 2020 in view of the necessary response to the COVID-19 pandemic. In previous years this involved demonstrating evidence against the EPRR core standards, however, the requirements for 2020/21 were simplified requiring answers to three specific elements. Following a review of the standards contained in the assurance process, the CCG was once again assessed as substantially compliant; two out of the 43 standards were deemed not fully compliant and an action plan was put in place to address this.

**Response to the COVID-19 Pandemic**

The COVID-19 pandemic was exceptionally challenging and the CCG's command and control and Incident Control Centre (ICC) was in operation from early March 2020 and then throughout the year. A seven day operating model was initiated, as directed by the National DHSC EPRR Strategic Commander.

The CCG took on the role to co-ordinate the response across primary care and the wider healthcare system. This included chairing the city wide health and care co-ordination gold cell, which was undertaken by the CCG's senior responsible officer for EPRR (our Deputy Accountable Officer, Brian Hughes).

The CCG also had its own internal systems in place to support primary care, care homes, and to deploy our own workforce in the most effective ways at peak times of need. This included specialist infection control advice and co-ordination of the distribution of PPE. The CCG played a vital role during the pandemic in communicating with general practices, community pharmacies and the voluntary sector and ensuring consistent messages, particularly as the vaccination programme got under way.

Our corporate response to COVID-19 included: a risk log which was kept under active review, a formal log of the key decisions which were taken, clear lines of decision making and communications for our staff, senior clinical leadership and advice and close liaison with all our providers and the primary care networks.

**Responding to European Union (EU) Exit**

The EU Exit Senior Responsible Officer (SRO) role was assigned to the Deputy Accountable Officer who was supported by the EPRR lead. The CCG worked with health and other partners to ensure that we were well prepared for the potential impacts of the EU Exit transition period.

National arrangements had been put in place to strengthen the supply of medicines, medical devices and clinical consumables, which included the creation of national buffer stocks and securing of freight routes for high priority items, which meant that we did not need to create local stockpiles of any items.

The CCG completed daily situation reports to NHS England from 1 January 2021 submitting a 'no concerns' response, until the requirement for this report ceased on 31 March 2021.

## Sustainable development

The CCG is a socially and environmentally responsible organisation. The Social Value Act 2012 requires us to consider how to use contracts to improve the economic, social, and environmental well-being of our communities.

We remain committed to the NHS Carbon Reduction Scheme and there is an ongoing focus to reduce our direct building related greenhouse gas emissions, business travel and waste going to landfill. We have ensured that all procurements have clauses requiring sustainability actions and all our core providers have sustainability plans in place, including the economic, social, and environmental wellbeing of our local communities.

NHS Property Services Ltd has provided our utility and waste data for 2020/21 for our premises at 722 Prince of Wales Road, Sheffield.

*CCG occupied consumption and spend for 2020/2021*

| Consumption | | | Cost | | |
|---|---|---|---|---|---|
| Electricity – kWh | Gas - kWh | Water – $m^3$ | Electricity | Gas | Water |
| 216,092 | 148,668 | 1,352 | £40,622 | £4,789 | £3,982 |

*CCG occupied consumption and spend for 2019/2020*

| Consumption | | | Cost | | |
|---|---|---|---|---|---|
| Electricity – kWh | Gas - kWh | Water – $m^3$ | Electricity | Gas | Water |
| 366,789 | 498,612 | 20,638 | £62,920 | £18,405 | £2,540 |

**CO2 emissions to atmosphere**

During 2020/21, 144 tonnes of CO2 to atmosphere was created by electrical and gas usage by the CCG, the equivalent energy used could power a light bulb for approximately 8,903,200 hours (1,016 years). Due to the reduction in the numbers of staff attending the CCG office during the COVID-19 pandemic, our CO2 to atmosphere has significantly decreased by 146 tonnes from the previous year. We continually examine our internal processes to ensure we meet our obligations through initiatives such as the use of technology to further embed paperless working, and the publication of our sustainable development management strategy and action plan in line with national best practice.

**Printing and paper**

We have reduced printing costs by changing all default printer settings to monochrome which will help to reduce our carbon footprint, as well as replacing our printing paper with recycled paper which is from the nationally contracted products list, also used by other NHS organisations.

| | 2019/2020 | 2020/2021 | Reduction |
|---|---|---|---|
| Sheets | 1,820,163 | 164,991 | 1,655,172 |
| Reams | 3,640 | 330 | 3,310 |
| Boxes | 728 | 66 | 662 |
| Trees (paper equivalent) | 140 | 13 | 12 |
| CO2 produced/kg | 14,790 | 1,324 | 13,466 |
| Equivalent light bulb hours (years) | 926,000 (106) | 82,895 (10) | 843,105 (96) |

**Waste recycling**

The CCG is committed to recycling within the organisation. Members of staff and visitors are encouraged to separate their rubbish into dedicated recycling containers which are located on both floors of 722 Prince of Wales Road.

The CCG introduced a number of recycling schemes including recycling of batteries and pens, and in the short period that the scheme has been running, the CCG has redirected 9.26 kg of batteries away from landfill to be recycled.

Sustainability forms part of the culture that transforms health, public health and social care delivery towards more integrated and enabling services. Sustainable and resilient services will only emerge from a culture that understands and values environmental and social resources alongside financial. This requires strong leadership from within the CCG coupled with raising the awareness of staff and the profile of sustainability.

Government advice during the COVID-19 pandemic has been to work from home and only attend site if it was absolutely necessary and for the minimal amount of time. Due to the COVID-19 pandemic, staff have adhered to these guidelines and worked from home. This has had a positive effect on the CCG's total emissions to atmosphere due in part to the following reasons:

- Reduced amount of travel miles undertaken. The NHS contributes to over 50% of carbon emissions in the UK domestic travel sector, by working remotely the number of travel miles undertaken by staff for attending the office or travelling for meetings has significantly been reduced
- Reduced water usage. From 20,638,000 litres to 1,352,000 litres (8.2 Olympic sized swimming pools to half a swimming pool)
- Reduction of our energy usage (gas and electric)
- Reduced printing and associated costs (paper, energy, ink)
- Reduction in the amount of waste going to landfill
- Reduction in the procurement of goods received at 722 due to staff working from home

**The Green Plan**

The UK government has committed to reaching net zero carbon by 2050. This means significantly reducing emissions as well as off-setting using carbon capture, such as planting trees.

The health and care system in England is responsible for an estimated four to five per cent of the country's carbon footprint so has a major role to play in supporting this. The NHS has therefore committed to reaching net zero as soon as possible. The Sustainable Development Management Plan is currently being updated and renamed to the Green Plan which will be made available in 2021/22. We have identified an executive director lead for sustainability and remain committed to the NHS Carbon Reduction Scheme. We are working with our landlord and their managing agents to find ways of reducing our direct building related greenhouse gas emissions; we will continue to review business travel and introducing ways of reducing this, together with reduction of waste going to landfill.

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

## Improve quality

NHS Sheffield CCG believes passionately that all patients should receive care that is of the highest quality, safe and reliable. We have a statutory duty to improve the quality of care that we commission under section 14R of the Health and Social Care Act 2012.

A key function of the CCG is to secure continuous improvement in the quality of the services it commissions. The safety of the services and the quality of care experienced by patients are paramount and this is evidenced through improved outcomes. The usual assurance process relating to the quality of care provision is implemented through the contract monitoring framework, quality assurance schedule, and quality reviews, each reporting to the quality contract meeting and the CCG's Quality Assurance Committee.

This usual way of working has been disrupted by the COVID-19 pandemic which caused changes, meaning that our ways of working had to be reconsidered.

On 25 March 2020 NHS England and Improvement (NHSE/I) published patient safety COVID-19 update draft guidance on anticipated changes to some quality and patient safety functions and this was further updated on 1 May 2020. As a consequence, both the NHSE/I guidance and the Coronavirus Act 2020 impacted on Sheffield CCG's quality assurance processes, with some activities being changed and some being stopped. The CCG continued to fulfil its responsibilities to gain assurance where there were concerns relating to patient safety.

The CCG continued to work in collaboration with Sheffield City Council, The Care Quality Commission (CQC), NHSE/I and Public Health England (PHE) to achieve shared quality goals and improved patient outcomes.

### Changes to serious incidents process

The CCG has a responsibility to oversee reportable Serious Incidents (SIs) which occur in our commissioned providers and agree that learning from incidents has been completed. In response to COVID-19, NHSE/I published (draft) guidance and made temporary changes to this process. Providers have continued to report 'never events' and SIs and where these have occurred, they were required to provide a core response so that any immediate action to protect patient safety could be undertaken.

### Supporting primary care

During COVID-19 the focus was to ensure that primary care continued to provide services safely and this was a priority for the CCG, for example by providing additional laptops and software so practice staff could work remotely, distributing PPE and providing specialist infection control advice.

The CCG's quality team supported the COVID-19 and influenza vaccination campaigns in a variety of ways, including:

- Supporting the identification of suitable COVID-19 vaccination sites and undertaking quality assurance visits
- Supporting care homes to increase staff uptake of influenza and COVID-19 vaccine

- Delivering vaccine and immunisation training and eight flu update events aimed at practice nurses and health care support workers
- Developing an induction programme for foundation dentists to support delivery of flu vaccines
- Ensuring practices had sufficient flu vaccine for their patients, which included working across localities to ensure that processes were in place to redistribute excess stock

Another example of providing support to primary care was the review of practice data to take action to improve uptake of cervical and diabetes eye screening across Sheffield.

**Update from the Primary Care Development Nurse (PCDN) team**

The PCDN team developed new ways of working to support general practice and contributed to citywide efforts around the COVID-19 pandemic:

- Very early on in the pandemic the team set up regular virtual Zoom meetings between the CCG chief nurse and general practice nurses (GPNs) to enable nurses to share their concerns and receive mutual support.
- The PCDN team set up virtual nurse forums and virtual meetings within each primary care network to provide support and advice on topics relating to COVID-19.
- More recently two new 'Nurse Hubs' have been developed as a resource for GPNs and the wider primary care community. The first one is a COVID-19 hub which acts as a repository for all COVID-19 information and the second one is a general practice nurse hub. This contains other general relevant information as well as training resources.
- The PCDN team were redeployed to run a Sheffield community swabbing (COVID testing) service for health, social care and voluntary sector employees and their families. The team set the service up from scratch with health and social care colleagues and within a couple of weeks were fully operational seven days a week.
- In the last quarter of the year, four members of the team undertook training to administer the vaccine and supported vaccination clinics in the primary care networks.

The PCDN team were also able to fulfil their regular role of supporting practices and helping to deliver key CCG priorities. For example, they reviewed and updated the process for annual health checks for people living with severe mental health and learning disability. We know that people with severe mental ill health and/or learning disabilities tend to have a reduced life expectancy compared to the general population, and increasing the effectiveness and uptake of the GP annual health check is a key way to detect physical health problems and create care plans. The PCDN team supported those practices which have traditionally had low uptake of the annual health check by sharing good practice

The PCDN team have also been involved in setting up a home blood pressure monitoring (HBPM) project. This involved making blood pressure monitors available to any patients on the hypertension register and focussed on people in areas of social deprivation, ethnic groups with a high prevalence of blood pressure issues and people aged over 65.

The team delivered monthly virtual training sessions which are open to general practice nurse teams. Topics being covered include: nutrition in chronic obstructive pulmonary disease, infection control, long COVID, diabetes, paediatric asthma, patient safety and anticoagulation.

Finally, the PCDN team developed a 'Nurse Ambassador Programme' for general practice nurses, which spans South Yorkshire and Bassetlaw. The programme is designed as an

introduction to leadership for nurses and to develop the next generation of nurse leaders. Attendees had the opportunity to explore some of the theories of leadership, consider themselves as leaders and undertake a small quality improvement project that has required them to make a bid for monies.

**Quality improvement in care homes**

As might be expected, the main focus of the Quality in Care Homes Team (QCHT) in 2020/21 was supporting care homes throughout the COVID-19 pandemic.

The QCHT provided a telephone and email support service to all the care homes across Sheffield, acting as the first point of contact when an outbreak was declared. The team worked collaboratively with colleagues from across Sheffield City Council, Public Health England, St Luke's Hospice and other key stakeholders to ensure that care homes received the support and guidance they needed.

The team led on the delivery of specialist clinical mask fit test training and arranging ongoing supply of masks to care homes and clients in receipt of Continuing Health Care (CHC) who required them.

The purpose of the team is to share innovation and good practice with care homes, so as to improve quality.

These are some examples of their work during the year:

- Improving nutrition and hydration - A specialist dietitian provided support, advice and guidance to care home staff with the aim of improving the nutritional status of residents.
- Recognising and managing deteriorating residents - A further two members of staff were recruited to support our clinical educator in teaching care home staff how to recognise when a resident is unwell. This includes observation techniques, responding to deterioration, and how to assess risk and escalate problems appropriately.
- NHS mail - All care homes have now been given an NHS email address and are being supported to use the NHS mail system. This has improved communication processes between the care home and NHS organisations, making sure that critical information is sent and received in a timely manner thereby helping to ensure the right care for the individual.

**Safeguarding children and adults**

The CCG is one of the three statutory partners of the Sheffield Children's Safeguarding Partnership (SCSP) jointly responsible, alongside the Local Authority and the police, for the partnership arrangements in the city. The chief nurse and CCG safeguarding team represent the CCG at every level of both the SCSP and the Sheffield Adult Safeguarding Partnership (SASP). Whilst there are two separate partnerships for children and adults, there is collaboration, including holding joint executive meetings and sharing the 'Think Family' agenda. The CCG contributed to the annual development day across both the children and adults partnerships in 2020 to share learning and set priorities for 2021/22.

Our safeguarding team work with their counterparts in South Yorkshire and Bassetlaw. An example of a joint safeguarding initiative across SYB was coming together to champion a

national programme supporting parents and carers of young babies with coping strategies when feeling overwhelmed, frustrated or distressed. The national programme – ICON – aims to reduce the numbers of babies being admitted to hospital with and suffering from head trauma as a result of being shaken.

During the first six months of the year some of the safeguarding team's routine work was temporarily suspended and they were able to support primary care by offering to complete all safeguarding reports, children and adults, on behalf of the practice. All GP practices were offered this support with only two declining. Over the six month period a total of 530 reports were produced by the safeguarding team approaching a total of 1000 adults and children. In addition to this the CCG safeguarding team also completed 200 adult health assessments, normally completed by general practice, for applicants who were being considered as potential adopters, foster carers or those applying for special guardianship orders.

Despite the challenges of social distancing rules imposed due to COVID-19 regulations the safeguarding team delivered a virtual training event for primary care staff in December. The event included presentations on the ICON project and adult self-neglect. The event was attended by most of the practices and was well received.

Finally, the safeguarding team is working with Sheffield Children's NHS Foundation Trust to review the service provided by the Trust's looked after and adoptive children's health. This is aimed at ensuring that all looked after children in Sheffield have a named professional who ensures that their health needs are met, wherever the young person is placed.

### The Infection Prevention and Control (IPC) team

The Infection Prevention and Control (IPC) team's workload in 2020/21 was predominantly focused on the COVID-19 pandemic and providing support to care homes and GP practices.

- Care homes: The IPC team has provided phone and email support and specialist advice to care homes during the pandemic. The team worked closely with Sheffield City Council, Public Health England (PHE) and health care providers across the city to implement national guidance and improve IPC practice.
- The team produced a number of local guidance documents and training packages, one of which was developed at national level developed with the Infection Prevention Society. The team facilitated education and training around PPE requirements for care homes early in the pandemic.
- General practice: The IPC team has also provided regular phone and email support to GP practices, helping to apply national IPC and PPE guidance in a local context. This also involved collaboration with PHE to provide outbreak management support when this was necessary.

## Engaging people and communities

### Involving people in our decision making

The CCG values the experience and opinions of local people and in a time when inequalities across the city have been exposed largely due to the pandemic, we have renewed our commitment to listening and hearing from those most vulnerable and with the greatest health

needs. Our approach has adapted to new technology and many conversations have happened online - this has brought new opportunities for us to hear from people in a more timely and consistent manner.

We continued to involve members of the public at the earliest opportunity in our decision making process. In addition to direct regular contact with our citizens through the Involve Me network and citywide involvement meetings, we proactively sought the views of underserved communities via partnership working with Healthwatch Sheffield; and the voluntary, community and faith sector in the city. We also identified opportunities for public representatives to be directly involved in our planning and decision making through participation in project meetings, partnership boards and procurement activities.

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

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

The CCG advertised for two lay members in the last year to strengthen the patient and public voice in our governance and strategic oversight; one member was re-appointed and a second member joined the team.

We consulted with relevant overview and scrutiny committees:

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

Whilst our work over the last year has had to adapt and change to the pandemic, there have been many positives that emerged from involvement with the public. These included:

**Initial impact of COVID-19**

The pandemic has touched us all. It has had an impact on the way we work, how we relate to each other, where we can go, how we can communicate, as well as the wider impact on family, friends, and communities. The majority of our work over the last year has been about understanding this impact on people in Sheffield and adjusting our decision making, to reduce inequalities, whilst being compassionate in our approach.

- In April 2020, we had already started conversations with community leaders, individuals and partner organisations about the impact the pandemic was having on people living in

the city. This formed an ‘Insights Log’ that provided a rich vein of lived experiences over the coming months.

- The data was segmented according to protected characteristics and provided a comprehensive repository about lived experience across our diverse city. This information was circulated widely to decision makers in real time and has been used to inform future commissioning intentions.
- By March 2021, the Insights Log had more than 650 pieces of information from community members, describing the journey of the pandemic locally and which offers a stark reminder of the range of lived experiences across different communities.

**Impact of temporary changes to health services because of COVID-19**

As a response to the challenges faced by the local healthcare system, some temporary changes to services had to be made. It was important for the CCG to understand what impact these changes were having on the population of Sheffield.

- Two pieces of involvement activity were commissioned to understand the impact of these changes on our communities. A telephone survey of a representative sample of the Sheffield population was undertaken by SMSR, a social research agency, and semi structured interviews by local community groups with residents involving Mencap, SADACCA, Together Women, Shipshape, Refugee Council, ZEST and the Chinese Community Centre.
- A total of 1,270 residents of Sheffield responded across the two methods. 1,107 through the telephone survey and 163 through the community organisation-led activities.
- The work influenced our future commissioning intentions for 2021/22 and joint intentions with Sheffield City Council. This will be reflected at every level of the organisation in terms of our strategic planning and implementation of commissioning decisions, alongside our partner organisations.

**COVID-19 vaccine rollout – Collaboration with the Voluntary, Community and Faith (VCF) Sector**

Once the vaccination programme was announced in November 2020, encouraging local people to take up the offer of the COVID-19 vaccine became a key priority. We were mindful from national and regional information, as well as local intelligence, that some communities were hesitant about the vaccine, whereas others faced physical and psychological barriers. The CCG team embarked on a campaign to listen and understand by:

- Working alongside 25 local community organisations who have long standing and trusted links with community members
- Organisations were chosen because of their extensive work with people from black and minority ethnic communities; as well as links with other vulnerable groups including people who are homeless; people who live with physical impairments; people with learning disabilities and people living in areas of high deprivation in the city
- Small and medium sized grants were awarded to enable direct engagement with people utilising the skills and knowledge of the community organisations’ staff and volunteers
- Community activity was planned and produced by the community organisations themselves based on their extensive experience of working within their communities

- Information was relayed fortnightly from community organisations about the latest feedback from community members regarding hesitancy and barriers to vaccine uptake. CCG staff were able to provide up to date facts and figures as well as produce information in a variety of formats, to help counteract concerns as well as work alongside primary care colleagues in vaccine clinics to reduce barriers.

**Black, Asian and Minority Ethnic (BAME) public health group**
In July 2020 public health colleagues and a VCF sector organisation called Faithstar convened a meeting for staff from provider and commissioner organisations across healthcare to meet with and listen to people from minority ethnic communities, the CCG was part of this meeting. People described racism, structural inequalities, lived experience of discrimination and prejudice, and the devastating impact of COVID-19 on people living across our city. There was a deep lack of trust from community members in statutory organisations and a perception that people were excluded from decision making in the city and not heard.

Senior leaders such as Brian Hughes, the CCG's Deputy Accountable Officer, attended to share how they intend to play their part to bridge the gap and lead the city in a more inclusive way that reduces health inequalities and ensures that past mistakes are not repeated.

The group reviewed progress in the last meeting of 2020 and comments from community leaders included:

*"It's been a visible learning experience – the authenticity and trust gap is closing through good leadership"*

*"This forum has meant that trust is being rebuilt – we face structural inequalities and racism on a daily basis but Sheffield is a great city and people's hearts are in the right place and that is shown in this group"*

*"I can't thank you enough. You can get something good out of a bad situation. Without covid we wouldn't have all met and worked out how we can all work together. I just hope this work continues"*

The group continues to meet fortnightly.

**Equality Delivery System (EDS2) – Interpreting services**
The Equality Delivery System **(**EDS2**)** is a toolkit designed by the Department of Health (DH) to help NHS organisations to improve the services they provide for their local communities, consider health inequalities in their local area and provide better working environments that are free of discrimination.

The CCG commissions a language interpreting service for GP practices across the city. The interpreting service contract and specification were reviewed through the lens of service users in 2020. The review involved interviewing and working alongside the community sector who support people whose first language is not English to gain feedback on how the interpretation

service worked for them. Extensive feedback was also offered by Healthwatch Sheffield regarding the experience of people with hearing loss and those who are deaf.

Using the NHS England Equality Delivery System tool, the current provision has been judged as “developing” and the Interpreter Contract Group and Reducing Health Inequalities Group within the CCG are overseeing an action plan for more suitable future provision.

**Flu outreach**

In September 2020 we embarked on a project to encourage uptake of the flu vaccine, given the increased risk that flu / COVID-19 combination could pose and the disproportionate impact COVID-19 has had on minority ethnic communities. This involved asking organisations that work alongside black and minority ethnic community members, via the public health communities group, to let us know how they would tailor messages and methods to increase uptake and how they would evaluate that work. Eleven organisations came forward to undertake a multi-methods approach to allay fears and encourage people to have their flu vaccine.

This work included conversations with people whilst food parcels were being delivered, educational films promoted via social media, slots on community radio targeted at taxi drivers, messages via community WhatsApp and WeChat groups, all delivered in community languages and tailored appropriately, whilst utilising the national flu campaign messages.

**Crisis care**

The mental health team brought together partners and experts by experience to co-design a new mental health crisis care model with the aspiration to eliminate gaps, utilise opportunities, and lead to better outcomes for people who need to access urgent and emergency mental health crisis care, support and treatment.

The team commissioned Co-Create to assist them with their co-design ambitions for this project. To date, the programme has undertaken the following activities:

- Programme Board has been established that includes service user representatives
- Desktop research was undertaken, including reports from ChilYPEP and Healthwatch Sheffield
- ‘Big Question’ facilitated discussion sessions with children and young people and adults with lived experience of crisis
- Voluntary, Community and Faith sector (VCF) engagement undertaken through the Mental Health Network Meeting
- BAME community specific engagement – capturing key themes from the "Black Mental Health Live" event

**Primary care**

The CCG’s engagement team has provided advice to GP practices who have been considering substantial service change, in order to ensure that they are effectively involving their patients, and that both they and the CCG meet their statutory duties to involve the public in commissioning.

- York Road Surgery consulted with their patients regarding a proposed relocation of their practice, receiving 200 responses
- Clover Practice consulted with their patients regarding the proposed closure of their branch site at Jordanthorpe Health Centre receiving 68 responses

Both practices undertook proportionate consultations with their registered patients, including assurance of their consultation plans through the Strategic Public Involvement, Equality and Experience Committee (SPIEEC), and fully completed quality and equality impact assessments.

**Other projects undertaken during 2020/21**

| Area of work | Activity and Impact |
|---|---|
| Primary and community mental health transformation programme | Four primary care network areas piloted community involvement activities with input from more than 200 individuals. 'You said, we did' log compiled and used to ensure clear line of sight between feedback and decisions. |
| Prescription Order Line | The Prescription Order Line (POL) provides a repeat medication ordering telephone service for patients. Based in the CCG, a team of medicines management support assistants, supported by pharmacy technicians operate the telephone call centre 9am to 3pm, Monday to Friday.<br>The current service model has been reviewed and 1,149 users of the service offered feedback to help inform the future direction of the service. |
| Stoma Ordering Service | Following a regional survey, the CCG team wanted to better understand the experience of current service users in Sheffield to help inform future activity. 45 responses were received and used to inform options for possible future service developments. |
| Post COVID pathway | The CCG's Engagement team has been working in partnership with Sheffield Teaching Hospitals to ensure that the patient voice has been embedded in the development of the post COVID pathway. The pathway has been set up in response to the needs of patients recovering from COVID.<br>Patient representatives with experience of COVID were recruited to be involved in the design of the pathway, semi structured interviews were undertaken with patients to gather their experience of post COVID services and information. Particular focus was given to groups disproportionately impacted by COVID-19 such as |

| | |
|---|---|
| | BAME communities and people aged over 70. Insight gathered by NHS Sheffield CCG was also used to influence the pathway design.<br>A hub has now been developed to assess the different needs of individual patients to make sure that they receive the right support they need from a variety of specialities. |

**Strategic Public Involvement, Experience and Equality Committee (SPIEEC)**
Our involvement activity is overseen and assured by our Strategic Public Involvement, Equality and Experience Committee (SPIEEC) whose members include local people, the Governing Body lay members, local GPs, Healthwatch Sheffield, the local authority and Sheffield University.

The committee has delegated responsibility from our Governing Body to:

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

The committee continued to go from strength to strength over the last year following feedback from previous attendees, previous committee members, and the current team. This enabled a review of the previous terms of reference and a change of membership to reflect the changing landscape of public involvement within the NHS and the need for stronger partnerships at a local level. In addition, the two public representatives continued to provide challenge in their role as a critical friend and offered insight that strengthened the approval process for individual projects and programmes.

**Our communications and engagement strategy**
Our communications and engagement strategy sets out the principles we follow when engaging with the public and the key ways we involve local people in our decision making.

We aim to deliver high quality engagement at all times. Our principles set out what this will look and feel like.

- We will engage people early on in our decision making processes
- Involve the public in the governance of the CCG
- Prior to starting the engagement activity, we will review existing sources of insight about patient and public views and experiences, and bridge any gaps
- Engagement will be an ongoing process, not a one-off exercise
- We will be clear and concise, and all engagement will have a purpose

- Engagement will be representative. We will take time to involve hard to reach groups and the most vulnerable people. We will use accessible formats and ensure equality of opportunity
- We will go out to external groups; we will not depend on them coming to us
- We will work with our partners to avoid duplication and overload for the public
- We will meet our responsibilities under the Equalities Act, 2010 and statutory responsibilities under section 14Z2 including Gunning principles
- Sheffield CCG will listen and hear what people tell us and we will feed back – so people will understand the impact of their views
- Sheffield CCG will recognise and record people's contributions
- We will recognise the difference between individual and collective engagement.

You can find our Communications and Engagement Strategy here.

**Understanding our communities**

As well as evidence gathered through consultation and involvement activities, we use monitoring information to help us identify possible impacts and to help shape and inform the equality impact assessment process. We use equality impact assessments to plan our involvement activity so we can target those people who are likely to be impacted to ensure their voice is heard in our decision making and any impacts or risks can be managed. Identifying potential impacts requires an understanding of how the city is made up and the issues that people face. To build this understanding we use a wide range of evidence including:

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

**Equality monitoring**

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

**Continuously improving how we involve**

The CCG's Engagement, Experience and Equality team is continually improving how it engages with, and hears the voice of, local people. Over the last two years, the NHS Oversight Framework Patient and Community Engagement Indicator has provided the opportunity to systematically improve our processes and submit evidence to NHS England to be assessed against.

The Patient and Community Engagement Indicator evidences CCGs' implementation of the revised statutory guidance on patient and public participation in commissioning health and care and compliance with the '14Z2' statutory duty to involve the public in commissioning.

The performance of CCGs is assessed annually by NHS England via the NHS Oversight Framework. In the most recent assessment period, 2019/20, the CCG received a rating of 'Green star' for our work on participation and engagement, this is the highest score possible and 'outstanding' ratings in each of the five domains:

- Governance
- Annual Reporting
- Day-to-day practice
- Feedback and Evaluation
- Equalities and health Inequalities

### South Yorkshire and Bassetlaw Integrated Care System (ICS) Engagement Report

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

During the COVID-19 Pandemic the ICS has continued to host the Citizens' Panel for virtual meetings, started to recruit to a new engagement membership online database 'Let's Talk Health and Care' and conducted a review of the engagement that took place in the system during the pandemic, to form an overarching report.

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

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

**Recruitment to the 'let's talk health and care' membership**

In July 2020 recruitment was launched to a brand new online health and care membership scheme across South Yorkshire and Bassetlaw. As a member, people are invited to be involved as little or as much as they would like in helping to shape health and care services. The aim is to create a community of 2,000 people who all want to make their health and care services better. They are connected through regular newsletters and sharing of opportunities to get involved. Recruitment is currently online and ongoing, with additional face to face recruitment planned when social distancing and restrictions allow.

**Views of people in South Yorkshire and Bassetlaw on health services during the pandemic**

South Yorkshire and Bassetlaw Integrated Care System published a report summarising the key findings from activity that took place across the system to hear the patient and public voice during the current COVID-19 pandemic.

In total, 18 pieces of work were considered in the report, with an estimated patient public voice reach of approximately 7,000. The work covers the South Yorkshire and Bassetlaw area and includes a wide range of COVID-19 related insight – some asking about people's understanding of information, some about wellbeing, and some about more specific changes to services such as alternative appointment types.

Read the full report here: www.healthandcaretogethersyb.co.uk/about-us/whychange/latest-news/new-report-shows-views-people-south-yorkshire-and-bassetlaw-health-services-during-pandemic

**Changes to the appendicectomy pathway for under-8s and children with complex needs**

In June 2017 the Joint Committee of Clinical Commissioning Groups (JCCCG) for South Yorkshire and Bassetlaw took a decision to change the way some children's surgery and anaesthesia services were provided in South and Mid Yorkshire, Bassetlaw and North Derbyshire. At that time the JCCCG agreed to clinical recommendations that children needing an emergency operation for a small number of conditions (such as appendicectomy), at night or at a weekend, would not be treated in hospitals in Barnsley, Chesterfield and Rotherham, and would instead have their surgery at Doncaster Royal Infirmary, Sheffield Children's Hospital or Pinderfields General Hospital in Wakefield.

Since that decision a number of factors changed, these were set out in a report to the Joint Health Overview and Scrutiny Committee (JHOSC), which can be read here. The changes meant that a new recommendation was put forward by local clinical experts. The SYB ICS presented an engagement report to the JHOSC, which compiled over 3,500 responses. The report can be read here.

**Children's healthcare website – Healthier Together**

A survey to seek the views of pregnant women, children, young people and their families, and health professionals on a 'Healthier Together' website to provide health information and advice for pregnant women, children, young people and their families across SYB took place in October 2019. The survey, which was conducted online and via partners' circulation, received just under 100 online responses and led to the development of a website during 2020. In November 2020 the SYB ICS ran a focus group with parents, recruited to via social media, online and partners' networks to test the site. The focus group provided feedback which saw the website adapted. It was launched as a pilot in February 2021.

**Listening Ear bereavement service survey into needs of Black, Asian and Minority Ethnic (BAME) communities**

Launched in April 2020 to respond to the pandemic, the Listening Ear South Yorkshire bereavement service was put in place to help people who have lost loved ones during the coronavirus pandemic, whether from the virus or otherwise.

In August 2020 it was recognised that since launching in April, almost 500 appointments had been accessed by people from across Barnsley, Doncaster, Rotherham and Sheffield with overwhelmingly positive feedback. However, the feedback had also shown that people from BAME communities were less likely to access the service and so a short survey was launched to ask people from those communities how the service could better meet their needs. Partners in voluntary sector organisations and community groups helped promote the survey. The results helped feed into the service specification for when the service was re-procured in January 2021.

**Barnsley and Rotherham stroke survivors and their families/carers asked for feedback about their care**

Following the introduction of three Regional Hyper Acute Stroke Units (HASU) in 2019 to provide specialist care 24/7 for people in South Yorkshire and Bassetlaw, the views from people affected by the change to the service have been sought as part of the service change evaluation. Feedback has been collected from people from Barnsley and Rotherham who had a stroke and were treated at either Doncaster Royal Infirmary, the Royal Hallamshire Hospital or Pinderfields Hospital in Wakefield before either being discharged home or transferred to Barnsley or Rotherham Hospitals.

The findings from the survey have helped to evaluate whether the HASU transformation achieved the anticipated benefits – one of which was to improve patient experience.

Gaining the patient and carer feedback proved invaluable and the team is now looking at setting up a Stroke Survivor and Carer Panel to help secure meaningful patient engagement into the work programme. The team is also producing regional patient information and supporting work on improving communication with patients and their families as part of their work programme. The full evaluation report and easy read versions will be available soon on the SYB ICS website here.

**Long COVID rehabilitation pathway**

Health and care professionals worked together to plan new rehabilitation services needed for the people who have had COVID-19 and as a result require ongoing health and care support.

In order to capture the views of patients to inform the service development, an engagement exercise took place. This included a wide-reaching survey which received more than 60 responses, a focus group with patients and their carers, and work with seldom heard communities. The work with seldom heard communities was overseen by the South Yorkshire Community Foundation.

Feedback has helped to shape the development of the services, including ensuring mental health considerations are taken on board and broad communication about the service is undertaken. Read the full engagement report here.

## Compliments, comments and complaints

NHS Sheffield CCG manages compliments, comments, complaints and MP enquiries relating to the services that we provide and the decisions that we make about how health care is provided in Sheffield.

We help patients and their representatives to make complaints and keep them informed about the action that we are taking in response to their complaint. We ensure that complaints are investigated properly, ensure that lessons are learned and that improvements are made to services. Our Governing Body receives a report each quarter about the complaints the CCG has received.

During this year the Parliamentary and Health Service Ombudsman (PHSO) accepted two complaints and the Joint Working Team of PHSO and Local Government Ombudsman (LGO) accepted an additional two. Of these two, one remains open and is being investigated with the Joint Working Team.

Of the three that have been investigated and concluded, all three were partially upheld though one of these required the Local Authority to provide financial recompense and the CCG had no recommended actions. From the PHSO's recommendations on both cases which were partly upheld in relation to the CCG, the CCG has developed a robust action plan for implementing lessons learned and provided written apologies to the complainants.

## Reducing health inequality

During 2020/21, in a year when existing inequalities were highlighted, Sheffield CCG worked hard to reduce them.

To address health inequalities and focus our work, the CCG identified the people in the city living in the 20% most deprived areas in Sheffield, those people who are Black, Asian and Minority Ethnic, and people who are homeless, as groups to prioritise in our decisions.

People living in deprivation, people from BAME backgrounds, and the homeless, are on average more likely to have poorer health, poorer access to health services and experiences, lower life expectancy and live more years in ill health. In Sheffield, the difference in life expectancy between the best and worse off is 20 years.

We also focused on eight urgent actions set out by NHS England.

We ended the year with a big focus on reducing health inequalities via the COVID vaccination programme and by agreeing on a joint commissioning plan with Sheffield City Council which had a strong focus on this area.

Here are some of the highlights of our initiatives and programmes.

**Racial inequalities**
In January we awarded a grant to Faithstar, a BAME-led community organisation to fund a bid writer to apply for funds on behalf of around 30 BAME community organisations. Voluntary and community organisations are really struggling for funding and BAME organisations have seen their funding cut more than other groups.

The grant aims to provide an expert bid writing service for Sheffield based BAME groups, writing Pre-Qualification Questionnaires (PQQ) for a pre-agreed list of 20 community groups, thereby increasing the number of successful bids and helping to develop infrastructure and resilience over the longer-term.

We submitted evidence to Sheffield's independent Race Equality Commission in the autumn. In May we will give oral evidence to the Commission. Once the report is published we will work with our partners to work harder to reduce racial inequalities.

**Digital exclusion**
Digital exclusion is a real concern in Sheffield. It's estimated around 10% of the population are internet non-users (circa 60,000 in Sheffield), eight per cent lack five basic digital skills (48,000 in Sheffield) and a further 12% have limited skills (72,000 or total 120,000 without digital skills).

A Sheffield-wide digital exclusion group looked at how to overcome the challenges and address the subsequent impact on health inequalities.

Mindful of the above, we committed to ensuring that our digital offer (including the development of digital literacy and accessibility) underpins any interventions e.g. pulse oximetry/near testing.

Some of our primary care networks worked in partnership with local voluntary organisations to tackle social isolation and also to improve digital skills, to enable people to remain in touch even whilst physical distancing. This has included some community organisations receiving funding to purchase equipment (iPads) for some of their most vulnerable residents.

**Diabetes**
We delivered the National Diabetes Prevention Programme in Urdu and some of the literature to accompany the programme is translated into several languages. We know diabetes is more prevalent in South Asian communities, so are targeted more at groups most in need.

In terms of diabetes management, we trialled the delivery of DESMOND type 2 structured education over a number of shorter sessions (as opposed to a whole day) to meet the needs of our South Asian population, with contextualised dietary advice and in venues as local as possible to the communities.

**Mental health**
Several pieces of work are being taken forward through our multi–agency 'Physical Health Implementation Group' (PHIG) to address the poor health and decreased life expectancy of people who are living with severe mental health. This includes work to support smoking cessation and tackle obesity in this population cohort, as well as enhanced monitoring in

primary care, for example, monitoring the cardiovascular side effects of some mental health medications.

**Community engagement**

Since the start of the pandemic, there has been weekly CCG engagement targeted and focused on people in the nine protected characteristics and those in the most deprived areas of the city. We commissioned telephone research on impacts of COVID-19 and needs with a representative sample of the population (1,110) and qualitative work with voluntary, community and faith groups focusing on most vulnerable communities – refugees and asylum seekers, South Asian communities, women at risk, people in most deprived areas. Read more about the engagement below.

**Homeless**

Throughout the year, the CCG was engaged in citywide working across health and social care, with other agencies such as the police, voluntary sector organisations, and the city centre practice which has significant expertise in caring for homeless people and rough sleepers. This “wrap around” approach continues as part of our planning for the prevention of outbreaks of COVID-19 amongst the most vulnerable people in Sheffield.

Homeless communities were prioritised for vaccines and teams of primary care staff went out to hostels and hotels to vaccinate these vulnerable people.

**COVID-19 vaccination programme**

From local and national research we know there are potential barriers to accessing the COVID-19 vaccination programme by groups based on the nine protected characteristics and other vulnerable groups that are known to face significant health inequalities. We also know many people are hesitant about getting a vaccine.

The CCG funded 26 community groups in the city to communicate with target audiences to build confidence in the vaccine and encourage uptake.

Community engagement had two primary purposes:

- Gain insights on hesitancy to shape wider communications and focused engagement
- Engage people in ways that suit them sharing key messages to build confidence in the vaccine, overcoming barriers and mistrust and encourage uptake of the vaccine

We funded community organisations to engage with the identified communities. The activity will be formed of two distinct approaches:

- Large grants targeted at specific organisations allowing them to co-produce their activity to engage with key communities and share key messages.
- Flexible small grants were available for key opinion holders within communities to share clear and accurate information provided by NHS Sheffield CCG.

The groups in the table below are our target audiences, those we know experience barriers to getting vaccines and/or are hesitant to vaccines or specifically COVID-19 vaccines. They cover people with the greatest health inequalities, areas of deprivation, and protected characteristics.

| Identified communities | Barriers | Hesitant | Sub-categories of communities |
|---|---|---|---|
| People with learning disabilities | x | | People living in residential settings |
| | | | People living in family homes |
| | | | People residing in independent living accommodation |
| People with physical and sensory disabilities | x | | People living with sight loss |
| | | | People living with hearing loss |
| | | | People living with long term conditions |
| | | | People living with physical impairments |
| Black, Asian and Minority Ethnic (BAME) communities | x | x | Black Caribbean |
| | | | Black African |
| | | | Pakistani |
| | | | Bangladeshi |
| | | | Chinese community |
| Unpaid carers | x | | Those living with people from all other groups over the age of 16 |
| Communities of higher deprivation and poverty | x | x | Firth Park |
| | | | Burngreave |
| | | | Southey |
| | | | Manor and Castle |
| | | | Arbourthorne |
| | | | Woodhouse |
| | | | Fir Vale |
| | | | Parson Cross |
| | | | Westfield |
| | | | Lowedges |
| Vulnerable migrants | x | x | Individuals seeking asylum |
| | | | Refugees |
| | | | Trafficked migrants |
| | | | Undocumented migrants |
| | | | Gypsy. Roma and Traveller communities |
| People experiencing homelessness | x | | Rough sleepers |
| | | | Those utilising accommodation due to Covid |
| | | | Sofa surfers |
| | | | Those in temporary accommodation |
| | | | Salvation Army and other hostels |
| Faiths | | x | Islam |

As we write this it is too early to tell the impact of the work, however, these groups have reached thousands of people with facts on the vaccine via conferences, videos and translated materials.

### Commissioning plan

For the first time, the CCG and City Council have a joint commissioning plan; reducing inequalities across Sheffield underpins all the intentions.

Working with the voluntary, community and faith services across Sheffield is a high priority within the joint commissioning objectives and will be an integrated approach across Sheffield CCG and Sheffield City Council.

Examples of Commissioning Intentions:

- Children and Young People: This will include reviewing existing pathways and specifications, such as neurodevelopmental, complex and palliative care and therapy services to maximise opportunities to deliver them in the community.
- (Targets BAME community and deprivation)
- Outpatients: Agree on a plan to deliver accessible alternatives to telephone or virtual technology for outpatient appointments.
- (Targets BAME, deprivation and homeless)
- Long Term Conditions: Work with partners to adopt and develop a personalised approach to re-establish long term condition monitoring and reviews to recover control and management of conditions to pre-Covid levels.
- (Targets BAME, deprivation and homeless)
- Flu: Fund BAME community groups, which include the faith sector,  to raise awareness of the vaccine and how to get it for those in at risk groups.
- (Targets BAME community)
- COVID vaccine: The CCG and council are funding key groups in the city to communicate with target audiences to build confidence in the vaccine and encourage uptake.
- (Targets BAME, deprivation, homeless, sensory disabilities (deaf, blind), vulnerable migrants, unpaid carers, learning disability)
- Public Engagement: Engage seldom heard groups, often vulnerable, on how services changes during the pandemic have affected groups, and mitigate these impacts.
- (Targets BAME and deprivation)

A full operational plan was signed off in April 2021.

## Health and Wellbeing Strategy

The CCG remained a leading partner of the Health and Wellbeing Board.

In 2020/21, for the first time, we developed our own health inequalities plan, which sets out how we will deliver Sheffield's Health and Wellbeing Strategy (2019/2024).

Most of the solutions to reduce health inequalities are not to be found within NHS and social care services alone – these are about tackling the social determinants of health. However, as a commissioner with an annual budget of £950m, there are lots the CCG can do to help improve people's health and wellbeing. In terms of Marmot review (2010), this is the objective "to strengthen the role and impact of ill health prevention".

Our two-year action plan sets out what NHS Sheffield CCG is trying to do. The plan informed our commissioning plan and in-year decisions. It is focused on what is in the CCG's gift to deliver as a commissioner or influence the wider system to deliver the ambitions in Sheffield Joint Health and Wellbeing Strategy (2019/2024).

***Sheffield Joint Health and Wellbeing Strategy's ambitions***


The CCG's interventions to tackle health inequalities will reflect the complexity of how health inequalities occur, we can't do this on our own so we will collaborate with partners and add value to existing work and initiatives.

**In all our work, our principles are:**

- We will live by our values when working with our staff, public and partners and when making decisions.
- We will tackle health inequalities by designing and investing in services to support those people most in need.
- We will involve the people of Sheffield in our decisions, especially targeting those with the greatest health inequalities and in the poorest health.
- Our work will focus on delivering value for money.
- Our decisions will have a positive, long-term impact on people of Sheffield and the environment.

The CCG is working within the context of several challenges that face our city, which we have identified after discussing with our partners.

To address health inequalities, the plan sets out many things we will do:

- Tackle conditions that are more prevalent with higher levels of deprivation
- Improve health literacy
- Improve access to health services
- Disproportionally invest in areas of greatest need.

# ACCOUNTABILITY REPORT

**[Insert signature]**

**Lesley Smith**
Accountable Officer

20 May 2021

# 1. Corporate Governance Report

## 1.1 Members' Report

Sheffield CCG is a clinically led member organisation. This means that GPs and nurses, and managers, make decisions about local health services by using their local knowledge to improve services and focus resources where there is the greatest need. The CCG is made up of 77 GP practices and is responsible for a budget of £946m. Together, the GP practices have a registered population of 582,506 patients (October 2019). The membership is represented by a governing body of local GPs, a nurse representative, a secondary care doctor and lay members, supported by our executive team.

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

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

Due to the restrictions on social distancing, Governing Body meetings have continued to be held and have been live streamed rather than meeting in public. Members of the public are invited to send in questions in advance of Governing Body meetings.

## 1.2 Composition of Governing Body

Governing body formal voting members throughout 2020/21 comprised:

- Chair
- Accountable Officer
- Deputy Accountable Officer (wef 1.08.2020)
- Medical Director
- Director of Finance
- Chief Nurse
- Director of Commissioning and Performance (to 31.07.2020)
- Director of Commissioning Development (wef 1.08.2020)
- Director of Delivery, Care Outside of Hospital (to 12.07.2020)
- Secondary Care Doctor - vacant
- Locality Nominated GPs x 4 (of which one currently is chair)
- Elected GPs x 4
- Lay Members x 4

In addition, one non-voting member was appointed in 2020/21:

- Associate Director of Corporate Services (wef 1.08.2020)

## 1.3 Member profiles

During 2020/21, the following individuals served on our Governing Body and remained in post throughout the year *(except where indicated – no date indicates that the member was in post the full financial year)* and up to the signing of this annual report and accounts:

**Dr Terry Hudsen – Chair and West Locality Nominated GP**

Dr Terry Hudsen has worked as an NHS doctor for 15 years and is currently a GP at Porter Brook Medical Centre in Sheffield. Terry joined the Governing Body of Sheffield CCG in 2017 and has developed interests in how health and care organisations can work together to improve care for people; organisational culture; and system leadership.

In his clinical practice, Terry has an interest in the care of young adults, women's health, sexual health and clinical informatics. He has an expertise in the use of information technology in health improvement and is the author of mobile and web applications for patients and doctors.
He is a keen advocate of working with communities to improve health outcomes and experience of care and is passionate about public involvement in how the NHS designs services and makes decisions.

Terry is also the Co-Chair of Sheffield's Joint Commissioning Committee, Co-Chair of the Health and Wellbeing Board and Deputy Chair of the Sheffield Accountable Care Partnership.

**Lesley Smith – Accountable Officer**

Lesley brings to the CCG a breadth of leadership experience of commissioning, service transformation, and Organisational Development. Lesley combines her work in Sheffield with the role of Deputy Lead for the South Yorkshire and Bassetlaw Integrated Care System. She is a very experienced Chief Executive having spent 15 years as a Chief Executive in the NHS, both in Yorkshire and in Scotland, and with 18 years of board level experience, across provider and commissioning organisations.

Her experience has included leading strategic change in large and complex cities comparable to Sheffield and she has played a leading role in the development of the South Yorkshire and Bassetlaw Integrated Care System. She was Accountable Officer at Barnsley CCG from 2015 and joined Sheffield CCG in June 2019 as Interim Accountable Officer.

Lesley lives in Leeds and is married with a grown up son and daughter

**Dr Zak McMurray – Medial Director**

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

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

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

**Brian Hughes – Deputy Accountable Officer**

Brian Hughes is our Deputy Accountable Officer and Place Based Executive Lead for our commissioning organisation. He is responsible for the strategic development of our relationships with our partners across the city, including primary care development. He is our identified lead for tackling health inequalities, responsible for Emergency Planning, Preparedness and Resilience; is the designated SIRO – Senior Information Risk Owner - responsible for the organisation's information risk policy and responsible for Communications, Engagement Equality and Experience, Complaints and Freedom of Information. He joined Sheffield CCG as Director of Commissioning and Performance in May 2017. Before that he was employed within NHS England in the role of Locality Director for West Yorkshire. His career has focused on performance improvement and delivery, holding previous roles at Regional (Yorkshire and Humber) and sub-Regional (South Yorkshire and Bassetlaw) levels, including Director roles in Operations and Delivery and Performance and Accountability. He also has experience in primary care commissioning as Director of Business Development and Innovation and has worked within an acute hospital environment on hospital-wide improvement programmes and strategic development. A career in performance improvement was enhanced through working in the Audit Commission in the Value for Money arena. He studied in Sheffield, in a subject area that he has subsequently worked in for over 20 years

**Jackie Mills – Interim Director of Finance**

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

**Alun Windle – Interim Chief Nurse**

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

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

**Sandie Buchan – Director of Commissioning Development (wef 01.08.2020)**

Sandie's career began in 2002 as an assistant clinical psychologist for one of the country's high secure forensic hospitals. After completing two master's degrees she joined the UK mental health research network, then moved into her first management position at a large mental health NHS provider and then a large acute NHS trust. Here she completed her MBA, great preparation for her first director's position where she found a passion for delivering transformational change for the benefit of patients.

Sandie joined NHS Sheffield CCG in 2015 as Head of Programme Management Office and was appointed Deputy Director of Commissioning and Performance in 2018. Sandie has expertise in delivering large scale programmes. She gets results by having good people and analytical skills and her work has been published in various academic and health journals.

As Director of Commissioning Development, Sandie is responsible for commissioning services across the city. Working with our Sheffield City Council to reduce the impact of health inequalities across Sheffield and ensuring high quality and safe services for all.

**Cath Tilney – Associate Director of Corporate Services (Non-voting) (wef 01.08.2020)**

Cath graduated in 1990 with a master's degree in operational research and then worked as an information analyst for British Gas and Bradford Social Services. Cath began her career in health commissioning in 1997 when she joined the information team of Sheffield Health Authority. She has worked in several different teams for the PCT and CCG including performance and more recently contracting where she became the Deputy Director of Contracting and the lead for the Sheffield Teaching Hospitals Contract.

During the COVID pandemic Cath led Bronze Command and was responsible for ensuring Sheffield CCG staff were able to work effectively during the pandemic. This was good preparation for her current role as Associate Director of Corporate Services.

As Associate Director of Corporate Services, Cath ensures the delivery of a range of high quality and responsive support functions to Sheffield CCG including Information, IT, Corporate Governance, Information Governance, Risk Management, Facilities, Business Support Services and in some cases other CCGs in South Yorkshire. These functions are key to ensuring CCG staff can work effectively and that the CCG fulfils its legal requirements.

## Lay members

**Professor Mark Gamsu**

Mark is a professor at Leeds Beckett University. He believes that if people's health and wellbeing are to improve, and inequalities are to be addressed, then it is essential to do this in collaboration with members of the public. In his career, he has worked for a range of community organisations as well as local government and the civil service. He established 'Altogether Better', an award winning national health champions programme that continues to flourish.

Mark chairs the Strategic Public Involvement, Experience and Equality Committee (SPIEEC) which supports the CCG to improve the way it consults, collaborates and engages with people in Sheffield. He is also vice chair of the Primary Care Commissioning Committee and Deputy Chair of the CCG. He is particularly interested in the way the CCG can help general practice and the voluntary sector work together better in the more disadvantaged parts of the city. Mark was re-appointed for a further term of office wef 1 January 2021

**Anthea Morris**

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

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

**Chris Nield**

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

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

**Judi Thorley (wef 01.01.21)**

Judi is a dual Registered Nurse with a background in Learning Disability and General Adult, and has over 34 years' experience working within the NHS. Judi has worked in senior clinical and strategic leadership roles and for the five years prior to retiring from the NHS full time she held the role of Chief Nurse and Executive Director of Quality and Safeguarding within two Clinical Commissioning Groups. Judi has developed particular experience and skills relating to quality in healthcare, person-centred care, inequalities and co-production.

She is passionate about fair and equal access to health and

social care for all. Judi believes that it is essential to understand the ‘lived experience’ of the whole population, listen to and hear the voice of individuals; patients and carers along with that of frontline staff, to gain insight and understanding about the impact, quality and outcomes of commissioned services and work together to continually improve.

## Elected GP members

### Dr Nikki Bates

Dr Nikki Bates has been a GP for 30 years. She is senior partner at Porter Brook Medical Centre and elected by Sheffield GPs as one of their representatives to the CCG Governing Body in 2014. Nikki has recently been re-elected for a further term of office with effect from 1 January 2020.

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

### Dr Marion Sloan

Dr Marion Sloan is a senior partner within a large inner-city practice offering person centred care. Marion has been involved with the PCT and now CCG over the past 10 years. Starting with the development of training for GP teams in long acting reversible contraception, making sure the right incentives were in place. Marion then developed the strategy to bring chlamydia screening up to national coverage levels. Marion worked with the group developing education for GPs to learn the skills to be able to offer gynaecology clinics in primary care. She worked with the team enabling interested GPs to become competent in taking pipelle biopsies removing cervical polyps and doing First fit Ring pessaries in primary care.

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

Along with other leading practices, she has actively promoted seven day working in primary care to take the pressure off Out of Hours services and the A&E departments of the city. Marion believes that Sheffield is a great place to live and by working together with Sheffield City Council we can reduce the inequalities that still exist.

Her current work includes working with CCG colleagues developing and embedding the green agenda, looking for straightforward ways to promote practising in a sustainable way across the Sheffield health community including green travel. She is part of a group using e-bikes for work and has driven an electric car for over 15 years. Marion has recently been re-elected for a further term of office with effect from 1 January 2020

**Dr Leigh Sorsbie**

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

She is passionate about ensuring high-quality evidenced based clinical care is available for everyone within the city, regardless of postcode or background.

Her work in Firth Park has enabled her to experience the challenges faced by communities in ethnically diverse areas of high deprivation, she is committed to working within the CCG to reduce health inequalities and address the factors which perpetuate them.
Leigh is experienced in the management of mental health and understands the significant impact this has on every area of an individual's life, families and in the wider community. She is a member of the mental health commissioning team, working together to ensure that mental health is given equal importance as physical health problems, both in terms of treatment and prevention.

**Dr Lisa Philip**

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

Lisa was born and raised in Sheffield and went on to study medicine later in life with the full support of her husband and three daughters. On completion of the Sheffield GP vocational training scheme in 2016, she continued her career at Chapelgreen Practice, in addition to working as a locum GP across the neighbouring cities.

Working at multiple practices allowed her to gain an insight into a wide variety of services around the region and the differing needs of specific patient populations. Her regular involvement in the voluntary sector highlights the impact of social and economic factors on health, and the importance of health education.

Lisa is passionate about tackling health inequalities and shaping a health service which will meet the needs of our ever-changing communities.

## Locality nominated GPs

### Dr Amir Afzal (Central)

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

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

### Dr David Warwicker (North)

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

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

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

**Dr Andrew McGinty (Hallam and South)**

Andrew is a clinical director at Sheffield CCG where he is the clinical lead for active ageing, cancer, end of life care and long term conditions and medicines. He is also the CCG Caldicott Guardian supporting information governance issues.

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

Andrew stepped down from his role as Governing Body GP wef 4 May 2021.

**Secondary Care Specialist Doctor**
This role remained vacant throughout 2020/2021

## Profiles of members who ceased to be members of Governing Body during 2020/21

**Nicki Doherty – Director of Delivery, Care Outside of Hospital (to 12.07.2020)**
Nicki was responsible for the Transformation and Delivery Directorate. Her areas of responsibility included Primary Care, Active Support and Recovery, Active Ageing, Long Term Conditions, End of Life Care and Person Centred Care, Communications and Engagement, Equality and Diversity, Public Health, Partnerships, Estates and Capital, Health and Wellbeing Board and the Better Care Fund. Nicki worked for the CCG since February 2015, before this she developed a broad range of operational and corporate experience in the acute hospital sector.

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

**Amanda Forrest – Lay Member (to 31.12.2020)**
Amanda has worked in the voluntary and public service for over 30 years - predominantly working on issues around patient and public engagement, working in partnership, and service innovation. Until the end of July 2014, Amanda was Chief Executive of Sheffield Cubed - an organisation that enables voluntary sector organisations to work collaboratively. Amanda is Chair of the Sheffield Carers Centre.

For the CCG, Amanda chaired the Quality Assurance Committee and was Vice Chair of the Audit and Integrated Governance Committee. She was also a member of the Remuneration Committee, the Primary Care Commissioning Committee and the Strategic Patient Engagement, Experience and Equality Committee. She held a major role in patient and public involvement, supporting meaningful and effective engagement with the public and patients from a well thought through approach at all levels.  Mandy was elected as the Deputy Chair of the CCG with effect from 1 April 2019.

## 1.4 Appointments to Governing Body in year

The following appointments were made to our Governing Body during 2020/2021. Appointments were made in accordance with the Standing Orders set out within the CCG's Constitution

Sandie Buchan – Director of Commissioning Development wef 1 August 2020
Mark Gamsu – Lay Member reappointed wef 1 January 2021
Judi Thorley – Lay Member wef 1 January 2021

Cath Tilney – Associate Director of Corporate Services (Non-voting) wef 1 August 2020

## 1.5 Member Practices

The following is a list of all of NHS Sheffield CCG's 77 GP member practices listed by locality.

| Central Locality (21) | Hallam and South Locality (19) |
|---|---|
| Abbey Lane Surgery<br>Baslow Rd, Shoreham Street and York Road Surgeries<br>Carrfield Medical Centre<br>Clover City Practice<br>Clover Group Practice<br>Darnall Health Centre (Mehrotra)<br>Dovercourt Group Practice<br>Duke Medical Centre<br>East Bank Medical Centre<br>Gleadless Medical Centre<br>Handsworth Medical Practice<br>Heeley Green Surgery<br>Manor Park Medical Centre<br>Norfolk Park Health Centre<br>Sharrow Lane Medical Centre<br>Sloan Medical Centre<br>The Matthews Practice<br>The Medical Centre<br>Veritas Health Centre<br>The White House Surgery<br>Woodseats Medical Centre | Birley Health Centre<br>Carterknowle Surgery<br>Charnock Primary Care Centre<br>Crystal Peaks Medical Centre<br>Falkland House Surgery<br>Greystones Medical Centre<br>Hackenthorpe Medical Centre<br>Jaunty Springs Health Centre<br>Meadowgreen Health Centre & The Avenue Medical Centre<br>Mosborough Health Centre<br>Nethergreen Surgery<br>Owlthorpe Surgery<br>Richmond Medical Centre<br>Rustlings Road Medical Centre<br>Sothall Medical Centre<br>Stonecroft Medical Centre<br>The Hollies Medical Centre<br>Totley Rise Medical Centre<br>Woodhouse Health Centre |

| North Locality (19) | West Locality (18) |
|---|---|
| Barnsley Road Surgery<br>Buchanan Road Surgery<br>Burngreave Surgery<br>Chapelgreen Practice<br>Ecclesfield Group Practice<br>Elm Lane Surgery<br>Firth Park Surgery<br>Forge Health Group<br>Foxhill Medical Centre<br>Green Cross Group Practice<br>Grenoside Surgery<br>Mill Road Surgery<br>Norwood Medical Centre<br>Page Hall Medical Centre<br>Sheffield Medical Centre<br>Shiregreen Medical Centre<br>Southey Green Medical Centre<br>Upwell Street Surgery<br>Wincobank Medical Centre | Broomhill and Lodge Moor Surgeries<br>Deepcar Medical Centre<br>Devonshire Green and Hanover Medical Centres<br>Dykes Hall Medical Centre<br>Far Lane Medical Centre<br>Harold Street Medical Centre<br>Manchester Road Surgery<br>Oughtibridge Surgery<br>Porterbrook Medical Centre<br>Selborne Road Medical Centre<br>Stannington Medical Centre<br>The Crookes Practice<br>Tramways & Middlewood Medical Centre<br>Tramways Medical Centre (Bradley)<br>University Health Service<br>Upperthorpe Medical Centre<br>Valley Medical Centre<br>Walkley House Medical Centre |

## 1.6 Committees, including Audit and Integrated Governance Committee

The Governing Body has five directly reporting committees as follows:

- Primary Care Commissioning Committee (PCCC)
- Audit and Integrated Governance Committee (AIGC)
- Quality Assurance Committee (QAC)
- Remuneration Committee (RemCom)
- Strategic Patient Involvement, Experience and Equality Committee (SPIEEC)

Highlights from each of the committees are detailed in the Annual Governance Statement on page 65 onwards.

## 1.7 Audit and Integrated Governance Committee

Core members of the Audit and Integrated Governance Committee throughout 2020/21 included:

- Anthea Morris, Lay Member (Chair and Conflicts of Interest Guardian)
- Amanda Forrest, Lay Member (Deputy Chair) (up to 31 December 2020)
- Chris Nield, Lay Member
- Judi Thorley (wef 1 January 2021)
- Dr Andrew McGinty
- Dr Lisa Philips

The Committee includes the following regular attendees:

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

Further details of the work of the Audit and Integrated Governance Committee can be found in the Annual Governance Statement on page 71.

## 1.8 Register of Interests of Governing Body Members

The CCG maintains a number of Registers of Interests. Details of the CCG's registers of interests can be found at http://www.sheffieldccg.nhs.uk/about-us/declarations-of-interest.htm

At the start of each meeting of the Governing Body and all formal committee / sub-committee meetings, members are required to declare any conflicts of interests in the items for consideration on the agenda and these are formally recorded. The CCG has set out how it will formally manage any declared conflicts of interest within its Standards of Business Conduct and Conflicts of Interest Policy and Procedure which was reviewed and updated in September 2017 in line with NHS England's: Managing Conflicts of Interest Statutory Guidance for CCGs and again in March 2020.

## 1.9 Personal data related incidents

There were no serious untoward incidents relating to data security breaches, including any that were reported to the Information Commissioner during 2020/21.

## 1.10 Statement of disclosure to auditors

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

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

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

## 1.11 Modern Slavery Act

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

## 1.12 Statement of Accountable Officer's responsibilities

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

The responsibilities of an accountable officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- The relevant responsibilities of accounting officers under Managing Public Money
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended))
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended)

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

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis

- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

**[Insert signature]**

**Lesley Smith**

Accountable Officer

20 May 2021

# Annual Governance Statement

## 1. Introduction

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

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

As at 1 April 2021, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

## 2. Scope of responsibility

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

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

## 3. Governance arrangements and effectiveness

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

### 3.1 The CCG governance framework

NHS Sheffield is a clinically led, member organisation comprising 77 member practices and has a responsibility to ensure that robust corporate, clinical and financial governance arrangements are embedded within the organisation in accordance with best practice. Each practice is aligned to one of four localities across the city and has a registered key representative who is appointed to vote on behalf of their practice. A full list of member practices is set out within the Accountability Report on pages 61 and 61.

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

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

The CCG has supplemented the governance framework by the formal adoption of the Nolan Principles on Standards in Public Life, the Code of Conduct and Accountability for NHS Boards, together with development of the Standards of Business Conduct and Conflicts of Interest Policy and Procedures.

The CCG has established a properly constituted Governing Body with the appropriate clinical, managerial and lay member skill mix. Details of membership and attendance of those members are set out on page 69.

The Governing Body has responsibility for leading the development of the CCG's vision and strategy, as well as providing assurance to Member Practices via the Members' Council with regard to the achievement its objectives. It has established five committees and one sub-committee to assist it in the delivery of its statutory functions and key strategic objectives. The Governing Body receives minutes from each of its committees. These, together with a wide range of other updates, enable the Governing Body to assess performance against its objectives and direct further action where necessary.

The Audit and Integrated Governance Committee (AIGC) provides the Governing Body with an evaluation of the sources of assurance available to the CCG. Significant risks highlighted from each of the high level committees are escalated through the risk and control framework and reviewed by the AIGC at each of its meetings. The Governing Body is represented on all the committees ensuring that it remains sighted on all key risks and activities across the CCG.

The Governing Body takes overall responsibility for governance throughout the organisation but discharges some of its responsibilities to a number of committees. A full list of committees, including their responsibilities, membership and key highlights are set out at paragraph x of this Statement. In addition to governance, the Governing Body and its delegated committees place a clear focus on the services, performance and patient safety of its commissioned providers.

Organisational structures and accountabilities are clear and well defined. Where capacity and / or capability gaps have been identified, actions have been put into place with expected outcomes and timescales. The CCG clearly articulated its values to stakeholders through its Commissioning Intentions for 2020/2021.

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

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

### 3.2 NHS Sheffield CCG constitution

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

The CCG's Constitution and associated Standing Orders, Prime Financial Policies, Standing Financial Instructions and Scheme of Reservation and Delegation, have been approved by the CCG's Governing Body and certified as compliant with the requirements of NHS England/Improvement. Collectively these documents enable the maintenance of a sound and robust system of internal control. The CCG remains accountable for all of its functions, including those delegated.

The Constitution sets out the arrangements in place to meet the legal duty for commissioning care for the people for whom it is responsible.

Our Constitution sets out arrangements for the exercise of our functions and governance arrangements as well as the arrangements to meet our legal duty to involve patients and the public in our work. Above all, the Constitution exists to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to all that the CCG does.

Our Constitution details:

- Membership of the CCG and the area covered
- Arrangements for the exercise of our functions including good governance

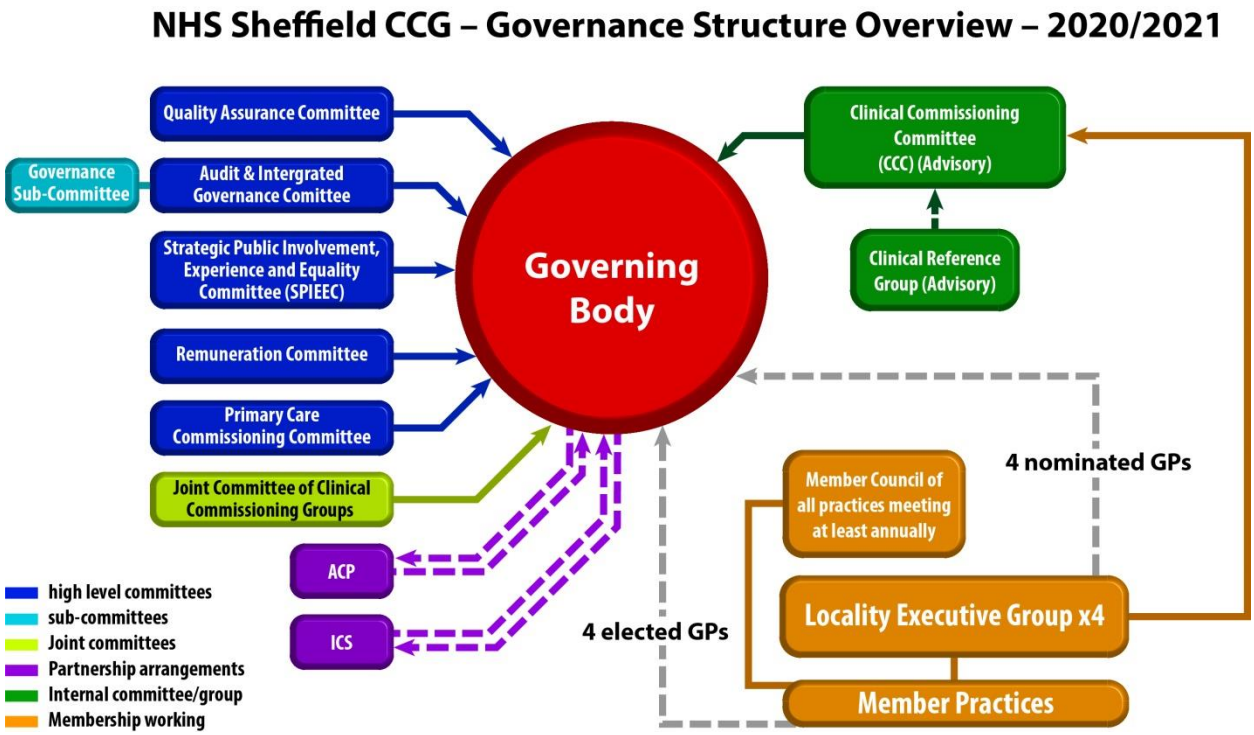
- Procedures for making decisions
- The Governing Body and its committees
- Collaborative commissioning arrangements
- Provisions for conflict of interest management and standards of business conduct and managing conflicts of interest
- The CCG as an employer
- Transparency, ways of working and Standing Orders

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

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

### 3.3 Governing Body and its committees, sub-committees and joint committees of the governing body

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



*Following review by the committee, the Strategic Patient Engagement, Experience and Equality Committee (SPEEEC) was renamed to the Strategic Public Involvement, Experience and Equality Committee (SPIEEC) on 14 January 2021.*

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

## Governing Body

The functions of the Governing Body are conferred by sections 14L(2) and (3) of the 2006 Health and Social Care Act, inserted by section 25 of the 2012 Health and Social Care Act. In particular, it has responsibility for:

- Ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance (its main function)
- Determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act; and
- Those matters delegated to it within the CCG's constitution.

The CCG Governing Body has met 10 times during the year and was quorate on each occasion. Its agendas have incorporated a comprehensive range of reports supporting delivery of its key functions including the 2020/21 Operational Plan, Performance and Quality Reports. The Governing Body has also considered the Governing Body Assurance Framework (GBAF) on a quarterly basis.

It has continued to evaluate its effectiveness through development sessions throughout the year and initiating changes which build and strengthen its functionality.

The Governing Body takes overall responsibility for governance throughout the organisation but discharges some of its responsibilities to a number of committees which include:

a) Audit and Integrated Governance Committee (AIGC)

b) Primary Care Commissioning Committee (PCCC)

c) Remuneration Committee (RemCom)

d) Quality Assurance Committee (QAC)

e) Strategic Public Involvement, Experience and Equality Committee (SPIEEC)

f) Governance Sub-committee (GSc)

A full list of committees, including their responsibilities, membership and key highlights are set out from page 71 onwards. In addition to governance, the Governing Body and its delegated committees place a clear focus on the services, performance and patient safety of its commissioned providers.

During 2020/2021, our Governing Body reached into the organisation in a more open and collaborative way than ever which included:

- Ongoing strong engagement with localities throughout the pandemic, despite the challenges we had all faced
- Closer working relationships between lay members and executives
- Establishment of the staff-led COVID Learning Group with
- GB sponsorship and support into the resulting work streams Increased GP/clinical presence at the Quality Assurance Committee, which has become a more regular occurrence
- Actively part of the weekly COVID gold risk monitoring programme

## Attendance of voting members at governing body meetings in public

| Governing Body Member | 7.5.20 | 18.6.20 | 6.8.20 | 3.9.20 | 5.11.20 | 14.1.21 | 4.3.21 |
|---|---|---|---|---|---|---|---|
| Dr Amir Afzal - Locality nominated GP | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dr Nicki Bates - Elected GP | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Sandie Buchan - Director of Commissioning Development (wef 1.8.20) | | | | ✓ | ✓ | ✓ | ✓ |
| Nicki Doherty - Director of Delivery, Care Outside of Hospital (to 12.7.20) | ✓ | ✓ | | | | | |
| Amanda Forrest – Lay Member (to 31.12.20) | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Prof Mark Gamsu - Lay Member | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dr Terry Hudsen – Chair | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Brian Hughes - Deputy Accountable Officer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dr Andrew McGinty - Locality nominated GP | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ |
| Dr Zak McMurray - Medical Director | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ |
| Jackie Mills – Interim Director of Finance | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Anthea Morris - Lay Member | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Chris Nield - Lay Member | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ |
| Dr Lisa Philip - Elected GP | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dr Marion Sloan - Elected GP | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ |
| Lesley Smith - Accountable Officer | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ |
| Dr Leigh Sorsbie - Elected GP | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Judi Thorley - Lay Member (wef 1.1.21) | | | | | | ✓ | ✓ |
| Dr David Warwicker - Locality nominated GP | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Alun Windle – Interim Chief Nurse | ✓ | ✓ | X | ✓ | ✓ | x | ✓ |

Please note, the blocked sections on the chart indicate 'not a member at the time'.

The meeting arranged to be held on 2 April 2020 was cancelled due to the COVID-19 pandemic.

## Audit and Integrated Governance Committee

The Audit and Integrated Governance Committee (AIGC) met four times during 2020/21, considering relevant issues in line with its annual work plan, and was quorate on each occasion. The average attendance was 100%.

The committee has an agreed work plan with Governing Body approved terms of reference and is chaired by a Lay Member with responsibility for financial strategy and governance who is also the Conflicts of Interest Guardian.

AIGC has delegated responsibility for critically reviewing the CCG's financial reporting and internal control principles and for maintaining an appropriate relationship with both internal and external audit as well as the Counter Fraud Service. A key responsibility of the committee is to review the financial statements prior to submission to Governing Body with a recommendation for approval. The committee also has delegated responsibility 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 work of AIGC is underpinned by the functions of the Governance Sub-committee and an ongoing dialogue with internal and external auditors.

## Key performance highlights

- Approval of the annual programme of work to be undertaken
- Receiving and reviewing updates from external audit, following approval of the annual plan for the March 2020 year end
- Review of Internal Audit and Counter Fraud Services; approval of annual plans and in year monitoring of delivery against plans

- Review of policies against NHS Protect Standards for Bribery and Corruption against the Bribery Act 2010
- Ongoing review of various aspects of internal control, including updates on key quality and performance issues from the Quality Assurance Committee
- Review of the Governing Body Assurance Framework with particular focus on ongoing identified gaps in control and/or assurance
- Annual review of the CCG's Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies
- Approval of the CCG's Risk Management Strategy and Action Plan
- Receiving and noting updates on guidance on conflicts of interest
- Review of Registers of Interests, procurement and gifts and hospitality and sponsorship
- Annual Review of the Committee's Terms of Reference
- Reviewing the draft and final accounts, including the annual and quality reports and the CCG's Annual Governance Statement, prior to recommending approval by the CCG Governing Body in May 2020

## Attendance at Audit and Integrated Governance Committee meetings

| AIGC Member | 18.06.20 | 10.09.20 | 10.12.20 | 11.03.21 |
|---|---|---|---|---|
| Anthea Morris – Lay Member | ✓ | ✓ | ✓ | ✓ |
| Amanda Forrest – Lay Member (up to 31.12.20) | ✓ | ✓ | ✓ | |
| Chris Nield – Lay Member | ✓ | ✓ | ✓ | ✓ |
| Dr Andrew McGinty - Locality nominated GP | ✓ | ✓ | ✓ | ✓ |
| Dr Lisa Philip – Elected GP | ✓ | ✓ | ✓ | ✓ |
| Judi Thorley – Lay Member (wef from 1.1.21) | | | | ✓ |

Please note, blocked sections indicate 'not a member at the time'.

## Primary Care Commissioning Committee

The CCG assumed delegated commissioning responsibility for primary care medical services from 1 April 2016. Primary Care Commissioning Committee (PCCC) functions as a corporate decision making body for the management of the functions and the exercise of the powers delegated by NHS England.

The committee is established in accordance with statutory provisions to enable its decisions to be made on the review, planning and procurement of primary care services.

The advent of COVID-19 and implementation of command and control arrangements to support the NHS response meant that there were some changes to the operation of the committee, with a concentration on matters that required the exercise of delegated powers and functions and an oversight of the primary care response to the pandemic.

The committee met six times during 2020/21 and was quorate on each occasion, meetings in May and June 2020 were held in private only, considering relevant issues in line with its annual work plan but development sessions were suspended to free up capacity for the COVID-19 response.  Average attendance was 94%.

## Key performance highlights

During 2020/21 the Committee:

- Approved arrangements to implement Enhanced Care in Care Homes within Sheffield and associated Locally Commissioned Services.
- Reviewed the risk assessment for Black, Asian and Minority Ethnic and High Risk Staff in Primary Care in response to COVID-19.
- Approved a number of practice mergers and the closure of one practice site.
- Approved plans and related spend in regard to Sheffield CCG GP Forward View (GPFV) strategy
- Considered the approach taken to protect practice capacity and income in light of COVID-19 including adjustments to 2019/20 QOF payments
- Considered regular reports on the practices within Sheffield and agreed appropriate actions to improve service quality and delivery where necessary and in line with guidance issued by NHS England
- Considered regular reports on the arrangements put in place to secure the delivery of primary medical services in Sheffield during the COVID-19 pandemic and arrangements put in place to support practices and their workforce at this time of exceptional pressure
- Received information on the arrangements put in place for Primary Care Networks in 2020/21
- Approved the ICS Wave 4 Capital Bid Programme Business Case
- Monitored CCG progress to deliver primary care estates developments identified as part of the successful ICS Wave 4 Capital Bid.
- Approved the Primary Care Annual and Financial Plan for 2020/21
- Reviewed the future operation of the committee in the context of the emerging SYB ICS
- Reviewed progress against the Sheffield Primary Care Estates Strategy
- Approved plans to develop new approaches to the leasing and occupancy of void space in primary care buildings to secure effective services for local populations
- Approved plans in relation to finding released by the equalisation of practice payments under GMS and PMS contracts

- Considered plans to increase practice resilience in Sheffield including workforce recruitment and retention
- Considered the results of the 2020 National Patient Survey, how survey data should be used to improve patients' experience of primary care, and ensure that the CCG commissions for a high quality patient experience
- Received regular reports on the progress of the 2020/21 flu vaccination campaign and on primary care COVID-19 vaccination
- Approved the use of funding to ensure winter resilience in general practice
- Considered the ICS Primary Care Strategy and the CCG 2021/22 Commissioning Intentions for Primary Care

## Attendance at Primary Care Commissioning Committee meetings

| PCCC Member | 4/6/20 | 23/7/20 | | 17/9/20 | | 19/11/20 | | 21/1/21 | | 18/3/21 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Private only | Public | Private | Public | Private | Public | Private | Public | Private | Public | Private |
| Chris Nield - Lay Member | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mark Gamsu - Lay Member | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Judith Thorley - Lay Member (wef Jan 21) | | | | | | | | ✓ | ✓ | ✓ | ✓ |
| Brian Hughes - Deputy Accountable Officer | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Jackie Mills – Interim Director of Finance | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Alun Windle - Interim Chief Nurse | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x | x |
| Lesley Smith - Accountable Officer | ✓ | x | x | x | x | x | x | x | x | x | x |
| Sandie Buchan - Director of Commissioning Development (wef 1.8.20) | | | | x | x | x | x | ✓ | x | ✓ | ✓ |
| Amanda Forest - Lay Member (up to 31.12.20) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | |

| | | |
|---|---|---|
| Nicki Doherty - Director of Delivery, Care Outside of Hospital (up to 12.7.20) | x | |

Please note, the blocked sections indicate 'not a member at the time'

## Remuneration Committee

The remuneration committee is chaired by a lay member and met on four occasions during 2020/2021 and was quorate on each occasion. Average attendance was 92%. The purpose of the Committee is to make determinations about pay and remuneration, for employees of the CCG (who are outside of agenda for change terms and conditions including Governing Body Members), taking into account any national Directions or guidance on these matters. The Committee has the delegated authority to consider the outcome of any performance review of the Accountable Officer and other senior CCG employees. In addition, the Committee has delegated authority to consider the severance payments of the Accountable Officer and of other senior staff. The Committee advises the Governing Body on its determinations about allowances under any pension scheme it might establish as an alternative to the NHS pension scheme and on any other potential alternative remuneration and conditions of service for CCG employees outside of, or in place of, national Agenda for Change arrangements.

## Key performance highlights

- Annual review of the Remuneration Committee Terms of Reference and recommendation to Governing Body for approval
- Review and approval of all proposed redundancy business cases
- Review of the remuneration of all Governing Body members and all other staff in the CCG who are not on Agenda for Change terms and conditions
- Review of the performance of all Directors on Very Senior Manager contracts and determination of appropriate financial awards
- Oversight of the recruitment processes for all other Governing Body members
- Oversight of the exit arrangements for the Accountable Officer and oversight of the subsequent appointment of the Interim Accountable Officer

## Attendance at Remuneration Committee meetings

| Remuneration Committee Member | 7.5.20 | 2.7.20 | 3.12.20 | 14.1.21 |
|---|---|---|---|---|
| Dr Amir Afzal - Locality nominated GP | x | ✓ | ✓ | ✓ |
| Dr Nicki Bates - Elected GP | ✓ | ✓ | ✓ | ✓ |
| Amanda Forrest – Lay Member (up to 31.12.20) | ✓ | ✓ | ✓ | |

| | | | | |
|---|---|---|---|---|
| Prof Mark Gamsu - Lay Member | ✓ | ✓ | ✓ | ✓ |
| Anthea Morris - Lay Member | ✓ | ✓ | ✓ | ✓ |
| Judi Thorley – Lay Member (wef from 1.1.21) | | | | ✓ |
| Dr David Warwicker - Locality nominated GP | ✓ | ✓ | ✓ | x |

Please note, the blocked sections on the chart indicate 'not a member at the time'

Meetings arranged for 3 September 2020, 5 November 2020 and 4 March 2021 were cancelled.

## Quality Assurance Committee

This Committee is chaired by a Lay Member with a lead role in Patient and Public Engagement. The committee has responsibility for seeking assurance that all providers with whom the CCG places service contracts are delivering high quality and safe care and that a culture of continuous quality improvement is embedded within organisations and services. The committee meets on a six weekly basis and has provided exception reporting to the Governing Body on quality concerns and good practice across Sheffield.

## Key performance highlights

During 2020/21 the committee has continued to develop and deliver its responsibilities against the reduction of reporting during the Covid-19 period. Specifically, there has been good attendance from GPs, internal audit and Healthwatch. It has:

- Provided a Patient Safety, Quality and Experience report highlighting key quality assurance and issue of risk. Received triangulated data considering, safety, effectiveness and experience for each provider. The committee has also sought assurance of continued improvement and outcomes for all commissioned services
- Continued to review the reporting format to streamline exception reporting and highlight provider concerns
- Systematically reviewed provider performance in relation to all areas of quality, for both Sheffield CCG commissioned providers (including not for profit organisations, Primary Care providers) and Sheffield in-area providers that are not directly commissioned by the CCG
- Reviewed feedback relating to providers from the Care Quality Commission (CQC) and other regulatory bodies and taken action with providers where appropriate
- Monitored patient safety issues, including Serious Incidents, Never Events, targets and plans to reduce hospital and community acquired infection
- Monitored performance of providers relating to Clinical Quality and Innovation Schemes (CQUINs)

- Approved strategies and monitored action plans linking with the quality assurance and contracting process
- Extensively monitored patient experience feedback from providers including provider and public websites
- Reviewed and approved clinical policies and procedures
- Received reviews from Internal Audit that demonstrate effective internal functions of the CCG's quality assurance systems (Primary Care Quality Assurance internal Audit March 2019 reported 'significant assurance')
- Planning to undertake further provider Committee to Committee meetings
- Provided quarterly exception reports and recommendations to Governing Body

## Attendance at Quality Assurance Committee meetings

| QAC Member | 30.4.20 | 28.5.20 | 25.6.20 | 30/7/20 | 27.8.20 | 29.10.20 | 17.12.20 | 28.1.21 | 25.3.21 |
|---|---|---|---|---|---|---|---|---|---|
| Amanda Forrest – Lay Member (up to 31.12.20) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Prof Mark Gamsu - Lay Member | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x |
| Dr Andrew McGinty - Locality nominated GP | x | x | x | x | ✓ | x | x | x | ✓ |
| Dani Hydes – Deputy Director of Quality (wef 11.1.21) | | | | | | | | x | ✓ |
| Dr Zak McMurray - Medical Director | ✓ | ✓ | ✓ | x | ✓ | x | x | x | ✓ |
| Dr Marion Sloan – Elected GP | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Judi Thorley – Lay Member (wef from 1.1.21) | | | | | | | | ✓ | ✓ |
| Alun Windle - Interim Chief Nurse | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ |

Please note, blocked sections indicate 'not a member at the time'

[1] Meeting arranged to be held on 24 September 2020 was cancelled due to COVID-19 pandemic

## Strategic Public Involvement, Experience and Equality Committee

The committee has delegated responsibility for approval of the arrangements for discharging the CCG's statutory duties relating to public engagement and consultation and equality. It is

responsible for assuring that engagement, patient experience and equality and diversity activity is being carried out in line with statutory requirements and to a high standard and that information from these activities is used appropriately to influence commissioning.

## Key performance highlights

- Assurance of involvement process for the prescription order line
- Assurance of involvement process for the stoma service review
- Assurance of the consultation process for the relocation of York Road Surgery
- Assurance of the consultation process of Jordanthorpe Health Centre branch closure
- Oversight of the review of the Terms of Reference
- Assurance on the revised Quality and Equality Impact Assessment Policy
- Assurance meeting legal duties due to temporary service changes during the pandemic
- Assurance of process for delivery of Equality Delivery System 2
- Oversight of the engagement into the impact of Covid-19 and lockdown, and the mitigations put in place
- Oversight of the Communications and Engagement Strategy development
- Oversight of the Covid-19 Vaccination Engagement Plan

## Attendance at Strategic Public Involvement, Experience and Equality Committee

| SPIEEC Member | 21.7.20 | 1.9.20 | 13.10.20 | 24.11.20 | 5.1.21 | 16.2.21 | 30.3.21[1] |
|---|---|---|---|---|---|---|---|
| Amanda Forest – Lay Member (up to 31.12.2020) | ✓ | ✓ | ✓ | ✓ | | | |
| Prof Mark Gamsu - Lay Member | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Brian Hughes - Deputy Accountable Officer | x | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Dr Lisa Philip – Elected GP | ✓ | x | ✓ | ✓ | ✓ | ✓ | |
| Judi Thorley - Lay Member (wef 01.01.2021) | | | | | ✓ | ✓ | |
| Dr Leigh Sorsbie – Elected GP | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Alun Windle - Interim Chief Nurse | ✓ | ✓ | ✓ | ✓ | X | ✓ | |
| Adele Robinson - Senior manager with responsibility for equality and engagement, Sheffield City Council | x | x | x | ✓ | x | ✓ | |
| Lucy Ettridge – Deputy Director of Communications, Engagement and Equality | ✓ | ✓ | x | ✓ | ✓ | ✓ | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lucy Davies – Chief Operating Officer, Healthwatch | ✓ | ✓ | ✓ | x | ✓ | x | |
| Leah Laputre – Public Representative | ✓ | x | x | ✓ | ✓ | ✓ | |
| Mahara Hague – Public Representative | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Parveen Ali – Equality Representative, Sheffield Hallam University | ✓ | x | x | x | x | x | |
| Jane Ginniver - ACP Representative | ACP representative agreed on TOR 14.1.21 Governing Body | | | | | ✓ | |
| Sarah Neil – Patient Experience Manager | x | ✓ | ✓ | ✓ | x | ✓ | |
| Helen Mulholland – Engagement Manager | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Richard Kennedy – Engagement Manager | x | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Nicki Doherty - Director of Delivery, Care Outside of Hospital (up to 12.7.20) | | | | | | | |

Please note, blocked sections indicate 'not a member at the time'

Meetings arranged for 28 April 2020 and 9 June 2020 were cancelled due to the pandemic.

[1]Workshop held on this date

## Governance Sub-committee

The Governance Sub-committee (GSC) is established as a sub-committee of the AIGC with a remit to ensure that a sound system of integrated governance, risk management and internal control is in place to support the achievements of the CCG's objectives, providing the AIGC, and ultimately Governing Body, with assurance as both an employer and a statutory body. It receives reports on high level risks, reviews risk registers and scrutinises any new organisational risks and their associated risk scores. GSC also receives reports from a number of sub-groups including Information Governance and Health and Safety. Reports to GSC include quarterly updates in relation to workforce, Freedom of Information requests and MP enquiries, legal claims and litigation and compliments and complaints. GSC also receives reports with regard to the review and implementation of CCG policies for which it has delegated responsibility for approval of both corporate and HR policies.

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

## Key performance highlights

- Review of policies throughout the year with significant assurance that the process for review and management of policies is well managed
- Review of the management of Freedom of Information (FOI) requests during the year which has achieved 100% response to requests for information.
- Incident reporting reviewed at each meeting, providing assurance that actions were taken following reported incidents in order to minimise the likelihood of future re-occurrence
- Requests for lessons learned to be included in all future incident reports to Governance Sub-committee.
- Investigations shared with staff where appropriate
- Assurances received with regard to Information Governance systems and processes, including Data Security and Protection Toolkit, Data Quality, Information Governance Incidents, Compliments and Complaints, Emergency Preparedness, Resilience and Response (EPRR) Framework and Business Continuity Planning, Research Governance
- Positive assurance received in support of health and safety initiatives, premises inspections, security and fire risk assessments
- Scrutinised all high level risks from the Corporate Risk Register at each meeting.
- All new risks added to the Corporate Risk Register are reviewed at each meeting, together with a particular focus on risks that had increased in score, and risks which had remained static over the review period. This included reviews of the effectiveness and progress of mitigating actions
- Robust and detailed workforce reports including sickness absence, statutory and mandatory training, equality and diversity information
- Annual review of the sub-committee's Terms of Reference which were reviewed following changes to the membership
- Received the Annual Health and Safety Report and organisational risk assessment
- Provided quarterly assurance to AIGC of the sound systems of internal control, highlighting any areas where further scrutiny may be required

## Attendance at Governance Sub-committee meetings

| Governance Sub-committee member | 1.9.20 | 17.11.20 | 12.2.21 |
|---|---|---|---|
| Gary Barnfield– Deputy on behalf of the Medical Director<br>(wef 17.11.20) | | ✓ | ✓ |
| Sarah Burt / Kate Gleave – Deputy Director of Commissioning<br>(joint post – 1 attendee required) | ✓ | ✓ | X |
| Chris Cotton – Deputy Director of Finance | ✓ | ✓ | ✓ |

| | | | |
|---|---|---|---|
| Katie Hodgson – Staff Side representative | ✓ | ✓ | ✓ |
| Sue Laing - Corporate Services Risk and Governance Manager | ✓ | x | ✓ |
| Adam Lavington – Deputy Director of Information Technology<br>(member from 17.11.20 ) | | ✓ | x |
| Sam Oliver – Deputy Director of Human Resources | ✓ | ✓ | ✓ |
| Tracey Standerline – Deputy Director of Information, Performance and PMO (Deputy SIRO)<br>(member from 17.11.20) | | ✓ | ✓ |
| Cath Tilney – Associate Director of Corporate Services<br>(member from 17.11.20) | | ✓ | ✓ |
| Alun Windle - Interim Chief Nurse | x | ✓ | ✓ |

Please note, blocked sections indicate 'not a member at the time'

Meeting arranged for 1 May 2020 was cancelled due to the COVID-19 pandemic

## Other partnership arrangements

### Joint Committee of Clinical Commissioning Groups

In 2015 the CCG became a member of the Joint Committee of CCGs (JCCCG). At that time the Committee had agreed to delegate authority to make joint decisions on two service areas; hyper acute stroke services and some out of hours children's surgery and anaesthesia services. In June 2019 CCGs agreed to revised terms of reference and manual agreement and a new set of joint commissioning priorities with delegated authority for decision for a number of these, which can be found here:
https://www.healthandcaretogethersyb.co.uk/application/files/5915/6096/1736/JCCCG_-_26_June_2019_Agenda_and_Papers.pdf

During 2020/21 the JCCCG has continued to work to the revised Terms Of Reference and Manual Agreement and developed a joint priorities work plan, although much of the work involved was deferred from May 2020 as a result of the COVID-19 pandemic, as the NHS moved into a national level 4 incident operating under NHS England / Information (NHSE/I) command and control.

Due to the deferred work and that no joint decisions were required, most of the scheduled public meetings were cancelled. The last meeting held in public was held virtually on 26 August 2020. Papers for the JCCCG meetings can be found here:
https://www.healthandcaretogethersyb.co.uk/about-us/minutes-and-meetings

## South Yorkshire and Bassetlaw Integrated Care System/Sustainability and Transformation Plan

The CCG is also a partner in the South Yorkshire and Bassetlaw Integrated Care System (ICS). ICSs are systems in which NHS commissioners and providers, working closely with local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and population health outcomes. They are expected to transform the way care is delivered, to the benefit of the population they serve. Currently, the ICS does not replace any legal, or statutory, responsibilities of any of the partner organisations.

During 2020/21, the ICS governance remained the same as 2019/20, however, the frequency of some of these meetings was impacted by the COVID-19 pandemic with others carried out virtually.

In February 2021 the Government announced plans for the future of health and care, including the role of ICS'. This can be read here:
https://www.gov.uk/government/speeches/the-future-of-health-and-care

The governance of the ICS includes the following:

## The System Health Oversight Board

The System Health Oversight Board (HOB) is the ICS primary governance group comprising Executive and Non-executive members from across SYB statutory bodies and the regional NHS bodies.

The HOB provides a joint forum between health providers, health commissioners, NHS England and NHS Improvement and other national arm's length bodies, to respond to the national policy direction for health and implementation of the NHS Long Term Plan. A key purpose of the HOB is to give assurance to partners and the region on progress and delivery and to give strategic direction on healthcare issues. The HOB meets quarterly.

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

## Collaborative Partnership Board

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

### The System Health Executive Group

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

### The Integrated Assurance Committee

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

### The ICS System Health and Care Management Team

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

### Work Stream Programme Boards

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

The ICS has evolved from the establishment of a Sustainability and Transformation Partnership in January 2016, an Accountable Care System in April 2017, to then becoming one of the first and most advanced ICS systems in England.

### Sheffield Accountable Care Partnership (ACP)

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

The ACP worked very differently through 2020 as many work streams were paused to enable staff to focus on contributing to the pandemic response. The trust and relationships that had built up over the work of previous years came into their own enabling partners to work together in new ways.

In summer 2020 we came together as a partnership to agree how we would work together and address the priorities likely to affect health and care in Sheffield over the next six to nine months, moving from the urgent tactical approach that had been in place since March 2020. The output from this session was a set of 18 priorities across the areas listed below.

- Communications
- Mental health

- Urgent Care and Out of Hours Support
- Discharge and Transitions
- Community Provision
- Planned and elective care

More recently we have been reflecting on how we need health and social care services to adapt and re-focus in the longer term post Covid. Building on the ambitions in the 'Shaping Sheffield' plan we are developing a longer term vision for the partnership, which has been developed in conversations across Sheffield, including the NHS, Sheffield City Council, Sheffield's voluntary and community sector and patient representatives supported by the Nuffield Trust and PPL. A draft of the vision is now available and is in the process of being discussed and agreed with organisations' boards.

In the vision we have identified three priority areas that we will work on over the next few years to ensure that we achieve our goal:

1. **Tackling inequalities** - Covid-19 has been the 'great revealer' of inequalities in our system: shining a light on health inequalities, racial inequalities, income and other deep structural inequalities. Addressing these inequalities is a shared commitment of all our ACP partners.
2. **Integration of Care** - We will take positive steps to ensure that there is "no wrong door" for people accessing health and care support and that our pathways and systems are setup to respond accordingly, with
3. **People at the heart of what we do** (both the population of Sheffield and our workforce) – The importance of care which is more responsive to people's and families' particular needs is clear and we will continue to develop person centred approaches to care and provide our staff with the skills and opportunities to work together within a closely inter-connected system.

To reflect the shift in focus of the ACP, changes to senior leadership in the city and the need to adapt to meet the requirements of DHSC's Innovation and Integration White Paper, we have also refreshed the Terms of Reference of the ACP Board and the Board elected to ask one of the retiring Chairs of our organisation, Tony Pedder, to become the Board's temporary independent chair from the start of 2021.

## 4. UK code of corporate governance

NHS bodies are not required to comply with the UK Code of Corporate Governance; however, compliance with relevant principles of the Code is considered appropriate and good practice. This Governance Statement is intended to demonstrate how the CCG has due regard to the principles set out in the Code which are considered appropriate for CCGs. For the financial year ended 31 March 2021, and up to the date of signing this statement, we have regard to the provisions set out in the code and applied the principles of the code.

## 5. Discharge of statutory functions

In light of recommendations of the 1983 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

## 6. Risk management arrangements and effectiveness

### 6.1 Risk management arrangements

The CCG has assessed its key risks and uncertainties throughout the year using the Governing Body Assurance Framework (GBAF). The Assurance Framework sets out the principal risks facing delivery our strategic objectives and how these risks are managed. There is an established methodology in place to identify, monitor, control and mitigate risks throughout the CCG as part of, and within, the CCG's Risk Management Strategy and Assurance Framework. In addition to the GBAF, organisational risks for day-to-day activities are monitored through the Corporate Risk Register.

Our risk management process is underpinned by the Risk Management Strategy and Action Plan, the key elements of which include the application of logical and systematic methods and processes for:

- establishing the context for identifying, analysing, evaluating, treating risk associated with CCG activity, processes and functions
- monitoring and reviewing risks
- appropriate recording and regular reporting of risk

Effective risk management enables the CCG to set priorities and improve decision making to reach an optimal balance of risk, benefit and cost. Robust risk management assists in the prevention of risks and reduces the CCG's vulnerability in all its corporate objectives. Continuous monitoring of internal systems and processes together with regular deep dive reviews act as fraud deterrents and ensure the earliest identification of possible risks. Robust risk management assists in the prevention of risks whilst reducing the CCG's vulnerability in all of its corporate objectives.

Leadership of the risk management process is given a high profile within the CCG and as such the Risk Management Strategy is reviewed annually. It sets out the key roles and responsibilities of staff in handling and reporting risks and is built into the strategic planning process. Risk is managed operationally within the governance of decision making which is set out in the CCG's Scheme of Reservation and Delegation (SoRD).

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

As part of its fraud, bribery and corruption arrangements, the CCG utilises the services of the Principal Anti-Crime Specialist in the delivery of a robust counter fraud service. The Principal Anti-Crime Specialist provides the CCG with assurance through regular meetings with the Director of Finance to review the counter fraud plan and discuss cases which may arise. The Principal Anti-Crime Specialist also presented regular reports to the AIGC throughout the year, as well as training regarding counter fraud, bribery and corruption to all CCG Staff. Regular updates and alerts are communicated to all staff.

Within the organisation's embedded risk management process, the CCG also utilises Datix for local incident reporting. All staff are able to report incidents online, there is no specific login detail required as the CCG encourages open reporting to identify potential risks to in order to minimise harm.

Risks for escalation is an item for the agendas of each of the high level committees and sub-committee and risks identified at each meeting are escalated to the Audit and Integrated Governance Committee which has this as a standing item for each agenda.

### 6.2 Capacity to handle risk

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

Risk awareness is a key element of the organisation's approach to risk management, ensuring that all staff understand and are able to discharge their roles and responsibilities in relation to risk. This approach is led by the Corporate Services Risk and Governance Manager and includes highlighting the need for risk assessments and explanation of, and subsequent support through, the risk management process.

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

The Governing Body is responsible for ensuring that the CCG consistently follows the principles of good governance applicable to NHS organisations through its Assurance

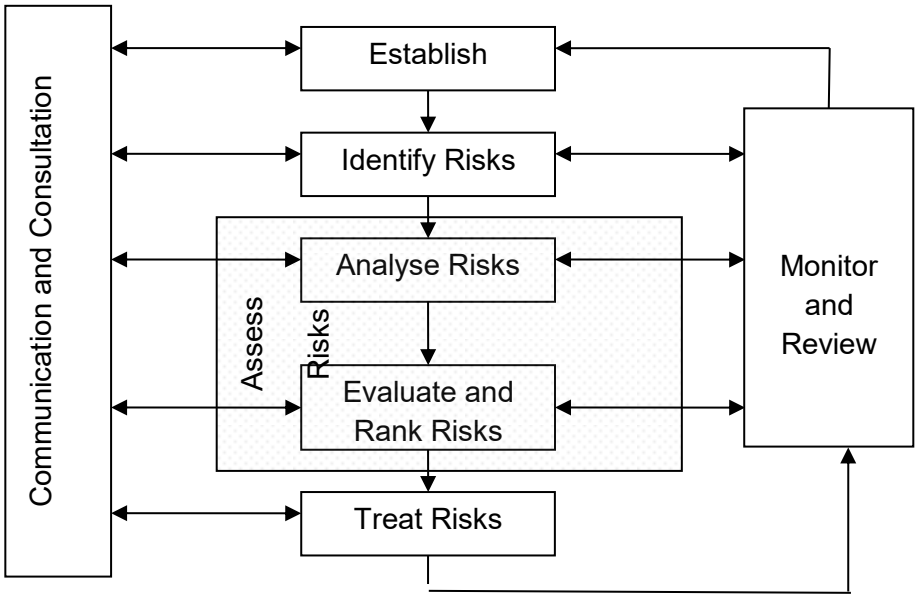
Framework and other processes including the development of systems and processes for financial and organisational control, clinical governance and risk management. The Director of Finance is designated as the executive director lead for implementing the system of internal control. All members of SMT are accountable for the effective management of risk within their areas of responsibility. This includes ensuring that appropriate controls are in place and that risk identification and mitigating actions are progressed and monitored.

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

Deputy Directors meet bi-monthly where risk management is a key item for the agenda. Deputies offer leadership and guidance on mitigating the level of risk and ensuring that risks are appropriately managed. Deputy Directors will also consider potential escalation from team risk logs to the Corporate Risk Register where this is appropriate. The Corporate Services Risk and Governance Manager is responsible for operational management of risk within the organisation.

### 6.3 Risk assessment

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



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

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

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

| Risk 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 |

Each risk added to the GBAF will have a set of three scores:

### Initial risk score:

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

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

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

Only current and target risk scores are required for those risks added to the corporate risk register.

### 6.3.1 Governing Body Assurance Framework (GBAF)
The GBAF is designed to meet the requirements of the Governance Statement, providing a structure and process to enable the organisation to focus on the high level strategic and reputational risks with the potential to compromise achievement of the organisation's objectives. Our GBAF is built around the CCG's five strategic objectives and principal risks aligned to the risk register. It is a dynamic tool that maps key controls, highlighting any gaps in control and assurance to mitigate the risks identified, providing a mechanism to assure Governing Body of its effectiveness of these controls.

During 2020/21, the GBAF was further refined in terms of its technical ability and also incorporated recommendations from our internal audit report. The GBAF is part of the wider governance and assurance framework to ensure the CCG's performance across the full range of its commissioning activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for patients. Crucially, the GBAF provides Governing Body with confidence that systems and processes are operating in a way that is safe and effective.

Executive directors meet annually with internal audit colleagues to discuss the high level of risk facing delivery of the organisations objectives. Meetings are followed by a 'Confirm and Challenge' session where review and challenge of risk scores of all principal risks highlighted on the refreshed framework takes place. The Governing Body was provided with details of the refreshed GBAF at its meeting in March 2020 which included details of the changes to be taken forward to 2020/21.

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

AIGC also reviews any identified gaps in control and / or assurance ensuring these are closed wherever possible. This approach ensures that principal risks are managed effectively towards

achieving the target risk score. As the CCG focuses on its role as a commissioner of safe and high quality services, it seeks to embed the principles and practice of risk management into its commissioning function. As a commissioner, the CCG seeks to ensure that all services commissioned meet nationally identified standards which are managed through the contracting process.

At the start of 2020/21, 20 risks were identified on the GBAF, at the end of the monitoring period no risks had been closed, and one new risk was added during the year. A total of 21 risks remained on the GBAF. The level of risk is set out below.

GBAF Risk Profile 1 April 2020 – 31 March 2021

| Review period | Critical | Very High | High | Medium | Low | Risks Closed | TOTAL |
|---|---|---|---|---|---|---|---|
| Up to and including 31 March 2021 | 0 | 8 | 9 | 4 | 0 | 0 | 21 |
| Up to and including 24 February 2021 | 0 | 9 | 9 | 3 | 0 | 0 | 21 |
| Up to and including 23 Nov 2020 | 0 | 10 | 9 | 2 | 0 | 0 | 21 |
| Up to and including 31 Jul 2020 | 1 | 7 | 10 | 2 | 0 | 0 | 20 |

At 31 March 2021, there were no Gaps in Control identified on the GBAF.

### 6.3.2 Corporate Risk Register

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

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

The table below identifies the level of risk by risk category at each quarter during 2020/2021.
Corporate Risk Register – Risk Profile

| Quarter | Critical | Very High | High | Medium | Low | Total |
|---|---|---|---|---|---|---|
| 4 | 0 | 4 | 21 | 14 | 2 | 41 |
| 3 | 1 | 4 | 31 | 9 | 7 | 52 |
| 2 | 0 | 6 | 25 | 12 | 6 | 49 |
| 1 | 1 | 5 | 18 | 12 | 3 | 39 |

The following four risks on the Corporate Risk Register were classified as very high at the end of Quarter 4 2021. There were no risks marked as 'critical'.

| Risk Ref | Risk Rating | Principal Risk |
|---|---|---|
| 1458 | 4 x 4 | There is a high risk that a current provider of Intermediate Care beds will be unable to continue to provide the current service due to significant financial difficulties. Barclays Bank have asked Price Waterhouse Cooper (PWC) to work with the provider to evaluate the different options available which are likely to include the sale of one or more of the care homes in Sheffield. The provider is also struggling to obtain public liability cover for the homes which is currently affecting visiting and the CQC therefore remain concerned. The impact of the COVID 19 pandemic had led to further stability issues across the care home sector further affecting these homes and this provider.<br><br>The risk has potential to increase if the provider is unsuccessful in securing any / enough of longer term Intermediate Care bed contract when it goes out to the market |
| 1716 | 4 x 4 | There is a risk of vulnerable/most in need groups (20% most deprived, SMI, LD BAME and homeless) having disproportionate access to and appropriate management of health needs due to structural and societal inequalities that exist resulting in disproportionately poorer health outcomes |
| 1736 | 5 x 3 | There is a risk of Speech and Language Therapy provision specified within Education Health and Care Plans (EHCPs) not being delivered. This is as a result of lack of capacity within the Speech and Language Therapy Team. This is leading to the CCG and Local Authority being unable to meet their statutory duties in relation to SEND and means that children and young people are not having their needs met appropriately. |

| | | |
|---|---|---|
| 1740 | 3 x 5 | There is a risk of the CCG network being infected with ransomware which encrypts data stored on PCs and Servers due to potential gaps/failures within the current patches and anti-malware software resulting in a potential ransom then being demanded for the decryption key to retrieve the data<br><br>Risk can be exacerbated by some ransomware being able to encrypt or disable or delete backups. Some criminal gangs may also make a copy of your data and threaten to share it on the internet if a ransom is not paid. |

### 6.3.3 Impact of the COVID-19 virus

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

The Governing Body has approved strong reporting lines from committees, with each one required to submit a report on its work to Governing Body meetings and reporting and escalation of key risks to each meeting of the AIGC. This, along with robust governance processes and other reporting arrangements, ensures that the CCG Governing Body has the appropriate degree of rigour and oversight of the CCG's management of risk.

## 7. Other sources of assurance

### 7.1 Internal control framework

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

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

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

- Integrated Governance Handbook 2006

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

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

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

The AIGC has oversight of the internal control mechanisms on behalf of the Governing Body, supported by the Governance Sub-committee. Executive directors oversee the management and delivery of internal control mechanisms. The AIGC bases its assessments, and therefore assurances, on the effectiveness of the CCG's controls on:

- Assurances provided by the Governing Body and the work programmes of its committees
- Reviews of CCG policies and procedures, including the annual review of detailed financial policies
- Provision of assurance from independent sources (e.g. internal audit or third party reviews undertaken)

## 7.2 Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework. The CCG has undertaken the annual audit of conflicts of interests and has been assessed as having Significant Assurance. The following low level / advisory recommendations were made:

| Action / Recommendation | Risk and Score | Actions taken |
|---|---|---|
| The CCG has a policy in place which is available to all staff and includes the requirement to declare interests within 28 days. Furthermore, opportunities are taken to remind staff of the requirement on at least an annual basis. The action is therefore for the CCG to continue with these arrangements. | Low:<br><br>3 x 2 | Staff are reminded of their responsibilities as part of corporate induction and the Conflicts of Interest Executive Summary document available on the intranet. We will continue to remind staff of the need to declare any interests within 28 days, although the CCG is reliant on staff making the declaration. |
| The CCG to be cautious when receiving declaration of interest forms to ensure all information is recorded and uploaded to the CCG register. | Low:<br><br>2 x 2 | Any future declarations of interest which do not include the correct date format will be returned to staff.<br>Whilst staff have been working from home they have been unable to obtain their manager's signature on completed and updated declarations of interest. We have therefore accepted emails from reviewing line managers as authentication of the declaration. Although the audit has highlighted that full details of the reviewing line manager are not always recorded, there is an audit trail in place confirming the relevant approval.<br><br>Further guidance has been provided to administrators inputting information onto the public register with regard to the need for both vigilance and accuracy. |
| The CCG should remind committee chairs and minute takers of the recording requirements in relation to declarations of interest | Low:<br><br>3 x 2 | Training and awareness sessions have previously been provided to committee secretaries and administrators of the importance of recording requirements in relation to declarations of interest. An information pack is also available on the intranet for Chairs and secretaries which contains templates and checklists to support them in this role. Information is also available on the shared drive which is accessible to all administrators. A reminder has been shared with chairs and committee secretaries of the importance of ensuring any declarations raised in meetings are recorded in accordance with the Standards of Business Conduct and Conflicts of Interest Policy. Links to the relevant documents have been shared. |

### 7.3 Data quality

All reports received by the Governing Body provide information on how they link to the GBAF. The Governing Body receives a monthly Performance and Delivery Report which contains a significant range of data which officers ensure is the most up to date available and

from reliable sources such as contract data sets, nationally published data etc. (by local agreement local data is always noted as such to aid transparency).

The Governing Body, as part of its monthly discussions on all reports, seeks reassurance on the accuracy and timeliness of the data and has found it acceptable. Any queries or feedback is sent back to the Information Team to investigate and the responsible Director (Associate Director of Corporate Services) presents back the answers and additional information.

Periodic review of the contents / format helps ensure that processes reflect national changes in focus or monitoring. Joint working across the health economy and across South Yorkshire and Bassetlaw also exposes processes to review. This year the report has been expanded to include the quality of data that exposes the city's inequalities, the aim being to improve these datasets to enable commissioning of essential services for our most vulnerable and population demand.

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

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

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

## 7.4 Information governance

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

As an organisation we endeavour to embed good practice throughout the organisation and work to promote it across the wider health and care community. Staff are encouraged to report back all data security breaches which we become aware of when confidential information is sent to the CCG. This assists the responsible organisation in identifying process which can be improved.

We place significant importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and developed information governance processes and procedures in line with the Data Security and Protection Toolkit. We have ensured all staff undertake annual information governance training and have made available a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

Policies and processes are in place covering incident reporting and the investigation of serious (notifiable) data protection and cyber security incidents. These are also reported to and discussed at the Information Governance Group, which is chaired by the CCG's Caldicott Guardian or Senior Information Risk Owner (SIRO). This group reports to the Governance Sub-committee.

We have information risk assessment and management procedures and continue to nurture an information risk management culture throughout the organisation.

The CCG continues to observe and remain compliant with the Data Protection Act 2018 and the UK-GDPR (General Data Protection Regulations) as well as maintaining awareness of changes necessary as a result of the EU EXIT.

COVID-19 has led to a relaxing of restrictions on data sharing when dealing with the pandemic. A register of data sharing decisions under this relaxed regime has therefore been established.

The CCGs previous Data Security and Protection Toolkit (DSPT) was submitted on time, in line with the delayed September 2020 deadline. As expected, it was assessed as "satisfactory". This year's DSPT release was delayed as a result of the pandemic and subsequently the submission date has also been extended to the end of June 2021.

The actions necessary to gain a "satisfactory" assessment for the CCG's annual DSPT submission continue, with the expectation of reaching the expected standard as in previous years. This provides assurance that adequate safeguards and organisational measures are in place covering data security and the wider information governance realm.

The Toolkit has shifted focus recently and now also addresses foundational IT security requirements. In line with this change, cyber security testing and backup improvements are underway.

### Business critical models

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

## Third party assurances

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

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

For a number of key services, NHS England manages the contracts on behalf of all CCGs. Service Auditor Reports are expected to be received by NHS England and shared with CCGs in respect of the following services:

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

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

The CCG has a number of small third party contracts within the IT service and North East Commissioning Services (NECS) provides support relating to Data Management and Integration. Assurance is received through the contract which we hold with suppliers and through the oversight of the flow of data by an Information Sharing Contract which we hold with NHS Digital and an Information Sharing Agreement.

Certain support services are shared with local CCGs in South Yorkshire and Bassetlaw on a hosted basis. All partnership arrangements were overseen by NHS England when they were established and are supported by Memoranda of Understanding. Each hosted service has established formal arrangements through their Memorandum of Understanding for review and assurance of the service.

All CCGs in South Yorkshire and Bassetlaw contract with the same internal audit partner, 360 Assurance. Internal audit plans incorporate the assurances required for all partners in relation to hosted services. The Director of Finance reviews all internal audit reports, considers the implications of any deficiencies in control which are highlighted, and advises the AIGC accordingly.  Reports are presented quarterly to the AIGC of all high and medium level risks.

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

### 7.5 Freedom to Speak Up: Raising Concerns (Whistleblowing)

NHS Sheffield CCG has a policy and procedure in place for staff and external parties to raise concerns without fear of reprisal or victimisation which demonstrates the CCG's commitment and support to those who may need to come forward.

Concerns may relate to unlawful conduct, financial malpractice or malpractice related to patients, employees, the public or the environment. Where concerns have been raised, the CCG has carried out an investigation following due process outlined in our Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy and reported the outcomes as appropriate.

## 8. Control issues

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

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

The Governing Body has oversight of the appropriateness for the organisation's arrangements to exercise its functions effectively, efficiently and economically and as Accountable Officer I have exclusive responsibility for the use of resources. The following key processes and review and assurance mechanisms have been established in order to ensure proper stewardship of public money and assets:

- The CCG continues to meet all of its statutory financial duties. Budgets were established and maintained against all CCG business areas and performance monitored via a Performance and Delivery Report as a standing item at the Governing Body
- Budget holders have regular budget review meetings to ensure that any cost pressures are adequately considered, managed or escalated as necessary
- The CCG had clear internal and external audit and counter fraud arrangements which provided independent assurance to the organisation on a range of systems and processes that are designed to deliver economy, efficiency, effectiveness including the Annual Accounts and reporting processes. Our Annual Accounts are reviewed by the Audit and Integrated Governance Committee prior to formal approval by the Governing Body
- A Remuneration and Terms of Service Committee is in place with responsibility for reviewing the remuneration and terms of service for key senior leaders within the CCG. Arrangements are in place to ensure that no member of the Committee is involved in discussions and decisions about their own remuneration
- A key priority is to ensure that maximum value for money is achieved through effective commissioning arrangements, as the majority of the CCG's expenditure is spent on

commissioning healthcare services. Whilst all healthcare providers are required to deliver a continuous programme of QIPP, the CCG must also demonstrate that it is properly considering the health needs of the local population and commissioning those services that address those needs. The CCG uses the Joint Strategic Needs Assessment (JSNA) and other benchmarking tools to ensure that it is able to demonstrate a clear relationship between local needs, our commissioning decisions and the QIPP programme

- An internal audit programme of activity is agreed and established to assess the adequacy of assurances available to the CCG in relation to the economic, efficient and effective use of resources. The findings are reported to the AIGC
- Performance and Delivery Reports are presented monthly to Governing Body and published on the CCG's website, as part of an information pack with the finance report when it is a development session. Quality reports are presented bi-monthly to Governing Body
- The CCG's overall performance for 2020/21 will be evaluated formally by NHS England, our regulatory body, in the summer of 2021, and results will be made public. The assessment will focus on our contribution to the delivery of the overall plan for post COVID recovery, with an emphasis on the effectiveness of working relationships in local systems.
- Our most recent available performance rating from NHS England relates to 2019/20, when the CCG was assessed as "Good".

## 10. Delegation of functions

We have collaborative commissioning arrangements for 999 and Integrated Urgent Care (IUC) services provided by Yorkshire Ambulance Service (YAS) across CCGs in the Yorkshire and Humber region.

Assurance was previously provided as a Memorandum of Understanding and local representation at the Yorkshire and Humber Joint Strategic Partnership Board. More recently and as a result of the pandemic, we have been developing revised governance structures and ways of working to ensure appropriate delegation arrangements are in place which reflects the direction of travel going forward and are in line with the Integrated Care System governance arrangements. We have reflected on what does and what does not work and will use this information to shape how we work together.

## 11. Counter Fraud Arrangements

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

Our Counter Fraud Service is provided by 360 Assurance and the Principal Anti-Crime Specialist attends meetings of the AIGC to provide updates on progress against the annual work plan and compliance with the Standards for Commissioners in the following areas:

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

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

## 12. Head of Internal Audit Opinion

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

In reaching my Opinion, I have reflected on the context in which the organisation operates as well as the significant challenges currently facing the NHS.

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

The table below includes a summary of the work undertaken during 2020/21. There were three 2019/20 audits that were not concluded at the time of the 2019/20 Head of Internal Audit Opinion and therefore these are included below:

| Audit Assignment | Assurance level |
|---|---|
| **Outturn from 2019/20 audit plan** | |
| Older people – CQC local system review | Advisory |
| Health inequalities | Limited |
| Staff engagement: focus on the organisation's Improvement Plan | Significant |
| **Outturn from 2020/21 audit plan** | |
| Conflicts of Interest | Significant |
| IT Asset Management | Advisory |
| HR Shared Services Review | Significant |

| | |
|---|---|
| Integrity of the General Ledger, Financial Reporting and Key Financial Systems | Significant |
| Data Security Protection Security Toolkit | Indicative Substantial (NHS Digital Opinion) |
| Delegated Primary Medical Care Functions | In Progress |
| Personal Health Budgets | In Progress |

## 13. Review of the effectiveness of governance, risk management and internal control

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

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

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

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

The CCG has engaged both internal and external auditors to provide the Governing Body with independent assurance of its process of internal control and to provide assurance of the validity of this Governance Statement.

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

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

NHS England, as the regulatory body for CCGs, will take a simplified approach to the annual assessment of CCG performance for 2020/21, due to the ongoing impact of COVID-19. It will provide scope to take account of the different circumstances and challenges CCGs face in managing recovery across the phases of the NHS response to COVID-19 and focus on CCGs' contributions to local delivery of the overall system recovery plan. The result of the assessment is expected to be published in the summer of 2021.

## 14. Conclusion

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

Lesley Smith
Accountable Officer
20 May 2021

# Remuneration and Staff Report

## Remuneration Report

### 1. Remuneration Committee

Details of the membership of the Remuneration Committee can be found within the Annual Governance Statement (page 75). Governing Body delegates responsibility to the Remuneration Committee, as required as part of the CCG's Constitution, to make decisions or recommendations regarding the appointment, remuneration and conditions of service for employees of the CCG and people who provide services to the CCG

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

### 2. Policy on the remuneration of senior managers

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

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

The Accountable Officer of the CCG has determined that this definition applies to all voting members of the Governing Body as set out in the CCG's Constitution.

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

Senior Managers remuneration for 2020/21 was determined by the Remuneration Committee, taking account of national guidance, the prevailing economic climate, local market conditions and the requirement to obtain best value for money. The costs of all posts are met from within the notified CCG Running Cost Allowance.

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

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

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

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

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

The Remuneration Committee sets the framework within which the terms and conditions of the Very Senior Managers are developed and agreed. It also receives reports on performance against standards set in relation to local and national targets from the CCG's strategic and operational plans. The remuneration is set through a process that is based on a consistent framework and independent decision of performance measures against an individual's

performance with due consideration to comparative salary data, the labour market, and the financial circumstances of the organisation plus any national guidance.

The Accountable Officer, Deputy Accountable Officer and Director of Finance are entitled to performance related payments. However the Remuneration Committee agreed that due to the financial pressures faced by the CCG, performance related payments would not be made in relation to 2019/20.

### 3. Remuneration of Very Senior Managers

There were two Senior Managers on the Governing Body whose salary exceeded £150,000 per annum when adjusted to reflect a full time annualised equivalent post. These posts (CCG Chair and Medical Director) are filled by GPs on a part time basis and they are providing expert leadership and clinical advice to the CCG. The level of remuneration reflects this specialist input.

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

### 4. Salary and Allowances (subject to audit)

The table at Appendix Bi details the salaries and allowance for all the senior managers of the CCG, as defined above. Prior year comparators are shown for 2019/20 within Appendix Bii.

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

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

### 6. Payments to Past Senior Managers (subject to audit)

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

### 7. Pension Benefits (subject to audit)

The table at Appendix Biii details their pension entitlements. It is important to note that the pension values for the clinical members of the Governing Body relate to their Non-Practitioner employment only as provided by the Business Services Authority. Whilst this will include, from 1st April 2014, the work undertaken in their capacity as a senior manager of the CCG, it might also include other, non-practitioner work. These pension values will also include contributions made in previous employments in a non-practitioner role. Prior year comparators are shown within the main pensions table for 2020/21.

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

| Name | Title | Contract Commencement* | Contract Expiration |
|---|---|---|---|
| Dr Terry Hudsen | Chair<br>Locality Appointed GP | 01-Sep-19<br>01-Sep-19 | 31-Aug-22<br>31-Aug-22 |
| Mrs Lesley Smith | Accountable Officer | 13-Jun-19 | 11-Aug-21 |
| Mr Alun Windle | Interim Chief Nurse | 13-Jan-20 | 31-Mar-22 |
| Mrs Jackie Mills | Interim Director of Finance | 01-Jun-19 | 31-May-21 |
| Ms Nicola Doherty | Director of Delivery - Care Outside of Hospital | 03-Nov-17 | 12-Jul-20 |
| Mr Brian Hughes | Director of Commissioning and Performance | 29-May-17 | 31-Jul-20 |
| Mr Brian Hughes | Sheffield Place Based Lead / Deputy Accountable Officer | 01-Aug-20 | Substantive Post |
| Mrs Sandra Buchan | Director of Commissioning Development | 01-Aug-20 | Substantive Post |
| Dr Zak McMurray | Medical Director | 01-Apr-13 | Substantive Post |
| Dr Nikki Bates | GP Elected Member | 01-Jan-17 | 31-Dec-22 |
| Dr Marion Sloan | GP Elected Member | 01-Oct-13 | 30-Sep-22 |
| Dr Lisa Philip | GP Elected Member | 01-Dec-19 | 30-Nov-22 |
| Dr Leigh Sorsbie | GP Elected Member | 01-Nov-19 | 31-Oct-22 |
| Dr Andrew McGinty | Locality Appointed GP | 01-Aug-19 | 31-Jul-22** |
| Dr David Warwicker | Locality Appointed GP | 01-Sep-19 | 31-Aug-22 |
| Dr Amir Afzal | Locality Appointed GP | 01-Nov-18 | 31-Oct-21 |
| Ms Chris Nield | Lay Member | 01-Jul-18 | 30-Jun-21 |
| Ms Amanda Forrest | Lay Member and Deputy Chair | 01-Jul-13 | 31-Dec-20 |
| Miss Anthea Morris | Lay Member | 01-Apr-19 | 31-Mar-22 |
| Prof Mark Gamsu | Lay Member<br>Deputy Chair | 01-Jul-13<br>01-Jan-21 | 31-Dec-23<br>31-Dec-23 |
| Mrs Judith Thorley | Lay Member | 01-Jan-21 | 31-Dec-23 |

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

** Dr Andrew McGinty stepped down from his role as Governing Body GP with effect from 4 May 2021

## 8. Fair Pay disclosure (subject to audit)

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

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

The remuneration of the highest paid director or member of NHS Sheffield Clinical Commissioning Group in the financial year 2020/21 was £117,142 (£146,103 in 2019/20). In 2020/21, the highest paid member is the Sheffield Place Based Lead / Deputy Accountable Officer.

This was 2.9 times the median remuneration of the workforce which was £40,894 (in 2019/20 the highest paid member received 3.9 times the median remuneration of £38,168). The year-on year change is mainly due to the change in the post of the highest paid member. Previously the highest paid member quoted was the Accountable Officer. The Accountable Officer post was shared between Sheffield CCG/Barnsley CCG and South Yorkshire and Bassetlaw ICS to August 2020; and between Sheffield CCG and South Yorkshire and Bassetlaw ICS from September 2020 onwards. Clarified guidance states that where roles are shared across organisations it is the cost to the CCG only which is used to calculate the highest salary not the total salary and, on this basis, the Accountable Officer is no longer the highest paid member.

There has been a minimal change in the composition of the workforce. The size of the total workforce headcount including temporary staff that worked during the 12- month period in 2020/21 increased from 458 employees in 2019/20 to 479 employees. The main change is due to the IT service staff being brought in-house from a private provider Kier. The in-house IT service provides support to Barnsley, Bassetlaw and Sheffield CCGs.

There was a minimum 0.4% pay increase for all staff on Agenda for Change terms and conditions in 2020/21 which the majority of staff received. A higher % pay increase was applied to some staff depending on their pay band increment point with a maximum increase of 12.4%

In 2020/21 there are no employees of the CCG who received remuneration in excess of the highest paid director or member of the CCG's Governing Body (none in 2019/20) reflecting national guidance on the treatment of shared posts. Remuneration for CCG employees ranged from £13,704 to £117,142 where the salary is calculated on an annualised, full-time equivalent basis.

The South Yorkshire and Bassetlaw Integrated Care System (SY&B ICS) as stated above, is not a statutory body in its own right and therefore is not required to produce a set of accounts or annual report. Sheffield CCG hosts the SY&B ICS and accounts for national funding received from NHS England specifically for the ICS, some of which is used to fund members of the ICS leadership and staff team. In 2020/21 there were two individuals who received remuneration in excess of the highest paid member of the CCG's Governing Body when calculated on an annualised, full-time equivalent basis and excluding shared posts. The remuneration relates to the System Leader at £252,985 and the ICS Director of Finance at £141,816.

## Staff Report

### 1. Senior Managers

The number of senior managers on Governing Body as at 31 March 2021 is summarised below:

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

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

### 2. Staff numbers and costs (subject to audit)

The table below summarises the average number of people employed by Sheffield CCG in 2020/21, calculated on a whole-time equivalent basis, together with the net employee benefits costs. 'Other' relates to staff on secondment and temporary staff.

| | Total | Permanently employed | Other |
|---|---|---|---|
| Average number of Employees (WTE) | 368 | 313 | 55 |
| Net employee benefit costs in £'000s | 21,128 | 17,959 | 3,169 |

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

### 3. Staff composition

The table below provides an analysis of the number of persons of each sex who were Governing Body members, Very Senior Managers or total employees of the CCG as at 31 March 2021.

| | Female | Male |
|---|---|---|
| All Employees | 277 | 94 |
| Of which; Very Senior Managers (VSM) | 2 | 1 |
| Of which; Voting Members of the Governing Body | 10 | 8 |

### 4. Sickness absence data

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

The Department of Health and Social Care has taken the decision to not commission the sickness absence data production exercise for NHS bodies for 2020/21 data and that each organisation should instead provide a link to the NHS Digital publication series.

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

## 5. Staff Turnover

Staff turnover is reviewed on a regular basis and reported through NHS Digital's NHS workforce statistics.

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

## 6. Staff Policies and actions applied during the financial year

We follow a clear governance structure for the approval and ratification of policies for matters relating to current and prospective staff members. Policies are reviewed on a regular basis. 16 policies were reviewed within 2020/21.

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

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

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

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

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

## 7. Facilities time publication

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

**Relevant Union Officials:** The total number of employees who were relevant union officials during 1 April 2020 to 31 March 2021 was as follows:

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

**Percentage of time spent on facility time:** The percentage of time spent on facility time during 2020/21 was as follows:

| Percentage of time | Number of employees |
|---|---|
| 0% | 0 |
| 1%-50% | 4 |
| 51%-99% | 0 |
| 100% | 0 |

**Percentage of pay bill spent on facility time:** The percentage of the total pay bill spent on paying employees who were relevant union officials for facility time during 2020/21 was as follows:

| | |
|---|---|
| Total cost of facility time £ | **£3,726** |
| Total pay bill - £ | **£14,121,000** |
| Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) × 100 | **0.03%** |

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

| | |
|---|---|
| Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:<br>*(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) × 100* | **91%** |

## 8. Other Employee Matters

**Joint Staff Consultative Forum (JSCF)**

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

The purpose of the JSCF is to:

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

**Staff Forum**

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

The aims of the group are to:

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

**Staff Survey 2021**

During March 2021, a staff survey invitation was sent via email to all directly employed staff of the organisation.

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

The survey is designed to provide insight into opinion on many aspects of staff experience and engagement. The results of which will inform an action plan that is formulated with staff engagement and input. The staff engagement rates for the 2020 staff survey that closed in April 2020, was 61%.

**Health and Safety**

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

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

## 9. Expenditure on consultancy

NHS Sheffield Clinical Commissioning Group spent £1,111K in total on consultancy services in 2020/21. Of this, £964k related to consultancy services commissioned by the South Yorkshire and Bassetlaw Integrated Care System (ICS) which the CCG hosts, mainly in relation to the digital transformation agenda in primary care and to system development.

## 10. Off-payroll engagements

Following the Review of *Tax Arrangements of Public Sector Appointees* published by the Chief Secretary to the Treasury on 23 May 2012, CCGs must publish information on their highly paid and/or senior off-payroll engagements. Highly paid is defined as off-payroll engagements for more than £245 per day. Payments to GP Practices for the services of employees and GPs are deemed to be 'off-payroll' engagements and are therefore subject to these disclosure requirements.

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

### Table 1: Length of all highly paid off-payroll engagements

The off-payroll engagements as of 31 March 2021 paid more than £245 per day are as follows:

| | **Number** |
|---|---|
| Number of existing engagements as of 31 March 2021 | 13 |
| *Of which, the number that have existed:* | |
| for less than one year at the time of reporting | 3 |
| for between one and two years at the time of reporting | 3 |
| for between 2 and 3 years at the time of reporting | 0 |
| for between 3 and 4 years at the time of reporting | 1 |
| for 4 or more years at the time of reporting | 6 |

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

### Table 2: Off-payroll engagements and IR35 status

All off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day are as follows:

| | **Number** |
|---|---|
| Number of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021 | 31 |
| Number subject to off-payroll legislation and determined as in-scope of IR35 | 23 |
| Number not subject to off-payroll legislation and determined as out-of-scope of IR35 | 8 |
| Number of engagements where the status was disputed under provisions in the off-payroll | 0 |

| | |
|---|---|
| legislation | |
| Number of engagements that saw a change to IR35 status following the consistency review | 0 |

### Table 3: Off-payroll engagements / senior official engagements

Table 3 provides information on any off-payroll engagements of Governing Body members and/or senior officials with significant financial responsibility between 01 April 2020 and 31 March 2021.

| | |
|---|---|
| Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year | 0 |
| Total no. of individuals on payroll and off-payroll of Governing Body members during the financial year (this figure includes both on payroll and off payroll engagements). | 21 |

## 11. Exit Packages (subject to audit)

The table below details the number and value of the exit packages agreed in 2020/21 (2019/20 £12k).

### Table 1: Exit Packages

| Exit package cost band (incl. any special payment element | Number of compulsory redundancies | Cost of compulsory redundancies £s | Number of other departures agreed | Cost of other departures agreed £s | Total number of exit packages | Total cost of exit packages £s | Number of departures where special payments have been made | Cost of special payment element included in exit packages £s |
|---|---|---|---|---|---|---|---|---|
| Less than £10,000 | | | | | | | | |
| £10,000 - £25,000 | | | | | | | | |
| £25,001 - £50,000 | | | | | | | | |
| £50,001- £100,000 | 1 | 98,219 | | | 1 | 98,219 | | |
| £100,001-£150,000 | | | | | | | | |
| £150,001 –£200,000 | | | | | | | | |
| >£200,000 | | | | | | | | |
| **TOTALS** | **1** | **98,219** | **0** | **0** | **1** | **98,219** | **0** | **0** |

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

The exit package detailed in Table 1 relates to a compulsory redundancy for a senior manager of the CCG who was Clinical Head of Service for the Continuing Health Care Team.

### Analysis of Other Departures

There were no other departures in 2020/21

**[Insert signature]**

Lesley Smith
Accountable Officer

20 May 2021

## Appendix A – Register of Interests, Governing Body 2020/21

Details of all of the CCG's Registers of Interests can be found at http://www.sheffieldccg.nhs.uk/about-us/declarations-of-interest.htm

# Remuneration Report: Senior Managers: Salaries and Allowances 2020/21

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

| | 2020-21 | | | | | |
|---|---|---|---|---|---|---|
| **Name and Title** | **Salary** (bands of £5k) £000 | **Expense Payments (taxable)** (rounded to the nearest £100) £00 | **Performance pay and bonuses** (bands of £5k) £000 | **Long term Performance pay and bonuses** (bands of £5k) £000 | **All Pension Related Benefits** (bands of £2.5k) £000 | **TOTAL** (bands of £5k) £000 |
| T Hudsen<br>Chair of the Governing Body and Locality Appointed GP | 100 - 105 | 0 | 0 | 0 | 25.0 - 27.5 | 125 - 130 |
| *L Smith<br>Accountable Officer 0.4 wte (0.6 wte up to 31 August 2020) | 70 - 75 | 0 | 0 | 0 | 0 | 70 - 75 |
| B Hughes<br>Deputy Accountable Officer and Director of Commissioning & Performance | 115 - 120 | 0 | 0 | 0 | 25.0 - 27.5 | 140 - 145 |
| S Buchan<br>Director of Commissioning Development (from 1 August 2020) | 60 - 65 | 0 | 0 | 0 | 62.5 - 65.0 | 125 - 130 |
| N Doherty<br>Director of Delivery - Care Outside of Hospital (up to 12 July 2020) | 25 - 30 | 0 | 0 | 0 | 17.5 - 20.0 | 45 - 50 |
| Z McMurray<br>Medical Director | 115 - 120 | 0 | 0 | 0 | 0 | 115 - 120 |
| Jackie Mills<br>Director of Finance | 110 - 115 | 0 | 0 | 0 | 37.5 - 40.0 | 150 - 155 |
| A Windle<br>Chief Nurse | 90 - 95 | 0 | 0 | 0 | 85.0 - 87.5 | 175 - 180 |
| N Bates<br>GP Elected Member | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 |
| L Philip<br>GP Elected Member | 10 - 15 | 0 | 0 | 0 | 157.5 - 160.0 | 170 - 175 |
| M Sloan<br>GP Elected Member | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 |
| L Sorsbie<br>GP Elected Member | 10 - 15 | 0 | 0 | 0 | 5.0 - 7.5 | 20 - 25 |
| A Afzal<br>Locality Appointed GP | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 |
| Dr A McGinty<br>Locality appointed GP | 10 - 15 | 0 | 0 | 0 | 0 | 10 -15 |
| D Warwicker<br>Locality appointed GP | 10 - 15 | 0 | 0 | 0 | 27.5 - 30.0 | 40 - 45 |
| Post vacant<br>Secondary Care Doctor | 0 | 0 | 0 | 0 | 0 | 0 |
| **A Forrest<br>Lay Member (up to 31 December 2020) | 20 - 25 | 0 | 0 | 0 | 0 | 20 - 25 |
| **M Gamsu<br>Lay Member | 15 - 20 | 0 | 0 | 0 | 0 | 15 - 20 |
| **A Morris<br>Lay Member | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 |
| **C Nield<br>Lay Member | 15 - 20 | 0 | 0 | 0 | 0 | 15 - 20 |
| ** J Thorley<br>Lay Member (from 1 January 2021) | 0 - 5 | 0 | 0 | 0 | 0 | 0 - 5 |

**Notes**

*The Accountable Officer L Smith is employed by Sheffield CCG from September 2020 on a 0.4 wte basis (from April - August 2020 she worked across Barnsley and Sheffield CCGs). In line with the guidance on shared posts we are required to show Sheffield CCG's share of the total salary in the table above. As part of her role she is also Deputy Lead of the South Yorkshire & Bassetlaw Integrated Care System on a 0.6 wte basis . Her 100% salary across the 3 roles is £155,498.

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

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

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

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

Executive Directors on Very Senior Manager contracts can be considered by the CCG's Remuneration Committee for a performance bonus. The Accountable Officer, Deputy Accountable Officer and Director of Finance are on such a contract, the Remuneration Committee agreed that due to the financial pressures faced by the CCG, performance related payments, payable in 2020/21, would not be made to any staff on Very Senior Manager contracts in relation to 2019/20.

Appendix Bii

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

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

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

**Notes**

*The Accountable Officer (up to June 2019) M Ruff was employed by Sheffield CCG and as part of this role worked within the South Yorkshire & Bassetlaw Integrated Care System (SY&B ICS) on a 0.4 whole time equivalent basis. As Sheffield CCG hosts the SY&B ICS and accounts for its funding from NHS England, a 100% of M Ruff's costs are shown.
*The Accountable Officer (from June 2019) L Smith is employed by Barnsley CCG and works across both CCGs as Accountable Officer. In line with the guidance on shared posts we are required to show Sheffield CCG's share of the total salary in the table above. As part of these roles she is also Deputy Lead of the South Yorkshire & Bassetlaw Integrated Care System. Her 100% salary across the 3 roles is £152,647.

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

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

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

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

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

# Pension Benefits – 2020/21

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

| Name and Title | Real increase in pension age at pension age (bands of £2,500) | Real increase in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31 March 2021 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2020 | Real Increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2021 | Employer's Contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| T Hudsen<br>Chair of the Governing Body and Locality Appointed GP | 0 - 2.5 | 0 - 2.5 | 20 - 25 | 45 - 50 | 255 | 9 | 284 | 0 |
| **L Smith<br>Accountable Officer 0.4 wte (0.6 wte up to 31 August 2020) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| B Hughes<br>Deputy Accountable Officer and Director of Commissioning & Performance | 0 - 2.5 | (0 - 2.5) | 35 - 40 | 75 - 80 | 618 | 23 | 669 | 0 |
| S Buchan<br>Director of Commissioning Development (from 1 August 2020) | 0 - 2.5 | 2.5 - 5.0 | 20 - 25 | 35 - 40 | 236 | 24 | 288 | 0 |
| N Doherty<br>Director of Delivery - Care Outside of Hospital (up to 12 July 2020) | 0 - 2.5 | (0 - 2.5) | 20 - 25 | 30 - 35 | 266 | 1 | 288 | 0 |
| *Z McMurray<br>Medical Director | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Jackie Mills<br>Director of Finance | 2.5 - 5.0 | 0 - 2.5 | 40 - 45 | 95 - 100 | 759 | 41 | 827 | 0 |
| A Windle<br>Chief Nurse | 2.5 - 5.0 | 7.5 - 10.0 | 20 - 25 | 45 - 50 | 311 | 71 | 400 | 0 |
| *N Bates<br>GP Elected Member | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| L Philip<br>GP Elected Member | 5.0 - 7.5 | 20.0 - 22.5 | 15 - 20 | 40 - 45 | 143 | 134 | 282 | 0 |
| *M Sloan<br>GP Elected Member | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| L Sorsbie<br>GP Elected Member | 0 - 2.5 | 0 - 2.5 | 10 - 15 | 30 - 35 | 271 | 11 | 290 | 0 |
| *A Afzal<br>Locality Appointed GP | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| *Dr A McGinty<br>Locality appointed GP | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ***D Warwicker<br>Locality appointed GP | 0 - 2.5 | 0 | 10 - 15 | 0 | 95 | 15 | 114 | 0 |

* Dr McMurray, Dr Sloan, Dr Afzal, Dr Bates & Dr McGinty do not make contributions to the NHS Pension Scheme and hence no information is available to the CCG.
** Lesley Smith does not make contributions to the NHS Pension and hence no information is available to the CCG.
***Dr Warwicker - a lump sum is not automatically payable as contributions are made under the 2008 section of the existing scheme.

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

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

**Cash Equivalent Transfer Values**

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

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

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

The values in the table are calculated by comparing the accrued pension/lump sum as at 31 March 21 against the accrued pension/lump sum at 31 March 20 which is then adjusted by a factor of 1.7% to account for inflation (1.7% is a figure quoted in the Business Services Authority guidance on the Remuneration Report and is based on the Consumer Price Index). Where the result is a decrease in the pension or lump sum this reflects the fact that the previous years nominally inflated pension/lump sum is higher than the pension/lump sum value as at March 2021 and/or that the remuneration of the individual has decreased in the current financial year compared to the previous financial year.

## Parliamentary Accountability and Audit Report

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

# ANNUAL ACCOUNTS

Lesley Smith
Accountable Officer

20 May 2021

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

# Annual Accounts for the Period

# 1st April 2020

# to 31st March 2021

## FOREWORD TO THE ACCOUNTS

## NHS SHEFFIELD CLINICAL COMMISSIONING GROUP

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

These accounts for the year ended 31 March 2021 have been prepared by NHS Sheffield Clinical Commissioning Group under section 17 of schedule 1A of the National Health Service Act 2006 (as amended by the Health & Social Care Act 2012) in the form which the Secretary of State has, with the approval of the Treasury, directed.

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

**CONTENTS** **Page Number**

**The Primary Statements:**



**Notes to the Accounts**

**Statement of Comprehensive Net Expenditure for the year ended 31 March 2021**

| | Note | 2020-21 £'000 | 2019-20 £'000 |
|---|---|---|---|
| Income from sale of goods and services | 2 | (3,593) | (4,344) |
| Other operating income | 2 | (410) | (323) |
| **Total operating income** | | **(4,003)** | **(4,667)** |
| Staff costs | 4 | 21,128 | 19,491 |
| Purchase of goods and services | 5 | 1,027,149 | 908,399 |
| Depreciation and impairment charges | 5 | 98 | 87 |
| Other Operating Expenditure | 5 | 839 | 809 |
| **Total operating expenditure** | | **1,049,214** | **928,786** |
| **Net Operating Expenditure** | | **1,045,211** | **924,119** |
| Finance income | | - | - |
| Finance expense | | - | - |
| **Net expenditure for the Year** | | **1,045,211** | **924,119** |
| Net (Gain)/Loss on Transfer by Absorption | | - | - |
| **Total Net Expenditure for the Financial Year** | | **1,045,211** | **924,119** |
| **Other Comprehensive Expenditure** | | | |
| **Items which will not be reclassified to net operating costs** | | | |
| Net (gain)/loss on revaluation of PPE | | - | - |
| Net (gain)/loss on revaluation of Intangibles | | - | - |
| Net (gain)/loss on revaluation of Financial Assets | | - | - |
| Net (gain)/loss on assets held for sale | | - | - |
| Actuarial (gain)/loss in pension schemes | | - | - |
| Impairments and reversals taken to Revaluation Reserve | | - | - |
| **Items that may be reclassified to Net Operating Costs** | | | |
| Net (gain)/loss on revaluation of other Financial Assets | | - | - |
| Net gain/loss on revaluation of available for sale financial assets | | - | - |
| Reclassification adjustment on disposal of available for sale financial assets | | - | - |
| **Sub total** | | **-** | **-** |
| **Comprehensive Expenditure for the year** | | **1,045,211** | **924,119** |

The notes on pages 5 to 24 form part of this statement.

**Statement of Financial Position as at 31 March 2021**

| | Note | 2020-21 £'000 | 2019-20 £'000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 8 | 210 | 308 |
| **Total non-current assets** | | **210** | **308** |
| **Current assets:** | | | |
| Trade and other receivables | 9 | 4,715 | 9,849 |
| Cash and cash equivalents | 10 | 821 | 324 |
| **Total current assets** | | **5,536** | **10,173** |
| **Total assets** | | **5,746** | **10,481** |
| **Current liabilities** | | | |
| Trade and other payables | 11 | (49,363) | (54,501) |
| **Total current liabilities** | | **(49,363)** | **(54,501)** |
| **Assets less Liabilities** | | **(43,617)** | **(44,020)** |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (43,617) | (44,020) |
| **Total taxpayers' equity:** | | **(43,617)** | **(44,020)** |

The notes on pages 5 to 24 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on [date] and signed on its behalf by:

**Chief Accountable Officer**
**Lesley Smith**
**10 June 2021**

**Statement of Changes In Taxpayers Equity for the year ended 31 March 2021**

| | General fund £'000 | Revaluation reserve £'000 | Other reserves £'000 | Total reserves £'000 |
|---|---|---|---|---|
| **Changes in taxpayers' equity for 2020-21** | | | | |
| **Balance at 01 April 2020** | (44,020) | 0 | 0 | **(44,020)** |
| Transfer between reserves in respect of assets transferred from closed NHS bodies | 0 | 0 | 0 | **0** |
| **Adjusted NHS Clinical Commissioning Group balance at 31 March 2020** | **(44,020)** | **0** | **0** | **(44,020)** |
| **Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21** | | | | |
| Net operating expenditure for the financial year | (1,045,211) | | | **(1,045,211)** |
| Net gain/(loss) on revaluation of property, plant and equipment | | 0 | | **0** |
| Net gain/(loss) on revaluation of intangible assets | | 0 | | **0** |
| Net gain/(loss) on revaluation of financial assets | | 0 | | **0** |
| **Total revaluations against revaluation reserve** | | **0** | | **0** |
| Net gain (loss) on available for sale financial assets | 0 | 0 | 0 | 0 |
| Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets) | | | 0 | 0 |
| Net gain (loss) on revaluation of assets held for sale | 0 | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | 0 | 0 |
| Net actuarial gain (loss) on pensions | 0 | 0 | 0 | 0 |
| Movements in other reserves | 0 | 0 | 0 | 0 |
| Transfers between reserves | 0 | 0 | 0 | 0 |
| Release of reserves to the Statement of Comprehensive Net Expenditure | 0 | 0 | 0 | 0 |
| Reclassification adjustment on disposal of available for sale financial assets | 0 | 0 | 0 | 0 |
| Transfers by absorption to (from) other bodies | 0 | 0 | 0 | 0 |
| Reserves eliminated on dissolution | 0 | 0 | 0 | 0 |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year** | **(1,045,211)** | **0** | **0** | **(1,045,211)** |
| Net funding | 1,045,614 | 0 | 0 | **1,045,614** |
| **Balance at 31 March 2021** | **(43,617)** | **0** | **0** | **(43,617)** |

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

The notes on pages 5 to 24 form part of this statement

**Statement of Cash Flows for the year ended 31 March 2021**

| | Note | **2020-21 £'000** | 2019-20 £'000 |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Net operating expenditure for the financial year | | (1,045,211) | (924,119) |
| Depreciation and amortisation | 5 | 98 | 87 |
| (Increase)/decrease in trade & other receivables | 9 | 5,134 | 1,583 |
| Increase/(decrease) in trade & other payables | 11 | (5,101) | 5,646 |
| **Net Cash Inflow (Outflow) from Operating Activities** | | **(1,045,080)** | (916,803) |
| **Cash Flows from Investing Activities** | | | |
| (Payments) for property, plant and equipment | | (37) | (94) |
| **Net Cash Inflow (Outflow) from Investing Activities** | | **(37)** | (94) |
| **Net Cash Inflow (Outflow) before Financing** | | **(1,045,117)** | (916,897) |
| **Cash Flows from Financing Activities** | | | |
| Grant in Aid Funding Received | | 1,045,614 | 917,082 |
| **Net Cash Inflow (Outflow) from Financing Activities** | | **1,045,614** | 917,082 |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | 10 | **497** | 185 |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** | 10 | **324** | 139 |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** | 10 | **821** | 324 |

The notes on pages 5 to 24 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 Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC Group Accounting Manual 2020-21, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that 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 are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going concern**

The clinical commissioning group's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

1.2 **Accounting convention**

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

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

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

1.3.1 **Critical judgements in applying accounting policies**

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

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

1.3.2 **Sources of estimation uncertainty**

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

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

1.4 **Transfer of functions**

As public sector bodies are deemed to operate under common control, business reconfigurations within the DHSC group are outside the scope of IFRS 3 Business combinations. Where functions transfer between two public sector bodies, the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which they took place. 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.

1.5 **Pooled budgets**

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

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

1.6 **Operating Segments**

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

1.7 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

• The clinical commissioning group does not disclose information regarding the performance obligations part of a contract, that has an original expected duration of one year or less.

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

NHS Sheffield Clinical Commissioning Group are the host for several admin and clinical service functions including Procurement, HR, IT, Individual Funding Requests and Working Together. The provision of these services to other local clinical commissioning groups is the main source of income for NHS Sheffield Clinical Commissioning Group.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

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

1.8 **Employee Benefits**

1.8.1 **Short-term employee benefits**

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

1.8.2 **Retirement benefit costs**

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

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

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

1.9 **Other Expenses**

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

1.9.1 **Grants Payable**

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

1.9.2 **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.

1.10 **Property, plant and equipment**

1.10.1 **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 either;
- the item has 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, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

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 individual useful economic lives.

1.10.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment 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. Current values in existing use are determined as follows:

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

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

1.10.3 **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.

1.11 **Depreciation, amortisation and impairments**

Freehold land, assets under construction or development, investment properties, stockpiled goods, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the clinical commissioning group expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year end, the clinical commissioning group checks whether there is any indication that its property, plant and equipment have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

1.12 **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.

1.12.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the commencement 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 to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Net Expenditure.

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.

1.13 **Cash and cash equivalents**

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

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

1.14 **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 rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.95% (2019-20: negative 0.50%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of minus 0.02% (2019-20: positive 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.18% (2019-20: 0.55%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

1.15 **Clinical negligence costs**

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

1.16 **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 NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.17 **Continuing healthcare risk pooling**

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

1.18 **Contingent liabilities and contingent assets**

A contingent liability is:

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

A contingent liability is disclosed unless the possibility of a payment is remote.

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

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

1.19 **Financial assets**

Financial assets are recognised when the clinical commissioning group becomes party to the contractual provision of the financial instrument 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 when the asset has been transferred and the clinical commissioning group has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.19.1 **Financial assets at amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.19.2 **Financial assets at fair value through other comprehensive income**

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

1.19.3 **Financial assets at fair value through profit and loss**

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

1.19.4 **Impairment**

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

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

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

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

1.20 **Financial liabilities**

Financial liabilities are recognised 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 extinguished – that is, the obligation has been discharged or cancelled or has expired.

1.20.1 **Financial liabilities at fair value through profit and loss**

Derivatives that are liabilities are subsequently measured at fair value through profit or loss, Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

1.20.2 **Other financial liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

1.21 **Foreign currencies**

The clinical commissioning group's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Net Expenditure in the period in which they arise.

1.22 **Losses and 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).

1.23 **IFRS Standards that have been issued but have not yet been adopted**

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption.

IFRS 16 Leases - The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

## 2 Other Operating Revenue

| | 2020-21 Total £'000 | 2019-20 Total £'000 |
|---|---|---|
| **Income from sale of goods and services (contracts)** | | |
| Education, training and research | **573** | 548 |
| Non-patient care services to other bodies | **2,209** | 2,037 |
| Other Contract income | **811** | 1,759 |
| **Total Income from sale of goods and services** | **3,593** | **4,344** |
| **Other operating income** | | |
| Charitable and other contributions to revenue expenditure: non-NHS | **363** | 310 |
| Non cash apprenticeship training grants revenue | **47** | 13 |
| **Total Other operating income** | **410** | **323** |
| **Total Operating Income** | **4,003** | **4,667** |

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

For 2020/21, revenue shown under 'Other Contract income' includes £112k for Accountable Care Partnership services, £126k for Better Care Fund services and £109k in relation to Primary Care IT projects. Also included is £400k for the South Yorkshire & Bassetlaw Integrated Care System (ICS) which the CCG hosts.

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

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

| | 2020-21 Education, training and research £'000 | 2020-21 Non-patient care services to other bodies £'000 | 2020-21 Other Contract income £'000 | 2019-20 Education, training and research £'000 | 2019-20 Non-patient care services to other bodies £'000 | 2019-20 Other Contract income £'000 |
|---|---|---|---|---|---|---|
| **Source of Revenue** | | | | | | |
| NHS | 76 | 2,147 | 492 | - | 1,977 | 1,029 |
| Non NHS | 497 | 62 | 319 | 548 | 60 | 730 |
| **Total** | **573** | **2,209** | **811** | **548** | **2,037** | **1,759** |

| | 2020-21 Education, training and research £'000 | 2020-21 Non-patient care services to other bodies £'000 | 2020-21 Other Contract income £'000 | 2019-20 Education, training and research £'000 | 2019-20 Non-patient care services to other bodies £'000 | 2019-20 Other Contract income £'000 |
|---|---|---|---|---|---|---|
| **Timing of Revenue** | | | | | | |
| Point in time | 5 | - | 1 | - | 5 | 50 |
| Over time | 568 | 2,209 | 810 | 548 | 2,032 | 1,709 |
| **Total** | **573** | **2,209** | **811** | **548** | **2,037** | **1,759** |

## 3 Contract income recognition

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

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

**4. Employee benefits and staff numbers**

| **4.1.1 Employee benefits** | **Total** | | **2020-21** |
|---|---|---|---|
| | **Permanent Employees** | **Other** | **Total** |
| | **£'000** | **£'000** | **£'000** |
| **Employee Benefits** | | | |
| Salaries and wages | 13,757 | 2,670 | 16,427 |
| Social security costs | 1,443 | 243 | 1,686 |
| Employer Contributions to NHS Pension scheme | 2,599 | 256 | 2,855 |
| Other pension costs | 6 | - | 6 |
| Apprenticeship Levy | 56 | - | 56 |
| Termination benefits | 98 | - | 98 |
| **Gross employee benefits expenditure** | **17,959** | **3,169** | **21,128** |
| Less recoveries in respect of employee benefits (note 4.1.2) | **-** | **-** | **-** |
| **Total - Net admin employee benefits including capitalised costs** | **17,959** | **3,169** | **21,128** |
| Less: Employee costs capitalised | **-** | **-** | **-** |
| **Net employee benefits excluding capitalised costs** | **17,959** | **3,169** | **21,128** |

| **4.1.1 Employee benefits** | Total | | 2019-20 |
|---|---|---|---|
| | Permanent Employees | Other | Total |
| | £'000 | £'000 | £'000 |
| **Employee Benefits** | | | |
| Salaries and wages | 11,804 | 3,379 | 15,184 |
| Social security costs | 1,243 | 362 | 1,605 |
| Employer Contributions to NHS Pension scheme | 2,280 | 358 | 2,638 |
| Other pension costs | 5 | - | 5 |
| Apprenticeship Levy | 48 | - | 48 |
| Termination benefits | 12 | - | 12 |
| **Gross employee benefits expenditure** | **15,392** | **4,099** | **19,491** |
| Less recoveries in respect of employee benefits (note 4.1.2) | - | - | - |
| **Total - Net admin employee benefits including capitalised costs** | **15,392** | **4,099** | **19,491** |
| Less: Employee costs capitalised | **-** | **-** | **-** |
| **Net employee benefits excluding capitalised costs** | **15,392** | **4,099** | **19,491** |

**4.2 Average number of people employed**

| | 2020-21 | | | 2019-20 | | |
|---|---|---|---|---|---|---|
| | **Permanently employed Number** | **Other Number** | **Total Number** | Permanently employed Number | Other Number | Total Number |
| **Total** | **313.23** | **54.99** | **368.22** | **283.93** | **43.74** | **327.67** |
| Of the above: | | | | | | |
| **Number of whole time equivalent people engaged on capital projects** | **-** | **-** | **-** | **-** | **-** | **-** |

**4.3 Exit packages agreed in the financial year**

| | 2020-21 Compulsory redundancies | | 2020-21 Other agreed departures | | 2020-21 Total | |
|---|---|---|---|---|---|---|
| | **Number** | **£** | **Number** | **£** | **Number** | **£** |
| Less than £10,000 | - | - | - | - | - | - |
| £10,001 to £25,000 | - | - | - | - | - | - |
| £25,001 to £50,000 | - | - | - | - | - | - |
| £50,001 to £100,000 | 1 | 98,219 | - | - | 1 | 98,219 |
| £100,001 to £150,000 | - | - | - | - | - | - |
| £150,001 to £200,000 | - | - | - | - | - | - |
| Over £200,001 | - | - | - | - | - | - |
| **Total** | **1** | **98,219** | **-** | **-** | **1** | **98,219** |

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

| | 2020-21 Departures where special payments have been made | | 2019-20 Departures where special payments have been made | |
|---|---|---|---|---|
| | **Number** | **£** | Number | £ |
| Less than £10,000 | - | - | - | - |
| £10,001 to £25,000 | - | - | - | - |
| £25,001 to £50,000 | - | - | - | - |
| £50,001 to £100,000 | - | - | - | - |
| £100,001 to £150,000 | - | - | - | - |
| £150,001 to £200,000 | - | - | - | - |
| Over £200,001 | - | - | - | - |
| **Total** | **-** | **-** | **-** | **-** |

**Analysis of Other Agreed Departures**

| | 2020-21 Other agreed departures | | 2019-20 Other agreed departures | |
|---|---|---|---|---|
| | **Number** | **£** | Number | £ |
| Voluntary redundancies including early retirement contractual costs | - | - | - | - |
| Mutually agreed resignations (MARS) contractual costs | - | - | - | - |
| Early retirements in the efficiency of the service contractual costs | - | - | - | - |
| Contractual payments in lieu of notice | - | - | - | - |
| Exit payments following Employment Tribunals or court orders | - | - | - | - |
| Non-contractual payments requiring HMT approval* | - | - | - | - |
| **Total** | **-** | **-** | **-** | **-** |

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

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

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

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

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

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

**4.5 Pension costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that 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:

**a) Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

**b) Full actuarial (funding) valuation**

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

**5. Operating expenses**

| | **2020-21 Total £'000** | 2019-20 Total £'000 |
|---|---|---|
| **Purchase of goods and services** | | |
| Services from other CCGs and NHS England | 349 | 446 |
| Services from foundation trusts | 665,995 | 589,105 |
| Services from other NHS trusts | 29,719 | 29,762 |
| Purchase of healthcare from non-NHS bodies | 88,609 | 69,066 |
| Purchase of social care | 24,952 | 21,346 |
| Prescribing costs | 99,023 | 93,215 |
| Pharmaceutical services | 263 | 304 |
| General Ophthalmic services | 297 | 351 |
| GPMS/APMS and PCTMS | 101,666 | 94,993 |
| Supplies and services – general | 7,550 | 3,245 |
| Consultancy services | 1,111 | 714 |
| Establishment | 1,808 | 1,311 |
| Transport | - | 41 |
| Premises | 3,570 | 3,800 |
| Audit fees | 66 | 48 |
| Other non statutory audit expenditure | | |
| · Other services | 14 | 7 |
| Other professional fees | 1,457 | 170 |
| Legal fees | 319 | 158 |
| Education, training and conferences | 334 | 304 |
| Non cash apprenticeship training grants | 47 | 13 |
| **Total Purchase of goods and services** | **1,027,149** | **908,399** |
| **Depreciation and impairment charges** | | |
| Depreciation | 98 | 87 |
| **Total Depreciation and impairment charges** | **98** | **87** |
| **Provision expense** | | |
| Provisions | - | - |
| **Total Provision expense** | **-** | **-** |
| **Other Operating Expenditure** | | |
| Chair and Non Executive Members | 325 | 310 |
| Research and development (excluding staff costs) | 451 | 446 |
| Expected credit loss on receivables | 9 | (2) |
| Other expenditure | 54 | 55 |
| **Total Other Operating Expenditure** | **839** | **809** |
| **Total operating expenditure** | **1,028,086** | **909,295** |

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

NHS Sheffield Clinical Commissioning Group spent £1,111k in total on consultancy services in 2020/21. Of this, £963k related to consultancy services commissioned by the South Yorkshire & Bassetlaw Integrated Care System (ICS) which the CCG hosts, mainly in relation to IT and system development.

Services from foundation trusts includes expenditure of £62,850k in 2020-21 that relates to additional funding to support the response to the COVID-19 pandemic, as well as system top up funding calculated to meet the expected expenditure of Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Children's NHS Foundation Trust and Sheffield Health and Social Care NHS Foundation Trust. In addition, the CCG directly incurred additional expenditure of £22,307k in relation to the COVID-19 response, of which £17,083k was drawn from the national Hospital Discharge Programme.

**6.1 Better Payment Practice Code**

| Measure of compliance | 2020-21 Number | 2020-21 £'000 | 2019-20 Number | 2019-20 £'000 |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total Non-NHS Trade invoices paid in the Year | 17,683 | 245,587 | 16,637 | 204,796 |
| Total Non-NHS Trade Invoices paid within target | 17,507 | 244,515 | 16,394 | 203,790 |
| **Percentage of Non-NHS Trade invoices paid within target** | **99.00%** | **99.56%** | **98.54%** | **99.51%** |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | 1,701 | 762,932 | 4,083 | 642,030 |
| Total NHS Trade Invoices Paid within target | 1,690 | 762,751 | 4,049 | 640,275 |
| **Percentage of NHS Trade Invoices paid within target** | **99.35%** | **99.98%** | **99.17%** | **99.73%** |

**7. Operating Leases**

**7.1 Payments recognised as an Expense**

| | Buildings £'000 | Other £'000 | 2020-21 Total £'000 | Buildings £'000 | Other £'000 | 2019-20 Total £'000 |
|---|---|---|---|---|---|---|
| **Payments recognised as an expense** | | | | | | |
| Minimum lease payments | 629 | 6 | **635** | 442 | 11 | **453** |
| Contingent rents | - | - | **-** | - | - | **-** |
| Sub-lease payments | - | - | **-** | - | - | **-** |
| **Total** | **629** | **6** | **635** | **442** | **11** | **453** |

Whilst NHS Sheffield Clinical Commissioning Group has an arrangement with NHS Property Services Limited which falls within the definition of operating leases, rental charges for future years have not yet been agreed. Consequently this note does not include future minimum lease payments for the arrangement. The financial value included in the Statement of Comprehensive Net Expenditure for 2020-21 is £629k (2019-20 £442k).

**7.2 Future minimum lease payments**

| | Other £'000 | 2020-21 Total £'000 | Other £'000 | 2019-20 Total £'000 |
|---|---|---|---|---|
| **Payable:** | | | | |
| No later than one year | - | **-** | 9 | **9** |
| Between one and five years | - | **-** | - | **-** |
| After five years | - | **-** | - | **-** |
| **Total** | **-** | **-** | **9** | **9** |

**8 Property, plant and equipment**

| 2020-21 | Information technology £'000 | Furniture & fittings £'000 | Total £'000 |
|---|---|---|---|
| **Cost or valuation at 01 April 2020** | 489 | 205 | 694 |
| Additions purchased | - | - | - |
| **Cost/Valuation at 31 March 2021** | **489** | **205** | **694** |
| **Depreciation 01 April 2020** | 181 | 205 | 386 |
| Charged during the year | 98 | - | 98 |
| **Depreciation at 31 March 2021** | **279** | **205** | **484** |
| **Net Book Value at 31 March 2021** | **210** | **-** | **210** |
| Purchased | 210 | - | 210 |
| **Total at 31 March 2021** | **210** | **-** | **210** |
| **Asset financing:** | | | |
| Owned | 210 | - | 210 |
| **Total at 31 March 2021** | **210** | **-** | **210** |

**8.1 Cost or valuation of fully depreciated assets**

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

| | **2020-21 £'000** | 2019-20 £'000 |
|---|---|---|
| Information technology | - | - |
| Furniture & fittings | 205 | 205 |
| **Total** | **205** | **205** |

**8.2 Economic lives**

| | **Minimum Life (years)** | **Maximum Life (Years)** |
|---|---|---|
| Information technology | 1 | 4 |
| Furniture & fittings | 0 | 0 |

**9.1 Trade and other receivables**

| | **2020-21 £'000** | 2019-20 £'000 |
|---|---|---|
| NHS receivables: Revenue | 882 | 1,316 |
| NHS prepayments | 774 | 3,649 |
| NHS accrued income | 262 | 866 |
| NHS Contract Receivable not yet invoiced/non-invoice | 38 | 800 |
| NHS Non Contract trade receivable (i.e. pass through funding) | 1,081 | 312 |
| Non-NHS and Other WGA receivables: Revenue | 71 | 66 |
| Non-NHS and Other WGA prepayments | 643 | 95 |
| Non-NHS and Other WGA accrued income | 447 | 672 |
| Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice | 94 | 354 |
| Non-NHS and Other WGA Non Contract trade receivable (i.e. pass through funding) | 222 | 1,602 |
| Expected credit loss allowance-receivables | (10) | (2) |
| VAT | 208 | 76 |
| Other receivables and accruals | 3 | 43 |
| **Total Trade & other receivables** | **4,715** | **9,849** |
| | | |
| Included above: | | |
| Prepaid pensions contributions | - | - |

**9.2 Receivables past their due date but not impaired**

| | **2020-21 DHSC Group Bodies £'000** | **2020-21 Non DHSC Group Bodies £'000** | 2019-20 DHSC Group Bodies £'000 | 2019-20 Non DHSC Group Bodies £'000 |
|---|---|---|---|---|
| By up to three months | 718 | - | 141 | - |
| By three to six months | 44 | - | 12 | - |
| By more than six months | - | - | 53 | - |
| **Total** | **762** | **-** | **206** | **-** |

NHS Sheffield Clinical Commissioning Group did not hold any collateral against receivables outstanding as at 31 March 2021.

| **9.3 Loss allowance on asset classes** | **Trade and other receivables - Non DHSC Group Bodies £'000** |
|---|---|
| Balance at 01 April 2020 | (2) |
| Lifetime expected credit losses on trade and other receivables-Stage 2 | (8) |
| **Total** | **(10)** |

**9.4 Provision Matrix on lifetime credit loss**

| | **31-March-2021 % Lifetime expected credit loss rate** | **31-March-2021 £'000 Gross Carrying Amount** | **31-March-2021 £'000 Lifetime expected credit loss rate** | 31-March-2020 £'000 Gross Carrying Amount | 31-March-2020 £'000 Lifetime expected credit loss rate |
|---|---|---|---|---|---|
| **Non NHS Debt** | | | | | |
| Current | 0.1 | 162 | - | 1664 | 2 |
| 1 - 30 days | 1.0 | 3 | - | - | - |
| 31 - 60 days | 2.0 | 27 | 1 | 1 | - |
| 61 - 90 days | 5.0 | 45 | 2 | - | - |
| Greater than 90 days | 10.0 | 69 | 7 | 2 | - |
| **Total expected credit loss** | | 306 | 10 | 1667 | 2 |

**10 Cash and cash equivalents**

| | **2020-21** | 2019-20 |
|---|---|---|
| | **£'000** | £'000 |
| **Balance at 01 April 2020** | 324 | 139 |
| Net change in year | 497 | 185 |
| **Balance at 31 March 2021** | **821** | **324** |
| | | |
| Made up of: | | |
| Cash with the Government Banking Service | 821 | 324 |
| Cash with Commercial banks | - | - |
| Cash in hand | 0 | 0 |
| Current investments | - | - |
| **Cash and cash equivalents as in statement of financial position** | **821** | **324** |
| | | |
| Bank overdraft: Government Banking Service | - | - |
| Bank overdraft: Commercial banks | - | - |
| **Total bank overdrafts** | **-** | **-** |
| | | |
| **Balance at 31 March 2021** | **821** | **324** |

**11 Trade and other payables**

| | **2020-21** | 2019-20 |
|---|---|---|
| | **£'000** | £'000 |
| NHS payables: Revenue | 1,288 | 6,661 |
| NHS accruals | 1,030 | 7,878 |
| Non-NHS and Other WGA payables: Revenue | 4,027 | 7,569 |
| Non-NHS and Other WGA payables: Capital | - | 37 |
| Non-NHS and Other WGA accruals | 40,474 | 31,139 |
| Social security costs | 220 | 197 |
| Tax | 173 | 150 |
| Other payables and accruals | 2,151 | 870 |
| **Total Trade & Other Payables** | **49,363** | **54,501** |

Non-NHS and Other WGA accruals includes £17.9m Prescribing accrual, £7.2m in relation to Primary Care, £8.0m Continuing Healthcare accruals and £5.6m in relation to Non-NHS contracts (31 March 2020: £16.3m Prescribing accrual, £5.8m in relation to Primary Care, £6.9m Continuing Healthcare accruals and £1.1m in relation to Non-NHS contracts).

Other payables include £1.1m to GP Practices for local services and £924k outstanding pension contributions (31 March 2020: £25K to GP Practices for local services and £823k outstanding pension).

**12 Provisions**

NHS Sheffield Clinical Commissioning Group had no provisions as at 31 March 2021 (as at 31 March 2020 nil).

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the NHS Sheffield Clinical Commissioning Group. The value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2021 is £0k (31 March 2020: £84k).

## 13 Commitments

### 13.1 Other financial commitments

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

| | **2020-21** | 2019-20 |
|---|---|---|
| | **£'000** | £'000 |
| In not more than one year | 186 | 292 |
| In more than one year but not more than five years | 7 | 152 |
| In more than five years | - | - |
| **Total** | **193** | **444** |

## 14 Financial instruments

### 14.1 Financial risk management

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

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

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

#### 14.1.1 Currency risk

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

#### 14.1.2 Interest rate risk

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

#### 14.1.3 Credit risk

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

#### 14.1.4 Liquidity risk

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

#### 14.1.5 Financial Instruments

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

**14 Financial instruments cont'd**

**14.2 Financial assets**

| | **Financial Assets measured at amortised cost 2020-21 £'000** | Financial Assets measured at amortised cost 2019-20 £'000 |
|---|---|---|
| Trade and other receivables with NHSE bodies | 2,162 | 2,444 |
| Trade and other receivables with other DHSC group bodies | 195 | 850 |
| Trade and other receivables with external bodies | 743 | 2,737 |
| Cash and cash equivalents | 821 | 324 |
| **Total** | **3,921** | **6,355** |

**14.3 Financial liabilities**

| | **Financial Liabilities measured at amortised cost 2020-21 £'000** | Financial Liabilities measured at amortised cost 2019-20 £'000 |
|---|---|---|
| Trade and other payables with NHSE bodies | 1,114 | 500 |
| Trade and other payables with other DHSC group bodies | 1,233 | 14,362 |
| Trade and other payables with external bodies | 46,623 | 39,292 |
| **Total** | **48,970** | **54,154** |

**15 Operating segments**

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

| | **Gross expenditure** | **Income** | **Net expenditure** | **Total assets** | **Total liabilities** | **Net assets** |
|---|---|---|---|---|---|---|
| | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** |
| Commissioning of Healthcare | 1,049,214 | (4,003) | **1,045,211** | 5,746 | (49,363) | **(43,617)** |

During the year NHS Sheffield Clinical Commissioning Group paid £495,372k, approx. 47% of total expenditure, (2019-20: £445,029k approx. 48%) to Sheffield Teaching Hospitals NHS Foundation Trust for the purchase of healthcare and other services provided.

**16 Pooled budgets**

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

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

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

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

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

| | 2020/21 | | | 2019/20 | | |
|---|---|---|---|---|---|---|
| | NHS Sheffield CCG | Sheffield City Council | Total | NHS Sheffield CCG | Sheffield City Council | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| The Better Care Fund | 280,844 | 214,938 | 495,782 | 269,863 | 183,472 | 453,335 |

The CCG net contribution to the Better Care Fund for 2020/21 shown above is included within the expenditure recorded in note 5 to these accounts (Services from foundation trusts £197,462k; Purchase of healthcare from non-NHS bodies £59,577k; GPMS/APMS and PCTMS £824k; and Purchase of Social Care £22,981k).

The memorandum account for the pooled budget is:

| **The Better Care Fund** | **2020/21** | **2019/20** |
|---|---|---|
| Gross Income | **£'000** | **£'000** |
| NHS Sheffield Clinical Commissioning Group | 280,844 | 269,863 |
| Sheffield City Council | 214,938 | 183,472 |
| | **495,782** | **453,335** |
| Allocation of expenditure | | |
| Theme 1 - People Keeping Well in their Local Community | (14,886) | (14,039) |
| Theme 2 - Active Support and Recovery | (56,517) | (57,993) |
| Theme 3 - Independent Living Solutions | (9,632) | (8,520) |
| Theme 4 - Ongoing Care | (216,626) | (184,564) |
| Theme 5 - Adult inpatient Medical Emergency Admissions | (69,569) | (68,622) |
| Theme 6 - Mental Health | (124,448) | (115,755) |
| Theme 7 - Capital Grants | (4,104) | (3,842) |
| | **(495,782)** | **(453,335)** |

**17 Related party transactions**

**Details of related party transactions with individuals are as follows:**

| Name & Role of Individual | Related Parties for which transactions made & Role of Individual | Purpose of Payment/Receipt | Payments to Related Party<br>£000 | Receipts from Related Party<br>£000 | Amounts owed to Related Party<br>£000 | Amounts due from Related Party<br>£000 |
|---|---|---|---|---|---|---|
| A Afzal, Locality Appointed GP | Duke Medical Centre - GP Principal | GP Practice payments | 892 | 0 | 182 | 0 |
| | Primary Care Sheffield - Practice is a shareholder in PCS | Contract payments | 10,514 | (315) | 287 | (84) |
| | Astra Zeneca - Chair of Medical Education meeting | Prescribing | 0 | (7) | 0 | (3) |
| N Bates, GP Elected Member | Porterbrook Medical Centre - GP Partner | GP Practice payments | 2,371 | 0 | 239 | 0 |
| | Primary Care Sheffield - Practice is a shareholder in PCS | Contract payments | 10,514 | (315) | 287 | (84) |
| N Doherty - Director of Delivery - Care Outside of Hospital (up to 12 July 2020) | Voluntary Action Sheffield - Observer member | Voluntary Organisation contract, Health and Wellbeing Board funding | 210 | 0 | 0 | 0 |
| A Forrest - Lay Member (up to 31 December 2020) | Sheffield Carers Centre - Chair | Contract payment | 8 | 0 | 0 | 0 |
| M Gamsu, Lay Member | Darnall Wellbeing - Committee Member | CHP Charges/Voluntary Sector Grant | 135 | 0 | 0 | 0 |
| | Sheffield Citizens Advice - Chair | Contract Payments | 250 | 0 | 0 | 0 |
| T Hudsen -Chair of the Governing Body and Locality Appointed GP | University of Sheffield Health Service - GP Principal | GP Practice payments | 3,256 | 0 | 138 | 0 |
| | Porterbrook Medical Centre - Salaried GP | GP Practice payments | 2,371 | 0 | 239 | 0 |
| | Primary Care Sheffield - Practice is a shareholder in PCS | Contract payments | 10,514 | (315) | 287 | (84) |
| A McGinty, Locality appointed GP | Woodhouse Health Centre - GP Partner | GP Practice payments | 1,461 | (5) | 423 | 0 |
| | Woodhouse Healthcare Services - Director | Pharmacy LES | 1 | 0 | 0 | 0 |
| | Primary Care Sheffield - Practice is a shareholder in PCS | Contract payments | 10,514 | (315) | 287 | (84) |
| C Nield, Lay Member | Sheffield Hallam University - Associate Lecturer | Course Fees, Research | 200 | (25) | 0 | 0 |
| L Philip, GP Elected Member | Chapelgreen Practice (Burncross Surgery) - GP Partner | GP Practice payments | 1,795 | 0 | 401 | 0 |
| | Primary Care Sheffield - Practice is a shareholder in PCS | Contract payments | 10,514 | (315) | 287 | (84) |
| M Sloan, GP Elected Member | Sloan Practice - GP Partner | GP Practice payments | 1,652 | 0 | 280 | 0 |
| | Primary Care Sheffield - Works as a CASES GP and practice is a shareholder in PCS | Contract payments | 10,514 | (315) | 287 | (84) |
| J Thorley (from 1 January 2021) | Judi Thorley Solutions Ltd | Consultancy payment (paid prior to January 2021) | 39 | 0 | 0 | 0 |
| D Warwicker, Locality appointed GP | Mill Road Surgery - GP Partner | GP Practice payments | 579 | 0 | 129 | 0 |
| | Primary Care Sheffield - Practice is a shareholder in PCS | Contract payments | 10,514 | (315) | 287 | (84) |

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

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

## 17 Related party transactions cont'd

**Prior Year Comparator 2019-20:**

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

**18 Losses and special payments**

**Losses**

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

| | **Total Number of Cases 2020-21 Number** | **Total Value of Cases 2020-21 £'000** | Total Number of Cases 2019-20 Number | Total Value of Cases 2019-20 £'000 |
|---|---|---|---|---|
| Administrative write-offs | 1 | 1 | - | - |
| Fruitless payments | - | - | - | - |
| Store losses | - | - | - | - |
| Book Keeping Losses | - | - | - | - |
| Constructive loss | - | - | - | - |
| Cash losses | - | - | - | - |
| Claims abandoned | - | - | - | - |
| **Total** | **1** | **1** | **-** | **-** |

**Special payments**

| | **Total Number of Cases 2020-21 Number** | **Total Value of Cases 2020-21 £'000** | Total Number of Cases 2019-20 Number | Total Value of Cases 2019-20 £'000 |
|---|---|---|---|---|
| Compensation payments | - | - | - | - |
| Compensation payments Treasury Approved | - | - | - | - |
| Extra Contractual Payments | - | - | - | - |
| Extra Contractual Payments Treasury Approved | - | - | - | - |
| Ex Gratia Payments | - | - | 1 | 3 |
| Ex Gratia Payments Treasury Approved | - | - | - | - |
| Extra Statutory Extra Regulatory Payments | - | - | - | - |
| Extra Statutory Extra Regulatory Payments Treasury Approved | - | - | - | - |
| Special Severance Payments Treasury Approved | - | - | - | - |
| **Total** | **-** | **-** | **1** | **3** |

**19 Financial performance targets**

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

| | **2020-21 Target £'000** | **2020-21 Performance £'000** | 2019-20 Target £'000 | 2019-20 Performance £'000 |
|---|---|---|---|---|
| Expenditure not to exceed income | 1,052,234 | 1,049,214 | 932,701 | 928,861 |
| Capital resource use does not exceed the amount specified in Directions | - | - | 74 | 74 |
| Revenue resource use does not exceed the amount specified in Directions | 1,048,231 | 1,045,211 | 927,959 | 924,119 |
| Capital resource use on specified matter(s) does not exceed the amount specified in Directions | - | - | - | - |
| Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | - | - | - | - |
| Revenue administration resource use does not exceed the amount specified in Directions | 12,160 | 11,505 | 13,366 | 11,141 |