NHS
Sheffield
Clinical Commissioning Group

NHS Sheffield Clinical Commissioning Group

Annual Report and Accounts

2018/19

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PERFORMANCE REPORT

Brian Hughes*

On behalf of

Maddy Ruff

Accountable Officer

23 May 2019

*Due to the sickness of the Accountable Officer, this statement is signed by Brian Hughes, Deputy Accountable Officer

Performance Overview

The purpose of this overview is to give you a short 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 Maddy Ruff, Accountable Officer and Dr Tim Moorhead, Chair

It was another challenging but also exciting year for the CCG as we continue to seek to develop and transform services to support improvements in the health and wellbeing of the people living in Sheffield. Throughout this report you will find facts and highlights about the CCG, as well as information on what we do, our performance over the last year and the challenges we face.

As Accountable Officer and Chair, we have welcomed the opportunity to reflect on what we have achieved as an organisation over the past 12 months, as well as think more about where we need focus our efforts in 2019/20 and beyond.

Some highlights in terms of our performance over the past year are; we continue to be rated as a 'good' CCG by NHS England, we have continued to deliver the national pledge on the 18 week wait from referral to treatment, we surpassed the national target for completion of assessments for ongoing care within 28 days, and do better than the target for completion of assessments in out of hospital settings. In addition to this, our practices are consistently diagnosing dementia in their patients at, or above, the level that could be expected using local disease prevalence data. At the same time we have managed our financial resources so that we have delivered against our statutory duty of remaining within our funding for the year.

This year saw the launch of the NHS Long Term Plan; this national plan has been developed in partnership with health and care staff, patients and their families and lists a number of important ambitions for the NHS for the next few years.

Many of our ambitions as a CCG, and work we already have underway, match up with what is outlined in the plan. It's positive that there is now a national focus on developing primary and community care, neighbourhoods (known as networks nationally), reducing health inequalities and prevention, all of which are already priorities for our organisation and with our key health and social care partners across Sheffield.

The primary care network model described in the national plan is exactly what we are trying to do here in Sheffield with neighbourhoods, whereby GP practices have joined together to form 16 groups across the city in order to work more closely together to enhance the services available and meet the needs of patients locally in their communities. The CCG was able to use both specific national funding and some of our own local resources to support the development of all the neighbourhoods and in March allocated over £0.7m to 36 practices working together in six different groups for innovative ways of working. We will be extending this investment to more neighbourhoods in 2019/20.

We were both personally involved in national groups that helped shape the Long Term Plan and we are pleased to see that NHS England listened to people's views. We welcome that the plan has a strong population-health focus.

With routine and urgent care needs, primary care services such as your GP practice, community pharmacist and optician should be your first point of call. We know this does not

always happen and we want to see more services delivered locally to you and will be supporting primary care professionals with training, development and finance to make this happen. We are re-considering our approach to urgent care following our consultation last year to ensure people who have an urgent care need can access the right care, in the right place first time.

In March 2019, we received an independent assessment of the CCG. We were particularly concerned to hear the views and experiences of some of our staff who we know work hard every day to support the delivery of services and care. We have listened carefully to what has been said both by our staff and key partners as part of this assessment and we fully accept that we need to make improvements in a number of different areas. Some things we can and are doing immediately. In addition, we have recruited an independent development director to support us develop and then implement an improvement plan. Our Governing Body is expected to approve the plan on 3rd July 2019.

Through partnership working, we believe we can make real and long lasting improvements to the health of local people. As individuals and organisations working alone, we would never be able to achieve the same results. The city is already seeing the benefits of stronger partnership working through the Accountable Care Partnership (ACP); a partnership of health, care, and voluntary and third sector organisations working together in a true team effort to further improve health and wellbeing for all the people living in Sheffield.

Our CCG is also part of the South Yorkshire and Bassetlaw Integrated Care System (ICS); a partnership of 23 organisations responsible for looking after the health and care of the 1.5 million people living in Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. Through working together, we have been chosen by NHS England as one of the first areas of the country to become an Integrated Care System.

We both have roles to play in the ICS. Maddy is seconded part-time to the ICS as Chief Executive Lead for population health and primary care for South Yorkshire and Bassetlaw and Tim provides advice from a primary care clinical lead point of view. We both enjoy this work, as we are passionate about improving population health. A lot of this work focusses on prevention, and ties in well with the CCG's aim to reduce health inequalities. There is approximately a 20-year life expectancy gap between the richest and poorest communities in Sheffield so this work is really important.

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

Maddy Ruff *Dr Tim Moorhead*

About us: NHS Sheffield CCG at a glance

We are NHS Sheffield Clinical Commissioning Group (CCG)

- Clinical: We are made up of GPs and other healthcare professionals who know your health needs and how to meet them.
- Commissioning: On your behalf, we plan, buy and monitor the majority of local health services that you need and use, such as those from hospitals and community services.
- Group: We are an NHS organisation working on behalf of 80 Sheffield GP practices, accountable to you, the taxpayer

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

Our vision

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

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

Our organisational objectives

- To improve patient experience and access to care
- To improve the quality and equality of healthcare in Sheffield
- To work with Sheffield City Council and other organisations to reduce health inequalities in Sheffield
- To ensure there is a sustainable, affordable healthcare system in Sheffield
- Organisational development to ensure that the CCG meets organisational health and capability requirements

Our strategic goals for 2018/19 were

- Deliver timely and high quality care in hospital for all patients and their families.
- Become a person-centred city: promoting independence for our citizens and supporting them to take control of their health and health care.
- Tailor services to support a reduction in health inequalities across the Sheffield population.
- Integration of physical and mental health, ensuring parity of esteem for people with mental health needs.
- Support people living with and beyond life threatening or long term conditions.
- Give every child and young person the best start in life.
- Prevent the early onset of avoidable disease and premature deaths.
- We will work in collaboration with partners across the Sheffield Accountable Care Partnership and South Yorkshire and Bassetlaw Integrated Care System to develop sustainable integrated care models and be recognized as a system leader for public sector reform.

Key Issues and Risks

Information about our key issues and risks is given in the Annual Governance Statement, which is part of the Accountability Report set out later in this document and can be found at page 57.

In summary, our Governing Body Assurance Framework (GBAF) provides the organisation with a clear view of the risks and issues affecting the achievement of our strategic objectives and eight supporting goals. The framework sets out how those risks are mitigated, the likelihood of occurrence and their potential impact. As at March 2019 there were 18 risks identified on the GBAF. One new risk was added during the year and no risks closed. .

The identified major risks throughout 2018/19 included:

- Our inability to deliver the QIPP (efficiency) savings plan due to lack of internal capacity and lack of engagement by our key partners
- System wide or specific provider capacity issues within secondary and or primary care which might prevent the CCG meeting its statutory requirements around the NHS Constitution and Five Year Forward View
- High volume of patients in hospital with delayed transfer of care (DToC) as a result of insufficient capacity to meet increasing demand on services (e.g. Active Recovery, Discharge to Assess)

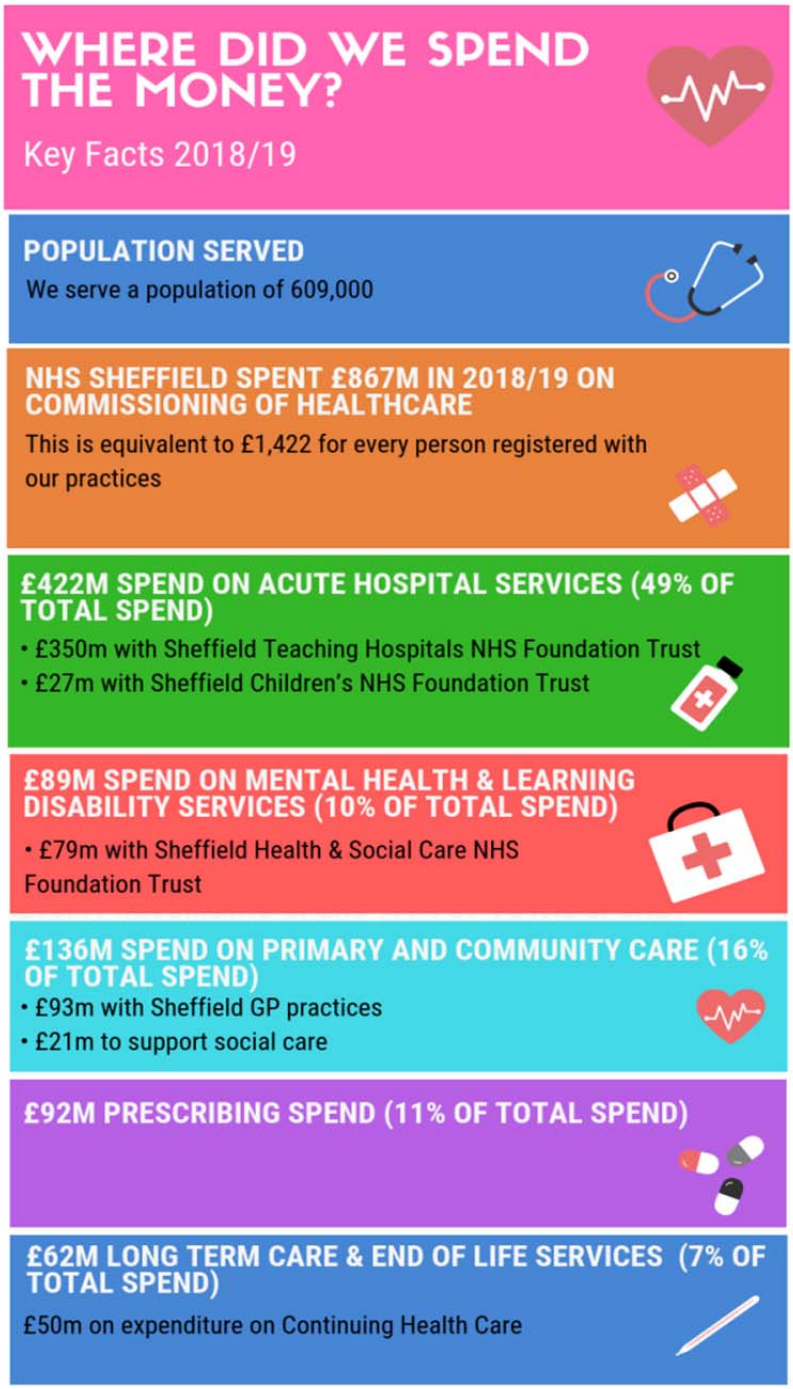
The risks continue into 2019/20 but we have controls in place to help mitigate any adverse impact.

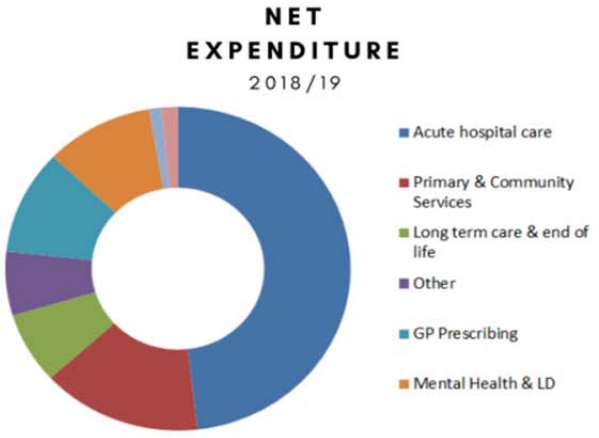
Finance at a glance

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

We delivered our financial plan of in year breakeven, that is containing our expenditure within the funding (allocation) issued to us by NHS England. In our financial accounts we are reporting a £16k surplus against this position.

CCGs are expected to maintain a minimum 1% cumulative (historic) surplus (£7.7m for NHS Sheffield CCG). Sheffield CCG, like many CCGs across the country, has a surplus in excess of this amount due to the national financial framework operated by NHS England in prior years which required CCGs to hold back 1% or 0.5% of their funding to contribute to national risk pool arrangements. As a result, in total Sheffield CCG has £18,030k of resources to carry forward into future years. The CCG may have access to the excess historic surplus (i.e. £10.3m) in future years subject to national planning rules.





Financial Performance

We spent £867m to commission health care services for the people of Sheffield.

Overall, we spent an average of £1,422 per person on health care for the people of Sheffield (compared to £1,411 in 2017/18). The table at the side provides a summary of where the money was spent. It includes spend against external income as well our revenue resources received from NHS England.

Our running cost allowance was £12.8m. This is used to fund the commissioning, governance costs and clinical engagement activities of the CCG and its Localities. In 2018/19, our actual spend was £10.0m (an underspend of £2.8m). This equates to £16.43 per head of population (compared to £17.50 in 2017/18). We used this underspend to support our commissioning of health services.

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

A quick look back over our year

It's impossible to capture all the work we have done at the CCG with our partners and stakeholders across the city but we want to give you a flavour – a quick look back at some of the achievements of 2018/19.

Funding boost for mental health

People at risk of a mental health crisis in Sheffield are now able to access new support services thanks to a £429,000 funding boost for the city.

This funding, secured by working as an ACP, was used to develop a new psychiatric decision unit, which Sheffield Health and Social Care NHS Foundation Trust will lead on, and for Sheffield Flourish, a mental health charity, to further develop and enhance the Sheffield Mental Health Guide self-help website.

The Psychiatric Decision Unit is a first point of call for anyone experiencing a mental health crisis. Based at the Longley Centre at the Northern General Hospital it gives people in a mental health crisis a safe place to receive emergency support.

The enhanced self-help platform will help people plan and manage their mental health care online, 24/7. The 'My Support' website will allow users to easily build plans and find appropriate support services and will be available to anyone, whether they are in contact with services or not.

This is great for Sheffield and also a great example of how Sheffield CCG is working as an ACP to make real changes for patients in the city.

Investing in Children's Mental Health Services (CAMHS)

Earlier this year we announced that we will be prioritising £616k from our new funding for 2019/20 to continue a range of services in children and young people's mental health support where pilot projects have proved successful. We have also set aside over £800k to support other CAMHS services from April 2019.

This funding has been committed in partnership with Sheffield City Council, as part of Sheffield's Emotional Wellbeing and Mental Health Strategy for Children and Young People.

Some of the funding will be used to sustain and expand Door 43, which is based at Star House in Sheffield City Centre and provided by Sheffield Futures and Sheffield Children's NHS Foundation Trust. Door 43 provides a holistic range of support for young people aged 13-25 including support for mild emotional wellbeing issues, education and housing. The aim of Door 43 is to support young people at the earliest possible point, before their needs escalate and they require more specialist support.

As well as providing the Section 136 Health Place of Safety in Sheffield for young people in crisis, Sheffield Children's Child and Adolescent Mental Health Service also provides a number of other services including Healthy Minds in schools, which is a programme that provides a whole school approach to supporting the emotional health and wellbeing of pupils, which this funding will support.

Practice Nurse Awards

Sheffield general practice nurses and healthcare assistants were recognised for their hard work and dedication to patients at the first ever Sheffield General Practice Nurse and Healthcare Assistant Awards. The awards were launched this year to recognise the often unsung work nurses do in primary care.

The award ceremony was organised by the CCG in collaboration with the Sheffield Practice Nurse Forum. Around 100 people attended the event that took place at the Sheffield United football ground on Wednesday 6 February and a number of key figures in healthcare from across Sheffield attended to present awards.

The shortlisted nominations highlighted a nurse who has worked in practice for almost 30 years, another who runs clinics for patients with language and cultural barriers, a healthcare assistant who mentors apprentices and nurses that are taking innovative approaches to nursing – to name just a few!

World Health Organisation recognition for Ageing Better

Our collective work with South Yorkshire Housing Association on tackling social isolation in Sheffield through the Ageing Better programme was highlighted as an example of 'inspirational practice' by the World Health Organisation (WHO) in their report 'Health 2020 priority area four: creating supportive environments and resilient communities'.

The Ageing Better programme provides a range of community-based resources and neighbourhood-based activities that promote social connections and networks. The overall initiative is a collaborative scheme with a range of locally-based delivery agencies and community groups that promote mental health and well-being across the city.

Cancer information hub award

The Sheffield Cancer Information Hub, based at The Moor Market won a prestigious Healthcare Transformation Award in the Improving Cancer Outcomes category in 2018.

The Hub is a partnership between the CCG, Macmillan and the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance and provides shoppers with cancer information and support in an informal, non-medical setting.

The Hub was the brain child of CCG Primary Care Lead Nurse for Cancer Louise Metcalfe. Louise came up with the idea as she looked for new ways to help support people affected by cancer in a more informal setting.

GP practices in Sheffield were rated 'good' by 8 out of 10 people

The results of the national GP survey painted a positive picture of Sheffield with 83% of patients rating their GP practice as 'very good' or 'fairly good'. We heard from over 8,000 patients from across the 80 GP practices in the city.

Each practice was ranked on a number of different criteria. Specific successes for Sheffield included 89% of those surveyed agreeing that GP receptionists were helpful. Sheffield also ranked higher than the national averages for patients getting enough support to help manage long term health conditions, with 80% of patients agreeing. 88% of patients agreed that

healthcare professionals recognised and/or understood any mental health needs that patients had had during their time at the practice.

Teams across the CCG support practices in so many ways, and with the information from the survey we're identifying even more opportunities to improve.

Waiting times reduced thanks to new GP practice system

Over half of all GP practices in Sheffield took steps to help patients receive the right service first time by introducing a new 'Care Navigation' system.

Through the new telephone system, trained receptionists are now able to advise whether patients need to see a GP, or can access healthcare directly through other services such as opticians, pharmacies, nurses, family services, or support groups.

As well as patients receiving care from the appropriate person, the Care Navigation system is working to reduce GP waiting times for patients where seeing a GP is the best course of action.

Regular Care Navigation events have been hosted by the CCG to help increase the number of practices involved, as well as share knowledge and ensure patients across Sheffield receive consistent advice.

Funding boost for diabetes programme

A diabetes programme in Sheffield was boosted with £845,000 of funding to continue to develop its valuable work in the city. This brings the total funding across two years to £1.4million.

The Diabetes Treatment and Care Programme, for people with Type 1 and 2 diabetes, provide extra support in both GP practices and hospitals.

Our primary care development nurse, Tracey Turton, has been leading the work to support GP practice staff in helping their patients with diabetes reduce their blood pressure, cholesterol and blood sugar levels.

The programme has worked with several hundred members of the public educating them about diabetes and providing lifestyle advice and feedback. The funding has been used to recruit extra staff to build on this work.

Sheffield stroke reduction

In Sheffield there's been a reduction in the number of people having strokes over the last two years due to people with irregular heart rhythm being put on appropriate medication.

We have been working with GPs to identify patients with atrial fibrillation, a quivering or irregular heartbeat that can lead to blood clots, stroke and heart failure, and giving them anticoagulation medication.

Anticoagulant medication is strong blood-thinner given to people with atrial fibrillation to reduce the risk of blood clots forming but anticoagulants continue to be under-prescribed across the country.

As the most common type of irregular heart rhythm, atrial fibrillation is responsible for approximately 20% of all strokes. Treating the condition costs the NHS over £2.2 billion each year. Survivors must live with the disabling consequences.

By continuing to identify people with atrial fibrillation and putting them on appropriate medication, we hope that the number of atrial fibrillation strokes will continue to decrease.

Sheffield's 13 ways of improving the lives of people with dementia

We were part of a partnership that has helped develop commitments to help improve the care and support for people living with – or caring for those living with – dementia in Sheffield.

Public, voluntary, community and private sector organisations across the city have worked together to develop 13 commitments around dementia care and support. These commitments aim to make sure that people with dementia, their families and their carers, can live life to its full potential.

There are approximately 7,000 people currently living with dementia in Sheffield, just over 1% of the whole of the city's population. These 13 commitments proposed by Sheffield organisations will create a structure for our strategy as a city to respond to the 'Prime Minister's 2020 Challenge on Dementia', released in 2015.

The commitments have been inspired by national guidance, as well as conversations had with people living with dementia, carers, health and social care professionals and volunteer groups.

The commitments are:

1. Sheffield will become a dementia friendly city.
2. We will ensure preventative health becomes an integral part of the dementia work.
3. We will improve access to the diagnosis of the diseases that cause dementia at the earliest possible stage for the people of Sheffield.
4. For people with dementia, support in Sheffield will be more personalised, local and accessible to help people to remain independent for as long as possible.
5. We will provide high quality support to families and carers of people with dementia in Sheffield to help people with dementia maintain their independence for as long as possible.
6. Sheffield will continue to provide out of hospital emergency assessments and short term care when people need it and in the most appropriate setting.
7. Sheffield will continue to provide specialist inpatient assessment and treatment for people who are unable to receive care in their own homes.
8. We will make sure that more people get access to personalised, good quality palliative and end of life care when they need it.
9. We will improve care for people with dementia attending A&E and those admitted to Sheffield Teaching Hospitals.
10. Care homes will take account of the needs of people with dementia.
11. We will support the clinical and non-clinical research community in Sheffield.
12. We will provide guidance to clinicians in relation to the best medicines for dementia, including when to initiate and review medication.
13. We will monitor the strategy and the implementation plan supporting it.

Urgent care services in Sheffield

Between 26 September 2017 and 31 January 2018, the CCG ran a consultation on changes to improve urgent care services in Sheffield. After working with members of the public, partner organisations and clinicians to review all the feedback received, in September 2018 the CCG agreed to reconsider the urgent care proposals for minor illnesses and minor injuries and not to progress with the proposed changes to urgent eye care.

Between September 2018 and March 2019 we held specific engagement sessions with patient representatives and our partner organisation. We also sought the views of the wider population, people who use the services, and those from harder to reach communities to really understand what the issues are.

Following on from feedback from the last consultation, we worked with members of the public and patients to develop the definition of urgent care. Urgent care means advice and treatment for illness and injuries for all ages, thought to be urgent (care needed within 24 hours) but not life threatening. In this definition, illness includes both physical and mental health conditions. We are still committed to ensuring Sheffield people who have an urgent care need can access the right care, in the right place, first time. And we believe we can improve services to make them fit for the future for the people of Sheffield.

We will be analysing the information collected and looking at ways we can improve the problems people face when accessing urgent care services.

City's £6m plan set to support people with complex needs

Sheffield's £6 million plan was agreed in July 2018 to support people with drug and alcohol problems, and other complex needs.

Over the next five years we will work in partnership with Sheffield City Council, Sheffield Teaching Hospitals and South Yorkshire Police to support hundreds of adults who have drug and alcohol problems; are homeless; have health or mental health problems and are repeat offenders.

Improving the health of adults with complex needs is a big priority for the CCG. By working together with other public services and investing more money, we can make a real difference to the lives of these often vulnerable people. Supporting people in the community will lead to better health and wellbeing and fewer emergency hospital admissions, reducing demands on our hospitals.

Investing in clinical pharmacists

During this year, Primary Care Sheffield successfully recruited 12 Clinical Pharmacists to work across 40 GP practices throughout Sheffield, as part of a national programme. The aim of this programme, which launched with Sheffield practices in January 2018, is to develop the role of Clinical Pharmacists within GP practices, freeing up busy GP time, but also to become medicines experts within practices and a key member of the practice multi-disciplinary team. NHS England is providing significant funding and training to the team over three years in order to ensure success at this role, including training to become Independent Prescribers. The funding is tapered over the three years, with additional contributions coming from the CCG and participating practices.

Working together to ease winter pressures

Winter is always a difficult time of year for the NHS but a partnership of all the major health and social care organisations in the city, including the CCG, Sheffield City Council, the city's hospitals and mental health trust, and voluntary sector organisations have worked closely together to make sure Sheffield people received the best possible levels of care at our busiest time of year.

The city's health and social care organisations developed a detailed winter plan to make sure urgent NHS services are resilient, and work well together. As well as working on operational plans we also worked with partners to educate the public on alternatives to A&E – such as a GP service, pharmacist, the walk in centre or the minor injuries unit at the Royal Hallamshire Hospital site unless they have a serious illness or life threatening emergency.

Promoting self-care and health and wellbeing

During self-care week 2018, we worked with our staff and the public to promote self-care and encourage people to take control of their health and wellbeing.

We had a number of resources available that educated people on how to look after minor illnesses and injuries at home or with the support of their local pharmacy. Self-care is important as it empowers people to take control of their own health and wellbeing but also ensures that urgent care services are available for those who really need it.

We also held a health and wellbeing week for our staff in 2018 where there were a number of initiatives and activities aimed at reducing stress, increasing wellbeing and giving staff the opportunity to take time out and look after their physical and mental health.

Performance analysis

Delivering on our performance standards

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

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

You can see our monthly “Performance, Quality and Outcomes” report on our website, published with the papers for our Governing Body. The report includes a dashboard which provides an at a glance overview of where we are meetings standards, and where we are currently falling short, together with an explanation of how we are working to improve things. The CCG is engaged in ongoing dialogue with our providers about quality, safety and access, for example: waiting times for routine surgery; A&E waiting times; health care acquired infections; ambulance handover times; cancelled operations; delays in transfer from hospital and access to mental health services. Standards such as these are embedded in the national contract framework, which we use as the basis of our relationships with provider NHS Trusts. This includes ensuring that we have contracted for, and can fund, an appropriate level of activity to meet local need and comply with standards for how long people should wait for their treatment.

There are some clinical areas which are more complex and challenging than others. You will see from our performance dashboard (below) that we have not been able to meet all of the national waiting time standards for Cancer treatments.

Some key successes in 2018-19:

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

- We have continued to deliver the national pledge on the 18 week wait from referral to treatment.
- Capacity problems in a small number of specialities at STH led to us missing the 6 week diagnostic wait standard for the first five months of the year; however the Trust put effective recovery plans in place and went on to deliver the standard for the remainder of the year.
- Following investment from the CCG and SHSCFT to boost capacity, SHSC has delivered the two week wait for the Early Intervention in Psychosis service throughout the year.
- We surpass the national target for completion of assessments for ongoing care within 28 days, and do better than the target for completion of assessments in out of hospital settings (national guidance suggests that assessments which take place outside hospital lead to a more realistic picture of the person’s ongoing care needs).

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

Waiting time challenges for Cancer treatments

There are currently nine national pledges which address how long patients should wait to be seen and diagnosed, and then the waiting time for various aspects of treatment (eg surgery, radiotherapy, chemotherapy). Unfortunately, Sheffield has not been able to meet all of these nine pledges consistently in 2018-19. There have been particular pressures in **urology**, in part due to more men presenting with signs and symptoms of prostate cancer, and requiring surgery. This is of course in some ways a good news story, as men are coming forward with their symptoms due to successful awareness raising campaigns. Delivery of the waiting times for surgery and radiotherapy for **head and neck** cancers can also be very challenging, as these cancers often require complex and invasive treatment. Patients sometimes need extra time to come to terms with the impact of their treatment and to make informed choices about their care. In addition, there are some vacant posts which are very hard to recruit to, due to national shortages in the highly specialised cancer workforce.

Sheffield CCG is a member of the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance, which works collaboratively to improve and strengthen services, including making decisions about where to target funding (e.g. to boost radiotherapy capacity) and supporting clinical co-operation between providers.

A&E four hour standard

Sheffield Teaching Hospitals NHS FT (STH), in common with many similar large teaching hospitals across England, was unable to deliver the Constitutional standard during 2018 -19 (95% of patients who attend an A&E department are to be admitted to a hospital bed, discharged from the department or transferred to another hospital within four hours of arrival).

STH had a wide ranging action plan in place to move the trust towards 95% achievement, and considerable progress was made in year, notably recruiting to new nursing posts, and appointing new medical staff to ensure that there was senior clinical cover in place at peak times. Improving assessment processes at the “front door” of the hospital, ensuring that there were beds available to admit patients when this was needed, and improving the speed of transport between the Northern General and Royal Hallamshire sites all contributed to making the system more efficient.

Towards the end of the year, achievement of the four hour standard began to improve, although performance continued to be variable and vulnerable to both peaks in the acuity of illness in patients who presented at A&E and gaps in clinical cover caused by sickness.

Sustained and consistent delivery of the four hour standard in the future will be as a result of co-operation right across the health care system, and the CCG is taking a number of steps to ensure that there are alternative sources of help and advice for patients to access, including in primary care. The CCG will seek to co-ordinate activity across the city to ensure that all the parts of the system work together effectively to meet patient need in a timely manner.

Quality and access standards in primary care

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

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

Many of these standards are also monitored nationally, and we are benchmarked against other CCGs which share similar characteristics with us. These form part of the national CCG Improvement and Assessment Framework (see below).

The CCG supports clinical improvement in general practice in a number of ways, notably:

- staff from our Medicines Optimisation Team visit practices and provide advice and support on medication, focusing on patient safety (as well as eliminating waste and over-prescribing);
- our Primary Care Development Nurses provide education and support for practices, using their specialist knowledge and skills in clinical areas such as hypertension, respiratory disease, diabetes and stroke;
- the CCG runs city wide education sessions (known as “Protected Learning”) for staff in general practice, on a wide range of subjects each year, in order to update clinical knowledge. Recent topics have included problem gambling, suicide prevention, end of life care, infection control, and supporting people with multiple long term conditions.

The CCG’s performance – how we measure up

Our overall performance and effectiveness is overseen by NHS England, the regulatory body for CCGs, and measured through the CCG Improvement and Assessment Framework (IAF).

The IAF sets out the standards where we as a CCG are held to account, across a wide range of themes including better care, better health, financial stability and quality of leadership. The IAF provides a balanced overview of how the CCG organises its own work and discharges its duties. We are measured against a wide range of indicators; some examples include:

- The timeliness of assessment processes for eligibility for continuing health care;
- How well we communicate and engage with our local citizens;
- What activities we have undertaken to raise awareness of Sepsis amongst local clinicians;
- Proportion of our population who are benefitting from extended hours access to primary care;
- One year survival from all cancers;
- Investment in mental health services.

NHS England uses the IAF to assign an overall rating for every CCG. Sheffield is currently rated as “GOOD”, based on our performance in the year 2017-18. The CCG IAF performance ratings for 2018-19 are expected to be published in July 2019 and will be made public on the

MyNHS website. They will also be discussed in our Performance, Quality and Outcomes report which we submit each month to our Governing Body and which you can find on our website.

Performance and quality dashboard

This dashboard provides an overview of our performance in 2018 -19 against key national measures, including The NHS Constitution pledges to patients about their care. The CCG holds our providers to account on their delivery of these pledges and other quality standards, and we work with them to create remedial plans when there are shortfalls.

NHS Constitution Rights and Pledges overview for 2018/19	Did we meet the standard?	Commentary
Waiting time in Accident and Emergency departments • 95% of patients who attend an A&E department are to be admitted to a hospital bed, discharged from the department or transferred to another hospital within four hours of arrival.	☒	Delivery of the A&E waiting time standard for adults (at Sheffield Teaching Hospitals NHS FT) continues to be our most challenging issue requiring system wide co-operation and focussed action. The CCG works closely with the Trusts, our practices and the ambulance service to take forward a range of actions to improve performance, which includes commissioning a range of services which provide alternatives to A&E, such as additional appointments in the primary care "hubs", pharmacy based minor ailments scheme and Emergency Care Practitioners, who see and treat people in their own homes. The final three months of the year showed some improvement and progress towards the standard. Sheffield Children's NHS Foundation Trust delivered the four hour standard throughout 2018/19.
Waiting times for elective treatment • 92% of all patients should wait less than 18 weeks for their treatment to start • No patients wait more than 52 weeks for treatment to start	✓ ☒	We remain in a strong position on delivery of this target, with some of the best performance in England. A very small number of Sheffield patients (fewer than 10) waited longer than 52 weeks for their treatment; in all cases these patients were waiting for treatment outside Sheffield, and some cases, the delay may have been partly due to patient choice.
Diagnostic waiting times • 99% of patients should wait six weeks or less for their test/s from the date they were referred	☒	Unfortunately there were issues with four diagnostic tests at STH NHFT, which led to a small number of patients waiting longer than the six week standard. The Trust was able to put effective recovery plans in place, and the standard was delivered during the second half of the year.
Waiting time for Cancer treatments and diagnostic tests • There are nine separate waiting time pledges for Cancer which address how	☒	The nine standards were not met consistently in 2018 -19, with particular challenges around the 62 day wait from urgent GP referral to first treatment, and the 31 day wait for second / subsequent treatment, where the treatment is

long patients should wait for various parts of their treatment journey		surgery. We have been able to consistently deliver the two week wait from GP referral to first outpatient appointment.
Mental Health • 95% of patients discharged from psychiatric inpatient care followed up by Mental Health Services within 7 days, to ensure that they have appropriate care and support.	☒	The latest information we have on CCG performance relates to Quarter 4 performance (January 2019 – March 2019), which achieved the standard of 95%, which was a pleasing improvement, although we were unable to meet the standard during the rest of the year.
• 50% of people referred to the Early Intervention in Psychosis Services should be seen within 2 weeks	✓	This target has been met consistently every month this year. The CCG invested in creating new posts to increase capacity in this service. Sheffield remains in a strong position on this indicator.
• Proportion of Sheffield's population who are accessing IAPT services (Improving Access to Psychological Therapies, i.e. talking treatments). This is about the expected number of our residents experiencing conditions such as depression, and who could benefit from IAPT.	✓	The CCG has commissioned ten new IAPT services which are designed to help people cope with the psychological aspects of living with long term physical conditions. Specialists are available to help people with conditions such as respiratory problems, ongoing pain, dermatological problems, and musculo-skeletal conditions.
• 75% of people referred to IAPT should wait 6 weeks or less until their first appointment; 95% of people should be seen within 12 weeks.	✓	Our service consistently delivers on this standard.
• 50% of people who receive IAPT services are moving towards recovery from their mental health condition.	☒	Our service treats a higher than average number of people with complex and long-standing needs. The more severe nature of their problems can mean that it takes longer for them to improve, and that they may be less likely to complete the whole course of treatment. Latest performance is that this standard is now being achieved after being close to it for the majority of the year.

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

- Mixed sex accommodation:
  There have been a small number of occasions (less than 5) where Sheffield patients were cared for in a mixed sex environment; at times this was due to significant bed pressures associated with the peak winter period. Each case is investigated and a remedial plan required.

- Operation cancelled on or after the date of admission, for non-clinical reasons to be offered another date within 28 days:

There have been a small number of breaches of this standard, each case is reported on in our monthly Performance and Quality report.

- Urgent operations cancelled for the second time:
  There have been a small number of breaches of this standard, each case is reported on in our monthly Performance and Quality report.

Ambulance standards

Ambulance response times are also covered in the NHS Constitution. In common with many other ambulance services, our provider, Yorkshire Ambulance Service NHS Trust (YAS) has not delivered these standards consistently across the year, although progress is being made month on month.

Ambulance services across England moved to a new set of standards and operating procedures in 2017-18. The new standards are designed to provide a more appropriate response to meet clinical need, prioritising the most acute and time sensitive conditions, and ensuring that the vehicle and personnel who are despatched are the best fit for the patient's need. The new ambulance response programme includes "hear and treat" (providing advice and signposting over the telephone) and "see and treat" where the patient is assessed and treated on the spot, rather than being conveyed to hospital.

Performance Indicator		Target	CCG Quarterly Q4 18/19	CCG Latest monthly Position		CCG Performance against standard (latest 6 months)
Ambulance response times	Category 1 (life threatening) calls resulting in an emergency response arriving within 7 minutes (average response time)	7 mins		6 mins 43 secs	Mar-19	
	Category 2 (emergency) calls resulting in an emergency response arriving within 18 minutes (average response time)	18 mins		17 mins 42 secs	Mar-19	
	Category 3 (urgent) calls resulting in an emergency response arriving within 120 minutes (90th percentile response time)	120 mins		89 mins 41 secs	Mar-19	
	Category 4 (less urgent) calls resulting in an emergency response arriving within 180 minutes (90th percentile response time)	180 mins		180 mins 7 secs	Mar-19	

Sustainable Development

The NHS Carbon Reduction Strategy for England sets an ambition for the NHS to help drive change towards a low carbon society. The strategy shows the scale of reduction in carbon required for the NHS to meet its legal targets set out in the Climate Change Act to reduce 34% of carbon emissions by 2020. NHS Sheffield CCG has identified an executive director lead for sustainability.

The majority of our carbon footprint derives from the health and care services we commission rather than the resources that we use as an organisation, therefore our priority must be to work with our providers to improve their performance and maximise the benefits that they deliver to the health and welling of the people of Sheffield.

Our Workforce

Raising the profile of sustainability in the workplace is key to maintaining a sustainable workforce and commissioning environmentally appropriate services to meet the health needs of our local population now and in the coming years. Current policies that promote wellbeing whilst at the same time aim to reduce our carbon footprint include remote access and home working policy, absence management and flexible working. Staff are also encouraged to suggest new ways and approaches of raising the sustainability and wellbeing of CCG staff through our Staff Forum.

Move More
We play an active part in supporting Move More, Sheffield's physical activity plan that aims to transform Sheffield into the most active city in the UK by 2020. In June 2019, the CCG, local GP practices and other healthcare providers in the city all participated in the Move More challenge which aims to increase the physical activity of participants by increasing their daily step count and hopefully promotes active means of transport for social and business travel over car journeys. Approximately 30 GP practices took part and the CCG had a number of teams made up of staff groups with some healthy competition to be the winners.

Community Engagement
Shaping and commissioning services now and for the future is key to delivering sustainable services for our local population. To support our vision we have developed our Communication and Engagement Strategy and throughout 2018/19 have sought to make sure patients and their carers had opportunities to engage in meaningful dialogue with us to help develop the services we commission. This approach ensures our services are fit for purpose and sustainable.

In the delivery of our community engagement work, we strive to commission local community organisations and venues so that our communities continue to benefit from local investment and infrastructure.

We have also undertaken a number of health campaigns to increase awareness of health care, health services and healthy behaviours to help people to live healthier lives and choose the right health services for their needs.

The key objectives of our communication and engagement strategy are to:

- Engage in meaningful dialogue and proactive listening with our citizens
- Be part of an integrated communications and engagement system across all partners that make best use of resources and information
- Champion true enquiry, openness and honesty and systems where our citizens offer the mandate for change
- Increase awareness of health care, health services and healthy behaviours so people can make informed choices; Build community capacity and responsibility
- Manage the reputation of the CCG so that our voice is credible and trusted
- Ensure opportunities for two-way dialogue with our staff and member practices. Keep them informed and empower them to fulfil their roles
- Role-model innovation, shared learning and progressive approaches

Contracting and Procurement

As a commissioner of services our aim is to assure the sustainability of the organisation and that of our commissioned services. We continue to work collaboratively with our procurement colleagues to identify and maximise opportunities to integrate sustainability considerations within our commissioning processes and functions.

Our procurement strategy reflects our obligations to comply with the Public Services (Social Value) Act 2012, to ensure that the CCG invests and acts to achieve the maximum benefit for the population now and in the future.

Successes in 2018/19:

- We are trying to maximise the influence we can achieve as a commissioner of services. Social value is included as a key requirement in tender documentation and

specifications; we are working towards the Social value approach of Sheffield City Council joining their 'Ethical Procurement' and 'Meet the Buyer' events.

- We take an active part in Sheffield's Progressive Procurement, a group comprising Sheffield City Council, The Universities, Sheffield College, The NHS Provider Trusts and Sheffield CCG seeking to procure jointly for the provision of similar services.
- We have run and delivered Joint procurement projects with Sheffield City Council for some patient services, such as the Care at Night.
- We have reduced the environmental impact across South Yorkshire & Bassetlaw by awarding contracts for Teledermatology and the GP Consultation App, thus reducing travel in the region.
- The NHS Standard Contract requires our providers to minimise adverse impact on the environment and report on sustainability in their annual report. In addition our providers must give due regard to the Public Services (Social Value) Act 2012.

Commissioning services for the people of Sheffield

In 2018/19 the city continued to develop an Accountable Care Partnership (ACP) approach to deliver health and social care to the people of Sheffield. Shaping Sheffield, the place based plan for Sheffield published in February 2017 http://www.sheffieldccg.nhs.uk/our-projects/Strategy.htm sets out the ACP plans for the next five years; this is currently being refreshed and will be signed off in early 2019/20. At the heart of these is an agreement to take a social value approach to commissioning and providing the services for which we are all responsible that seeks to ensure the best social and environmental outcomes for patients, communities and the population of Sheffield.

Facilities Management

NHS Property Services (NHSPS) are responsible for managing the lease for the building from which we operate, as well as monitoring utility costs. The following table indicates our utilisation for gas, electricity and water for 2018/19.

Consumption			Cost		
Electricity (kWh)	Gas (kWh)	Water (m3)	Electricity (£)	Gas (£)	Water (£)
249,100	325,082	1,756	41,241	12,812	9,789

The comparator 2017/2018 figures were:

Consumption			Cost		
Electricity (kWh)	Gas (kWh)	Water (m3)	Electricity (£)	Gas (£)	Water (£)
268,379	606,745	2,308	34,353	14,562	6,510

CO^2 emissions to atmosphere

During 2018/2019, 193.91tns of CO^2 to atmosphere was created by electrical and gas usage by NHS Sheffield CCG; a reduction of 62.46tns from the previous year.

The CCG will work further with NHSPS to obtain more accurate data of our utilities usage to establish a baseline for developing targets to reduce our carbon footprint during 2019/20. We acknowledge the responsibility to our patients, local communities and the environment by working to minimise our carbon footprint.

Within our offices we have implemented and continue to operate recycling schemes for waste paper, glass and other recyclables including copier toner cartridges. Unfortunately recycling data is not currently available split by financial year however, for the calendar year 2018 we recycled:

- Paper and cardboard 4,372 kg
- Glass 300 kg

This reduced our carbon footprint by six metric tonnes and saved 57 average sized trees. The amount recycled by the CCG during 2018/2019 saw a drop from the previous year's figures:

- Paper and cardboard 5,487 kg
- Glass 405 kg

Next steps

- Develop energy, water and waste baselines and reduction targets
- Monitor and report travel mileage and transport mode – miles avoided
- Develop Active Travel plan
- Work with providers to ensure there are plans in place to reduce carbon emissions
- Review and develop the Sustainable Development Management Plan
- Work with strategic partners and local stakeholders to support sustainable development preparing and adapting to the predicted effects of a future changing climate.
- Proactively promote energy efficiency through task and finish group (turn off computer/lights, heating, not on stand-by etc.)
- Develop sustainability communications strategy to include sustainability objectives and training opportunities
- Induction programme to include sustainability

Quality care for all - improving quality

Ensuring high quality care is at the very heart of what we do. Over this last year we have created the opportunity to stretch ourselves, develop stronger relationships and continue to work in collaboration with our colleagues across the city. Through collaborative working we have been able to build on the success of the previous year whilst also being able to focus our efforts on areas that we needed to strengthen.

By listening to patients and relatives we are able to provide a more user friendly service within continuing health care. Whilst our engagement work with this group is in the early stages, the impact is already starting to be felt.

Across the city, as with all NHS organisations, we are anticipating some nursing workforce issues. To try and counter this, this past year we have been raising the profile of the nursing profession through social media and other methods. Also we have been successful in developing the first ever Sheffield General Practice Nurse Awards, where the public, GPs and

other colleagues nominated their GP practice nurses for a number of awards. Subsequently three of these went onto further achieve attainment for the Regional Yorkshire and Humber Nursing Awards, presented by NHS England.

Mandy Philbin, Chief Nurse

Medicines Optimisation

Some highlights from our medicines optimisation team:

The first citywide Protected Learning Initiative (PLI) for practice staff focusing purely on prescribing and medicines safety was held in February 2019. The event was a big success with approaching 300 GPs and staff in attendance.

February 2019 also saw the first Practice Nurse Conference and Awards ceremony which attracted over 90 practice nurse attendees and received very positive feedback.

There is a continued focus on antimicrobial stewardship. Sheffield has seen a 50% reduction in prescribing of courses of broad spectrum antibiotics between 2014 and 2018.

Between 2015 and 2018, there has been a 12% increase in patients with atrial fibrillation who are receiving an anticoagulant for protection against stroke.

Sheffield is considerably below the national average for prescribing high dose opioids in non-cancer pain, as recommended by the Faculty of Pain Medicines.

We have successfully implemented the Eclipse - Advice and Guidance system across the city, which it is envisioned will help reduce the number of adverse drug events. In less than 6 months of use over 500 patients at risk of harm have been identified and reviewed.

The Sheffield Area Prescribing Group (APG) continues to develop recommendations on prescribing practice in Sheffield taking into consideration current evidence, NICE guidance and detailed consideration of new treatment options. In the past year it has reviewed and developed 23 prescribing guidelines, 15 shared care guidelines, 21 formulary chapters and 14 traffic light listings.

Primary Care Development Nurse (PDCN) achievements

The PCDN team have been working with practice staff to improve patient care and reduce inequalities across the city.

The Primary Care Development Nurses (PCDNs) have established quarterly Neighbourhood nurse meetings with all Neighbourhoods citywide, as a systematic approach to improve engagement with Practice Nurses (PNs) and health care assistants (HCAs) to support implementation of national and local guidance; support the facilitation of new models of care delivery and reduce inequalities in patient care citywide, as well as sharing best practice. Neighbourhood working has provided an opportunity for the PCDN’s to act as a conduit for information sharing between the CCG and practice nurses providing improved communication and practice engagement. Additionally, it has allowed PNs to network with other nurses, reducing isolation and helping to share best practice.

The PCDNs are supporting the NHS England diabetes treatment and care programme to improve the management of BP, HbA1c and Cholesterol to NICE target levels. This project has

now entered year 3, with additional funding supporting additional hours for practice nurses to undertake the extra diabetes management work and to share best practice across neighbourhoods.

The GRASP Diabetes Care audit March 2019, demonstrates significant improvements in the percent of patients achieving the NICE treatment targets in the 7 target practices with additional nurse funded hours since September 2018.

The PCDNs are undertaking a 6 month pilot across 3 neighbourhoods to upskill practice nurses and HCAs in relation to managing Chronic Obstructive Pulmonary Disease (COPD) and Asthma. 100% uptake of places has been achieved, with potentially up to 48 nurses receiving upskilling. To date excellent feedback has been received from delegates and a full evaluation of feedback and future plan will be completed at the end of the pilot.

Ongoing programmes of upskilling and support are being developed in response to neighbourhood needs. For example – management of paediatric asthma in primary care; inhaler technique and training in manual blood pressure recording for HCA's.

This year, a practice nurse vision was agreed and developed with input from practice nurses from across Sheffield. Their vision is: *We will build a sustainable, skilled and knowledgeable general practice nurse community that is respected throughout Sheffield Primary Care and beyond. We will achieve this by empowering and supporting the general practice nurse workforce to release and achieve their potential*.

Also this year work has started to develop a practice nurse strategy which will be developed and rolled out in 2019/20.

Quality Assurance in Care Homes

During the past 12 months the Quality in Care Home Team (QCHT) at the CCG has been working to develop a new model of gaining assurance. This approach consists of two parts, a risk based approach to address concerns, by gathering and collating intelligence and a proactive approach to capture the experience of those people using the service.

The risk based model utilises gathered intelligence which is captured on a risk log. This information is reviewed and where necessary a quality monitoring visit is undertaken. A themed monitoring tool is used, depending upon the nature of the concern the appropriate part of the tool supports the quality assurance visit. The tool is weighted depending on clinical risk. Any concerns identified during the visit are discussed with the home manager. An action plan is agreed to resolve concerns with support from the team.

The proactive 15 step challenge model was developed by the NHS in 2009 and is a tried and tested, patient-focused approach to quality assurance and improvement. The domains covered are informed by research on what matters most to those who use services and CQC fundamental standards. The domains include: is the service; welcoming, safe, caring and involving, also well organised and calm.

Continuing Health Care

In line with national requirements less than 15% of assessments for Continuing Health Care (CHC) should be completed in a hospital setting, we know that where patients are assessed in hospital, this can often give an inaccurate picture of their ongoing care needs and ability to

make progress in rehabilitation after their hospital stay. We can report that in the past year, the Sheffield CHC team have continued to have 100% of CHC assessments completed outside of the Hospital setting.

This year the CHC team has continued to complete on average 97% of assessments within 28 days, which is also in line with national requirements of 80% of assessments to be completed within 28 days. This ensures that patients are assessed and receive their eligibility outcome in a timely manner making a positive impact on patient experience.

Delivering the Enhanced Health in Care Home (EHCH) framework in Sheffield

The Enhanced Health in Care Homes Framework (EHCH) introduced New Models of Care which includes new ways of working with care homes and includes engagement to co-produce a workforce development plan. EHCH is based on a suite of evidence-based interventions, which are designed to be delivered within and around a care home in a coordinated manner in order to make the biggest difference to its residents.

The EHCH supports proactive and safe discharge in care homes with the completion of Data Security and Protection Toolkit (DSPT) in order to register for a secure email account. All care home providers are expected to achieve all required elements of the DSPT including the adoption of a secure NHS email account for transfer of personal information confidentially. We have supported the homes to complete DSPT with hands on support and information. Fifty-two out of 100 homes have completed DSPT and are able to register for an NHS email account.

The benefits are that it will speed up safe and secure communications between organisations, support improvement of information flows, promote integrated working across all areas and lead to reduction in delayed transfer of care, especially for patients waiting to be registered into a care setting and usual place of residence.

Care homes workforce development

The CCG is working in collaboration with Sheffield College and Sheffield Job Centre Plus to provide Sector Based Work Academy (SBWA) Programme for social care. The programme aims to improve recruitment and retention to the social care sector by providing the necessary skills, knowledge and qualification for employment candidates and working closely with employers to understand recruitment needs.

The CCG has been supporting the Health Education England (HEE) Trainee Nursing Associates Programme, a new role designed to help bridge the gap between health care assistants and registered nurses, by linking the trainees with care homes as placement providers and employers to provide a carer career pathway in Sheffield. The programme provides an experience of working in social care for a nursing role placement and an opportunity for a carer career pathway.

In March 2019 an apprenticeship pilot was launched to support care homes by transferring a percentage of the CCG's apprenticeship levy to provide funding for a care home apprenticeship. The pilot is working in collaboration with The Broomgrove Trust Nursing Home and Sheffield College as the educational provider. The pilot will support care homes that are performing well to develop staff as outlined at the Sheffield Care Homes Conference in June 2018.

Engaging people and communities

Involving people in our decision making

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

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

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

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

We consult with relevant Overview and Scrutiny Committees:

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

Strategic Patient Engagement, Experience and Equality Committee (SPEEEC)

Our involvement activity is overseen and assured by our Strategic Public Engagement, Equality and Experience Committee whose members include local people, Governing Body Lay Members, Healthwatch Sheffield, the Local Authority and Sheffield University.

The Committee has delegated responsibility from our Governing Body to:

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

Our communications and engagement strategy

Our 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 will ensure that we are always:

- Open, honest and transparent
- Accurate, fair and balanced
- Timely and relevant
- Cost effective
- Clear, using plain English and accessible, in line with the NHS England information accessibility standards

You can find our Communications and Engagement Strategy here.
The Communications and Engagement Strategy will be updated by June 2019.

Supporting people to be involved

Appropriately supporting local people to have their say and genuinely influence our commissioning decisions is a priority for us. We believe that our values and behaviours speak louder than words and have developed a Volunteering Policy to ensure our staff offer consistent and appropriate support to individuals who help our work. This includes reimbursement of out of pocket expenses tailored to an individual's circumstances, but as standard for travel, caring responsibilities and subsistence costs.

You can find our Volunteering Policy here.

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

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

Understanding our communities

As well as evidence gathered through consultation and involvement activities, we use monitoring information that we hold 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 Sheffield City Council's Joint Strategic Needs Assessment, State of Sheffield Reports and Community Knowledge Profiles, and NHS England's Right Care pack for Sheffield.

Equality monitoring

All our involvement activity is monitored to make sure that we are reaching all our communities. We do this by including an equality monitoring form with all our surveys and at all of our involvement events. This information is regularly reviewed so we can target communities who we are not hearing from. This helps us to provide the best services for **all** of our communities, and to make sure that we do not knowingly discriminate against any section of our community.

Making a difference

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

Area of work	**Impact of involvement with local people**
Choosing providers for our services – CASES and Extended Access Hubs	Members of the public were trained and supported to take part in two procurements, including assessing the bids from possible providers and being part of the decision making team.
Urgent Care	Following a public consultation a decision was made to reconsider the options for reconfiguring minor illness and minor injury services in the city. Since then we have held a number of workshops with partners and the public to achieve a collective understanding of the problems in urgent care in Sheffield. We have also been seeking the views of the wider population, people who use the services, and those from harder to reach communities such as Roma-Slovak communities to really understand issues and requirements.
Dementia Strategy	Public involvement at various stages has influenced the development of a city-wide Dementia Strategy. The information that people have shared throughout this work will also be used during a co-production event in 2019 to develop an action plan to deliver the Strategy.
Musculoskeletal services	A patient survey was undertaken in the waiting areas of all specialities of the Musculoskeletal service supported by the nursing staff. The feedback is forming part of a review to help us decide what to do when the Musculoskeletal service contract ends in 2020.
End of Life Care	Ninety-eight patients, their carers and families, as well as 133 members of staff have shared their feelings and experiences of the current system with us. This information will be used to help us in the development of an End of Life Strategy.
Enhanced Community Learning Disability	152 individuals engaged with us about what community services are needed to support people living with a learning disability, who have additional complex needs, to live more independently in less restrictive environments. Activities were co-produced and co-facilitated by Experts by Experience who have had experience of long stay hospital admissions. This feedback will help us and Sheffield Health and Social Care Trust to plan for future services for people with learning disabilities whose behaviour may challenge.

Meadowgreen Health Centre relocation	The public consultation about the relocation of Meadowgreen Health Centre identified issues with public transport access to the proposed new site at Jordanthorpe Health Centre. The local MP has since campaigned with the South Yorkshire Patient Transport Executive to make sure that suitable local bus services will be provided to allow communities in Lowedges, Greenhill and Bradway to access Jordanthorpe Health Centre and other local areas.

Public involvement activity

Developing a dementia strategy

Inspired by the 'Prime Minister's 2020 Challenge on Dementia', Public, voluntary, community and private sector organisations across Sheffield have committed to work together to improve the care and support for people of all ages living with or caring for those living with dementia to enable them to live life to their full potential.

The Sheffield Dementia Strategy has been developed through conversations with people living with dementia, their carers, volunteers and professionals who support people living with dementia from both health and social care.

Working together, partner agencies attended existing activities and groups to raise awareness of the Strategy and give people the opportunity to ask questions and share their views. Existing activities were used to target individuals affected by dementia as they are in the familiar circumstances and environments that they are used to participating in. These activities included face to face contact at Dementia Cafes, the Memory Clinic, and a Dementia friendly screening at The Light cinema. A survey was also produced to allow people to feedback in their own time. The survey was available as a paper and online version and distributed widely through partners' networks, GP Practices, and other community venues.

There is an on-going pledge to ensure that the voices of people living with dementia and caring for those living with dementia are heard and used to develop the action plans that will now drive the delivery of the Strategy. We will continue to involve the people who worked with us to develop the Dementia Strategy. If you would also like to be involved in making sure we have the best services for people living with dementia, please contact us on sheccg.engagementactivity@nhs.net or 0114 305 4609.

Urgent Care

Between September 2017 and January 2018, we ran a consultation on changes to improve urgent care services in Sheffield. 'Urgent care' is treatment for illnesses that are urgent but not life threatening, and minor injuries, and includes both physical and mental health.
We worked with our partners, clinicians and members of the public to review all the feedback we received during the consultation and consider whether we should go ahead with the proposals.

Taking into account the feedback and information reviewed, the CCG's Primary Care Commissioning Committee decided in September 2018 that we should reconsider the options for reconfiguring minor illness and minor injury services in the city.

We are still clear that change is needed to improve care for patients and are committed to making more urgent appointments available in GP practices. The proposals for the urgent

treatment centres were based on the benefits of co-locating them with A&E departments so we want to look at whether there might be benefits in other approaches that would outweigh these.

The decision should reassure people in Sheffield that we take their views seriously and are committed to working with them, and our partners, to determine how we can best provide urgent care in the city.

Since September 2018 we've been busy talking to people about the issues that we face with urgent care. We have held a number of workshops with partners and the public to achieve a collective understanding of the problems in urgent care in Sheffield. We have also been seeking the views of the wider population, people who use the services, and those from harder to reach communities such as Roma-Slovak communities to really understand issues and requirements.

Musculoskeletal service contract options

The Musculoskeletal service deals with conditions relating to bones, muscles and joints. The contract is due to end in April 2020 and as commissioners of the service we are reviewing the service to help us decide what the best options are for the future of the service with our musculoskeletal patients.

From the beginning of the Musculoskeletal service contract in 2015, patient engagement has been built into the contract arrangements and is monitored as a central part of the service. A Musculoskeletal Patient Ambassadors Group was set up consisting of patients who maintain a relationship with the MSK service to provide an infrastructure for patient feedback at a strategic level. The group have provided specific feedback on the MSK model.
A patient survey was also undertaken in the waiting areas of all specialities of the Musculoskeletal service supported by the nursing staff.

The feedback is forming part of our review alongside other activity, outcome and financial data to help us decide what to do when the Musculoskeletal service contract ends in 2020.

End of life care

Macmillan Cancer Support is working with the NHS Sheffield Clinical Commissioning Group and Sheffield Hallam University to deliver a project assessing end of life care in Sheffield. The purpose of the project is to identify and gather the information that will help us to provide a fairer service for everyone and commission services that meet the needs of the patients better. We are seeking to understand how end of life care is delivered from a number of providers across Sheffield, including the challenges to providing care as well as examples of good practice.

The project has involved talking to 98 patients, their carers and families, and 133 members of staff, to understand their feelings and experiences of the current system. We also held interviews with community groups (e.g. Darnall Dementia) and held an event with the Age, BAMER, Religion and Faith/No-faith Equality Hubs in the city.
The feedback from these conversations has been used alongside an analysis of activity data to produce a report outlining the current system and highlighting areas of further work as the local system develops a new End of Life Care strategy. This report will be made available to the public later in 2019.

Choosing providers for our services

Members of the public were trained and supported to take part in two procurement activities; CASES and the Extended Access Hubs. This involved assessing the bids from possible providers and being part of the decision making team. Involving people in this way is an invaluable way of making sure that the views of patients and the public are included throughout our commissioning. We are very grateful for their help in choosing the right provider for these services.

Patient Participation Group Network

We run the Sheffield Patient Participation Group Network which gives PPG members from across Sheffield the opportunity to come together to network with each other, share ideas on how they can develop their own PPGs, and find out about and contribute to projects happening across the City. We held three Patient Participation Group Network meetings throughout 2018/19. Topics at the PPG Network meetings this year have included:

- GP Practices' Patient experience data
- Engaging with patients about major service change in GP practices
- Finances in the NHS
- South Yorkshire and Bassetlaw Hospital Services Review
- Person Centred Care Planning
- Case studies from local Patient Participation Groups and local GPs about how they work together

Transforming care - co-producing future services for people with learning disabilities

Transforming Care is a national three-year transformation programme to improve the lives of people living with a learning disability, who have additional complex needs arising out of mental health conditions, autism and behaviour that is challenging for services to support.

In recognition that "hospitals are not homes" and that people have the human right to live in the least restrictive environment, Transforming Care aimed to reduce the over reliance on admitting people to learning disability specialist hospitals, through the introduction of a range of alternative community service models. In Sheffield, 23 people have been discharged into less restrictive environments, such as residential care and supported living, and are now living more "ordinary lives" within communities and closer to their families. This represents a huge achievement by social workers and clinicians working together to find individual bespoke alternative places for people to live, through careful and complex discharge planning arrangements, and with improvements to some community support services.

Additionally, working in partnership, Sheffield CCG, the Local Authority and Sheffield Health and Social Care Foundation Trust (SHSC) have successfully avoided over 45 people being admitted to learning disability specialist hospitals as part of this programme, and the length of stay has appropriately reduced so that people can return back home to resume an ordinary life, after treatment ends. This work has provided greater opportunities to reinvest resources from these hospital settings, into enhancing specialist learning disability community services to better support people with learning disabilities and their families, when they are struggling with behavioural or mental health conditions. This should help avoid an escalation into a crisis, which in the past would have inevitably led to a hospital admission, due to limited alternatives being available.

Sheffield CCG and SHSC have been working collaboratively with Experts by Experience and family carers to explore how we provide the best services for these individuals, and support these individuals to live within their own communities, as an alternative to hospital care.

Nine engagement sessions were held between December 2018 and January 2019. An additional session was also held with the Learning Disability Partnership Board. The sessions were all presented in Easy Read and accessible formats that had been co-produced by Speak Up Rotherham, an organisation of learning disabled self-advocates. The sessions for people with learning disabilities, were also co-facilitated by learning disabled Experts by Experience from Speak Up Rotherham, some of whom had had their own experience of long stay hospital admissions.

In total, 152 individuals took part in these activities including people living with a learning disability, families and paid carers, clinical staff, and stakeholder organisations, including providers from the statutory, voluntary and independent sectors. Following an equality analysis of these sessions, additional engagement activity targeted at Black and other Ethnic Minority groups has been planned for 2019/20.

People with learning disabilities, their families and paid carers told us they want:

- Extended hours support from enhanced specialist learning disability clinical service in the evenings and weekends, beyond the 9am-5pm, Monday-Friday service that is currently available
- Specialist staff to be contacted via telephone to manage escalating situations, and to reduce crisis, with access to additional support within the home setting when required to de-escalate situations
- Consistency of workers throughout a patient journey - “Key worker role”
- Community alternatives such as crisis houses, crisis cafes, emergency respite or short term step up beds, as an alternative to hospital admissions
- Access to a smaller number of appropriate inpatient beds when admissions are unavoidable, but with admissions for the shortest time necessary to enable someone to be assessed and treated and returned to home, or to the least restrictive option

This feedback will form part of a report by SHSC into their plans for the future services for people with learning disabilities whose behaviour may challenge.

Active Recovery

“Active Recovery – The Future” is a project which focuses on improvements that can be made to Community Health and Social Care in Sheffield. It involves Sheffield Teaching Hospital’s Community Intermediate Care Service, Sheffield City Council’s Short Term Intervention Team, and the CCG.

The Project Team spoke to people that had recently accessed support from Active Recovery services exploring their experiences of the current services across Health and Social Care, and discussed what was important to them about the care they receive. The feedback showed that individuals who accessed the services as patients and carers value clear and simple referral routes, and building positive relationships with the services. People also liked to work with Active Recovery staff members to develop their own care plans including:

- being involved in assessments
- making sure their care plans accommodated and complimented their existing daily routines and individual preferences

- ensuring personal information is up to date
- receiving appropriate signposting

The experience that people reported closely aligned with the Active Recovery Vision which describes flexible, accessible, multi-disciplinary services that work collaboratively towards common goals and feel ‘seamless’ which is encouraging that these services should result in a better experience for the people that access the Active Recovery service.

The Project Team spoke to a range of people, all with different experiences, preferences and needs, but identified some common themes and guidance as to what changes could be made to make the best service for people that access Active Recovery. The feedback will continue to inform and shape the project as further details are decided, and operating models are built.

Consultations

Meadowgreen Health Centre relocation

NHS Sheffield CCG encourages and supports GP practices working with their Patient Participation Groups (PPGs) to hear the voices of their patients, helping to keep patients in the know and inform their decisions. We regularly advise and support GP Practices on how they should involve their patients in major decisions about their practices. This has included Meadowgreen Health Centre, who proposed to relocate from their two current sites (Old School and Lowedges Road) to existing premises at Jordanthorpe Health Centre.

The proposed move was driven by the state of the buildings which were unfit for the purpose of providing modern day GP services and were becoming increasingly difficult to maintain to Health and Safety and Fire Safety standards. An Equality Impact Assessment was completed which identified communities that would be affected by the proposal. This helped the practice look into:

- who they needed to make extra efforts to engage with
- what steps could be taken to reduce negative impacts of proposals

The practice asked for feedback on the proposal from patients through a paper and online survey, as well as recording feedback from patients on the telephone, from letters, and during conversations with staff at the practice. The practice also held a public event at a local school which 175 people attended.

Texts were sent to around 8,000 patients who had mobile numbers registered with the practice, with the other 2,000 patients without mobile numbers being contacted by telephone and letter. The district nursing team helped to distribute a letter and survey to housebound patients whilst the practice took information to all home visits to make sure that all patients were made aware of the proposals, even though they would still receive home visits form the practice. The practice also worked with local community organisations including LBJ Community Forum, Reach and Bradway Action Group.

The public consultation identified issues with public transport access to the proposed new site at Jordanthorpe Health Centre. The local MP, Louise Haigh, has since campaigned with the South Yorkshire Patient Transport Executive to make sure that suitable local bus services will be provided to allow communities in Lowedges, Greenhill and Bradway to access Jordanthorpe Health Centre and other local areas.

Working with partners across the region

As part of the Integrated Care System (ICS) across South Yorkshire and Bassetlaw we have involved patients, the public, staff and stakeholders on the Hospital Services Review, NHS 111 procurement, over the counter medicines, ophthalmology services, and transport and travel with regard to accessing services. The Citizens' Panel has continued to develop with members offering feedback on involvement planning and direct involvement in working groups.

Hospital Services Review

In August 2017 the ICS commenced a piece of work looking at hospital services in the region. Patient, public and clinical involvement was key to this work. Recommendations from the review, which were published in a report (including an easy read version) in May 2018, proposed that to continue providing high quality services, hospitals in Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham and Sheffield must work together even more closely in a variety of different ways. This included ways for the hospitals to work together better with the development of hosted networks. It also included transforming the way we use our workforce, to make the best use of the staff we have at the moment, and to ensure that people receive care as close to their own homes as possible.

Patients and the public were invited to respond with their views on the full report. Over 400 patients, the public, staff and stakeholders were involved using a range of methods to gather views. Face to face workshops were held with organisations and groups of people including:

- Sheffield Futures young people's groups
- Prisons' service
- Sheffield Association for the Voluntary Teaching of English (SAVTE), a charity for people for whom English isn't a first language
- Mother and baby groups
- Dementia groups
- Groups for people with physical and mental disabilities
- Groups for vulnerable women
- Groups for people with alcohol dependencies
- People from a traveller background
- Asylum seekers
- ROMA communities
- Children and families affected by deprivation
- Carers
- Young carers
- Victims of domestic violence
- Sex workers
- People who live in isolated rural communities
- Deaf community
- Armed forces/veterans

Survey responses on the review recommendations were also obtained from workplaces including:

- Stagecoach
- South Yorkshire Fire & Rescue
- GP practices

- Patient Participation Group Network meetings
- National Citizenship Service events

Work was also carried out to communicate to wider audiences at public events such as NHS 70th Birthday celebrations, Annual General Meetings of NHS organisations and Sheffield University Health and Social Care nursing students lecture. Flyers were handed out and conversations held at local events and leaflets were also sent to local community centres and libraries.

In January 2019 focus groups with pregnant women, new mothers and groups most affected by gastroenterology conditions were conducted to help understand what is most important to the population, in particular current or recent service users, should there be any reconfiguration of services. The report is currently being finalised and will be given to the maternity, paediatric and gastroenterology workstream leads to inform their thinking and development of business cases, should the decision be made to further explore potential reconfigurations in these services.

Citizen's Panel

The Panel brings together people from across South Yorkshire and Bassetlaw to provide an independent view and critical friendship on matters relating to the work of the Integrated Care System. There are currently thirteen volunteers who sit on the Panel with all areas of the region represented. The Citizen's Panel has been speaking to different communities about the Hospital Services Review, contributed to the 569 million reasons medicines campaign shared their views on the orthopaedics pathway for hip and knee replacements and the NHS 111 procurement.

Transport and Travel Panel

A transport panel comprising of patients and members of the public from each area of South Yorkshire and Bassetlaw was set up in November 2018. The panel looks at the potential impact changes to services would have on patients, the public, carers and families with regard to travel including testing journey times where possible to provide realistic insight into the impact of any service change. The panel looks at how to improve transport and travel planning and infrastructure around NHS services.

NHS 111/ integrated urgent care service procurement

The Citizen's Panel has also taken a role in the procurement of a £17.6 million contract which will see the Yorkshire Ambulance Service provide an Integrated Urgent Care Service to the people of Yorkshire and the Humber. The Yorkshire Ambulance Service will continue to provide the NHS 111 call handling service which provides patients with core clinical advice but now patients will benefit from a number of enhancements. The new enhanced service has been procured in partnership by Yorkshire and Humber's CCGs and has commenced in April 2019. The Citizen's Panel were involved throughout this procurement work providing the patient representative voice.

Involving through 2019/20

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

- NHS Long Term Plan
- Sheffield Accountable Care Partnership

- Neighbourhoods
- Physical Health for those living with Mental Health conditions, Learning Disabilities and Autism
- Interpreting Services
- Changes to Primary Care services including GP Practices
- South Yorkshire and Bassetlaw Hospital Services Review
- Urgent Care services
- Dementia action plan and delivery

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

Reducing health inequality - bridging the divide

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

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

Many of the major determinants of health and life expectancy may be outside the direct influence of the health service (e.g. employment, lifestyle choices), but the CCG works with partners to inform and influence action in those areas, as well as taking action to ensure equality of access to quality healthcare and working with healthcare providers, including GPs, to contribute to reducing inequalities.

Some of our key achievements in 2018/19 include:

- Supported and committed to the Partnership Framework for An Inclusive and Sustainable Economy, as part of the Sheffield City Partnership
- Supported and contributed to the refresh of the city's Health and Wellbeing Strategy
- Actively participated in partnership work with the Police and other agencies on tackling knife and gun crime
- Worked with partners to understand the impact of Universal Credit and help develop support to people as well as help manage the anticipated impact on Primary Care
- Adopted a volunteering strategy
- Committed to the development of an ethical procurement strategy for the city
- Worked with our Deep End Practices as well as the MoveMore team to understand how to support communities where there are greater inequalities become more active
- Invested in further development of all of our neighbourhoods; additionally, investment in some of the more mature neighbourhoods to go further faster with their partners to provide targeted support that meets the needs of their local populations
- Continued to invest in social prescribing across the city to support wellbeing

- Invested in care navigation in GP practices to help people to access the support that they need
- Continued investment in Improving Access to Psychological Therapies

Health and wellbeing strategy

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

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

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

Emergency Preparedness, Resilience and Response (EPRR)

The CCG has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2015 and which meet the CCG requirements to act as a Category 2 responder. The Clinical Commissioning Group works in partnership with NHS England to regularly review and make improvements to local major incident plans. We review and make improvements to our incident response and business continuity plans and have a programme for regularly testing of our plans, the results of which are reported to our Governance Sub-committee and Governing Body.

The CCG undertook the annual self-assessment assurance process with NHS England, the outcome of which was substantially compliant.

The CCG also engages with other partners and supports the local authority emergency preparedness and resilience planning in Sheffield. We work with the emergency services and the local authority to overcome potential disruption to civil life caused by major incidents, outbreaks of infection, severe weather or acts of terrorism.

Significant preparatory work has been undertaken to plan for the implications of Brexit, with our partners and stakeholders actively supporting our planning and resilience activity across the city, regional and nationally.

EU Exit Preparedness

During the build up to the UK leaving the EU the CCG worked seamlessly alongside the system partners both within Sheffield and in the wider health economy through attendance at core local (South Yorkshire LHRP) meetings, national meetings with Professor Keith Willets and attendance at daily and weekly teleconference calls.

The CCG was fully supportive and compliant with the assurance requests from DHSC and NHSE regarding a 'No Deal Brexit'. All levels of assurance and SITREPS were completed on time and the guidance issued by Professor Keith Willets, EU Exit Strategic Commander/ Medical Director for Acute Care & Emergency Preparedness was followed. Assurance was sought from our providers and noted in both the Sheffield Local Health Resilience Forum and within the Gold Command meetings. NHS Sheffield CCG hosted and chaired the citywide system Executive Gold Command meetings to ensure that Sheffield heath organisations could, where possible, work systematically to identify risks, share mitigations and offer mutual aid in the scenario of a 'No Deal exit'. Following this a 'hot de-brief' was held with our Sheffield System partners using the NHSE template to capture any lessons learnt and feedback any issues to NHSE highlighted during the build up to the original EU exit deadline in March.

Our Governing Body have been sighted on the organisations preparedness and approach to 'Brexit' and the assurance provided to NHSE on the 25th March.

Complaints and compliments

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. Information on the numbers of complaints the CCG receives together with themes and trends are available on the CCG website.

During this year there have been no investigations reported on by the Parliamentary and Health Service Ombudsman. We have however responded to a request by the Ombudsman regarding further action which has resolved a complaint. A decision not to investigate a complaint was received from the Local Government Ombudsman (LGO) and Parliamentary and Health Service Ombudsman (PHSO) who act jointly to investigate health and social care complaints.

Whistleblowing

We encourage any employee who has a genuine concern that meets the definition of whistleblowing to raise this within the organisation at the earliest opportunity. We have a Freedom to Speak Up (Whistleblowing) Policy that aims to support employees in their right and duty to raise concerns safely. The policy provides guidance to employees on how to voice any concerns they may have and to ensure there is a clear process available whereby issues can be addressed quickly and effectively. Our Freedom To Speak Up Guardians can support people to raise concerns if they feel that they have difficulty doing so.

ACCOUNTABILITY REPORT

Brian Hughes*

On behalf of

Maddy Ruff

Accountable Officer

23 May 2019

*Due to the sickness of the Accountable Officer, this statement is signed by Brian Hughes, Deputy Accountable Officer

Corporate Governance Report

1 Members Report

Sheffield CCG is a clinically led member organisation. This means that GPs make decisions about local health services by using their local knowledge to improve services and focus resources where there is greatest need. The CCG is made up of 80 GP practices and is responsible for a budget of c£850 million. Together the GP practices have a registered population of 609,000 patients (January 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 Tim Moorhead, a GP at Oughtibridge Surgery, Maddy Ruff is the Accountable Officer. Our Governing Body members have specific areas of responsibility and sit on various committees of the Governing Body. The Members exercise their constitutional rights in respect of the CCG through the Members Council for which each Member practice has a representative.

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

1.2 Composition of Governing Body

Governing Body members (i.e. formal Voting members) throughout 2018/19 comprise:

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

1.3 Member profiles

During 2018/19, 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 Tim Moorhead - Chair and West Locality Nominated GP Representative

Dr Tim Moorhead has been a GP for 23 years and is Senior Partner at Oughtibridge Surgery. He was elected Chair of NHS Sheffield CCG in 2012, re-elected in 2015 and following a further application and assessment process re-elected again in October 2018 for a further 3 years - a role which he does whilst also continuing to see patients at his practice.

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

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

Maddy Ruff - Accountable Officer

Maddy Ruff was appointed as Accountable Officer for NHS Sheffield CCG in September 2015 and has over 28 years' NHS experience, 17 years working in a variety of board-level positions. Maddy is committed to achieving organisational success and drives improvement through her own passion and energy, engaging and inspiring others. Maddy is passionate about delivering high quality healthcare services to improve the health of everyone in the city.

Maddy has significant experience in the development of clear and transformative strategies, and holds a MMedSci in Primary Health Care, she has played a key role in supporting system transformation, through the development of the South Yorkshire and Bassetlaw Integrated Care System (ICS) and Accountable Care Partnership (ACP), and is Chief Executive lead for Population Health & Primary Care. She has also been instrumental in developing an agreed Sheffield place based plan, successfully ensuring focus on preventing ill health, reducing health inequalities and promoting wellbeing.

With a qualification in mediation, certificate in coaching practice and an Institute of Personnel Management Diploma (IPD), Maddy is strongly committed to developing a 'coaching culture', enabling performance across the organisation and broader system. Maddy feels that if people are given the right environment and encouragement they will excel on behalf of the NHS and its patients.

Maddy has confirmed her intention to resign on 7 June 2019 to take up a new post with a neighbouring Integrated Care System

Julia Newton - Director of Finance

Julia Newton was appointed as Director of Finance at NHS Sheffield CCG in July 2012. A Chartered Accountant, Julia has held a number of senior finance posts since joining the NHS in 1992. Julia oversees all aspects of financial strategy, planning and accounting for the CCG and leads on the CCG's financial and corporate governance. During 2018/19 she provided the lead finance representation for all CCGs across South Yorkshire and Bassetlaw Integrated Care System on the Joint Committee of CCGs and on the Executive Delivery Group of the Accountable Care System.

Julia is retiring on 31 May 2019 after 27 years in the NHS and will be replaced as the CCG's Director of Finance by Jackie Mills, currently deputy director of finance at the CCG from 1 June 2019.

Dr Zak McMurray - Medical Director

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

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

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

Brian Hughes, Director of Commissioning and Performance

Brian Hughes was appointed as Director of Commissioning and Performance in May 2017. He is responsible for the commissioning and contracting of services across the city, with lead responsibility for planned care, urgent care, and mental health, working in partnership with CCG's lead clinical directors. He also leads on Information, Performance and the Programme Management Office within the CCG. From September 2018 Brian has also been the Deputy Accountable Officer for the CCG in recognition of Maddy

Ruff's part time secondment to the South Yorkshire & Bassetlaw Integrated Care System.

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

Mandy Philbin, Chief Nurse

Mandy started her career as an auxiliary nurse in 1985. Her love for nursing subsequently saw her complete both Enrolled and Registered nurse training. By working in the health care setting for over 34 years, Mandy has gained experience working across hospital, community and hospice transformation programmes. She attained an MSc in Leadership in Health and Social Care from Bradford University and in 2016 completed the NHS Leadership Academy's Nye Bevan.

Mandy's passion is to reduce health inequalities and improve the quality of care by working closely with colleagues across the health and social care system in Sheffield. She is keen to work with service users to gain a greater appreciation of what needs to be done to ensure that we offer the best possible care, at the right time in the right place.

Nicki Doherty – Director of Delivery – Care Outside of Hospital

Nicki is responsible for the Transformation and Delivery Directorate. Her areas of responsibility include: Primary Care; Active Support & Recovery; Active Ageing, Long Term Conditions, End of Life Care and Person Centred Care; Communications and Engagement; Equality & Diversity, Public Health, Partnerships, Estates and Capital, Health and Wellbeing Board and the Better Care Fund. Nicki has worked for the CCG since February 2015, prior to 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.

Chris Whale, Secondary Care Specialist Doctor

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

ELECTED GP MEMBERS

Dr Nikki Bates

Dr Nikki Bates has been a GP for 28 years. She is Senior Partner at Porter Brook Medical Centre. Nikki was elected by Sheffield GPs as one of their representatives to the CCG Governing Body in 2014.

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

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

Dr Terry Hudsen

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

Terry has a keen interest and expertise in the use of information technology in improving people's health and health promotion, having produced mobile applications for patients and clinical computer systems for doctors.

He is passionate about preventative health by encouraging healthier lifestyles to prevent the burden of disease, reduce health inequality and improve people's lives

Dr Annie Majoka

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

Dr Marion Sloan

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

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

Along with other leading practices she has actively promoted 7 day working in primary care to take the pressure off Out of Hours services and the A&E departments of the city. Marion believes that Sheffield is a great place to live and by working together with Sheffield City Council we can reduce the inequalities that still exist.

LOCALITY NOMINATED GPS

Dr Amir Afzal (Central Locality) (From 1.11.18)

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 senior partner at the practice. He is passionate about general practice and is interested in how his practice can work with surrounding practices to work more cooperatively for the benefit of patients. He is also interested in how GPs can educate and empower patients to make the health care system truly fit for the 21st century. Amir hopes to develop a system where the best of British general practice is passed on to the next generation whilst adapting to the changes that are needed, making sure that the art

of medicine and human touch are not lost.

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

Dr Leigh Sorsbie - (North Locality)

Dr Sorsbie qualified in 1990 and has worked as a GP at Firth Park Surgery from 1996, as a partner for 22 years and continuing now as a salaried GP in the same surgery.
She has been North Sheffield Locality representative on NHS Sheffield CCG since 2013, and continues her practice work alongside this.

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

Her work in Firth Park has enabled her to experience the challenges faced by communities in ethnically diverse areas of high deprivation, she is committed to working within the CCG to reduce health inequalities and address the factors which perpetuate them.

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

Dr Sorsbie took sabbatical leave from 6 March 2018 to 31 October 2018. Dr Jenny Joyce was nominated by North Locality to cover for Dr Sorsbie during this period.

Vacancy – (Hallam and South Locality)

Following the resignation of the Hallam and South GP Representative Dr Kirsty Gillgrass, in February 2019 there has been a vacancy.

LAY MEMBERS

Amanda Forrest

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

For the CCG, Amanda chairs the Quality Assurance Committee and is Vice Chair of the Audit and Integrated Governance Committee. She is also a member of the Remuneration Committee, the Primary Care Commissioning Committee and the Strategic Patient Engagement, Experience and Equality Committee. She has a major role in patient and public involvement, supporting meaningful and effective engagement with the public and patients from a well thought through approach at all levels.

From 1 April 2019 Amanda has been elected as the Deputy Chair of the CCG.

Mark Gamsu

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

Mark chairs the Strategic Public Engagement, Experience and Equalities Committee (SPEEEC) which supports the CCG improve the way it consults, collaborates and engages with people in Sheffield. He is also vice chair of the Primary Care Commissioning Committee. He is particularly interested in the way the CCG can help general practice and the voluntary sector work together better in the more disadvantaged parts of the city

Chris Nield (from 1.07.18)

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.

Phil Taylor

Phil was appointed as a Lay Member in March 2016 with responsibility for Finance Governance & Strategy. He is a Chartered Accountant and has worked in the NHS as a finance director and deputy chief executive for 10 years as well as gaining director level experience within the Department of Health. Phil joined the NHS in 1991 as Finance Director of the Northern General Hospital. He has been chair of the Healthcare Financial Management Association and Senior Independent Trustee of the NHS Confederation.

Phil believes that excellent governance is crucial for the quality of health and wellbeing services in Sheffield and is committed to improving value for money. He has a mentoring qualification and is a trustee of the Sheffield Hospitals Charity. In addition to his role as Deputy Chair of the Governing Body, Phil is also Chair of both the Audit and Integrated Governance Committee and Remuneration Committee - he is also the Conflicts of Interest Guardian.

Phil completed his term of office at 31 March 2019. He is replaced in this post by Anthea Morris, who has taken up post from 1 April 2019.

Profiles of Members who ceased to be Members of Governing Body during 2018-19

Dr Gonapragasan Chetty – Central Locality Nominated GP Representative (1.09.17 – 31.07.18)

Dr Gasan Chetty has worked as a GP in Sheffield since 2006. He qualified as a doctor in South Africa in 1986. He has worked in General Surgery and Trauma in South Africa and chose an early path towards becoming a cardio-thoracic surgeon. He spent 6 years training in the Cardiothoracic Centre in Durban, South Africa. He

then worked for 3 years in the Cardiothoracic Centre, Sheffield as a Senior Registrar. He spent 12 months initially as a Transplant fellow before continuing in adult heart and lung surgery.

He decided in 2003, that a career in General Practice would be far more rewarding. His intention to become a GP was to make a difference to health care locally, and be part of the changing face of healthcare. He has worked as a Salaried and Locum GP for a few years, before joining Mathews Practice as a Partner. He also works as an Occupational Health doctor. He has been on the CCG Continuing Healthcare panel for 6 years. He also undertakes Out of Hours work as a GP. He remains passionate about primary care and the NHS as a whole with his main focus in bringing care closer to home. His interests lie in Minor Surgery and continues to provide this service for practices citywide Sheffield.

Dr Jennie Joyce – North Locality Nominated GP Representative (6.03.18 – 1.11.18)

Jennie qualified in 2003 and has been working as a GP at Pitsmoor surgery since 2010. She has been a GP representative on the North Locality Executive Group at the CCG since 2015 and is very keen to ensure the representation of practices dealing with people living in areas of deprivation. She has also been working with the mental health portfolio at the CCG since 2017 as clinical lead for the development of Primary Care Mental health, aiming to tackle the gap between care of mental and physical health. More recently Jennie has become involved in quality improvement and has taken part in training to join the national Primary Care Faculty, providing support and training in these techniques to groups of practices across the country. She believes that it is essential that health care providers work to continue to improve the safety, effectiveness and sustainability of the services they provide to ensure that the NHS can continue to provide high quality care to the population.

Dr Kirsty Gillgrass Hallam and South Locality Nominated GP Representative (14.05.18 – 1.02.19)

Dr Gillgrass has been a partner at Crystal Peaks Medical Centre for the past 5 years. She came to Sheffield in 1998 as a first year medical student and fell in love with the city and its population. Alongside clinical and managerial work she is passionate about inspiring the next generation of doctors to consider a future in primary care. Her work at Sheffield Medical School has seen her develop a new part of the curriculum '*Early Years in Primary Care'*. She was also part of a team who successfully secured a bid to expand the numbers of medical students in Sheffield.

Kirsty is committed to improving the health and wellbeing for all the people of Sheffield, ensuring they get '*right care, right place, right time'.* She is one of the founder members of 'Sheffield, Supporting Women in Medicine', and works with them to promote culture change within the NHS, by enabling women to achieve their individual goals through an inspiring and supportive community.

Prior to joining the CCG's Governing Body, Kirsty was clinical lead for Hallam and South locality for 3 years. As part of her role on Governing Body she served on the Audit and Governance Committee and the integrated QIPP Working Group.

Dr Ngozi Anumba – Hallam and South Locality Nominated GP Representative (18.05.15 - 17.05.18)

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

1.4 Appointments to Governing Body in Year

The following appointments were made to our Governing Body during 2018/19. Each of the appointments were made in accordance with the Standing Orders set out within the CCG's Constitution

- Dr Amir Afzal appointed as Central Locality GP Representative with effect from 1 November 2019 following the resignation of Dr Gonapragasan Chetty
- Dr Jenny Joyce appointed as North Locality GP Representative with effect from 6 March 2018 to 1 November 2018 covering Dr Leigh Sorsbie's sabbatical
- Chris Neild appointed as Lay Member from 1 July 2018

Following application and assessment process in line with our Constitution, Dr Tim Moorhead was re-appointed as Chair of NHS Sheffield CCG for a further 3 years with effect from 1 October 2018.

1.5 Member practices

The following is a list of all of NHS Sheffield CCG's 80 GP member practices listed by locality.

Central Locality (21)	Hallam and South Locality (22)
Abbey Lane Surgery	Birley Health Centre
Baslow Rd, Shoreham Street and York Road Surgeries	Carterknowle Surgery
Carrfield Medical Centre	Charnock Primary Care Centre
Clover City Practice	Crystal Peaks Medical Centre
Clover Group Practice	Falkland House Surgery
Darnall Health Centre (Mehrotra)	Greystones Medical Centre
Dovercourt Group Practice	Hackenthorpe Medical Centre
Duke Medical Centre	Jaunty Springs Health Centre
East Bank Medical Centre	Manchester Road Surgery
Gleadless Medical Centre	Meadowgreen Health Centre
Handsworth Medical Practice	Mosborough Health Centre
	Nethergreen Surgery

Heeley Green Surgery	Owlthorpe Surgery
Manor Park Medical Centre	Richmond Medical Centre
Norfolk Park Health Centre	Rustlings Road Medical Centre
Sharrow Lane Medical Centre	Selbourne Road Medical Centre
The Sloan Medical Centre	Sothall Medical Centre
The Matthews Practice	Stonecroft Medical Centre
The Medical Centre	The Avenue Medical Centre
Veritas Health Centre	The Hollies Medical Centre
The White House Surgery	Totley Rise Medical Centre
Woodseats Medical Centre	Woodhouse Health Centre
North Locality (22)	**West Locality (15)**
Barnsley Road Surgery	Broomhill and Lodge Moor Surgeries
Buchanan Road Surgery	Deepcar Medical Centre
Burngreave Surgery	Devonshire Green and Hanover Medical Centres
Chapelgreen Practice	Dykes Hall Medical Centre
Dunninc Road Surgery	Far Lane Medical Centre
Ecclesfield Group Practice	Harold Street Medical Centre
Elm Lane Surgery	Oughtibridge Surgery
Forge Health Group	Porterbrook Medical Centre
Foxhill Medical Centre	Stannington Medical Centre
Grenoside Surgery	The Crookes Practice
Mill Road Surgery	Dr Milner and Partners
Norwood Medical Centre	Tramways Medical Centre (O'Connell)
Page Hall Medical Centre	University Health Service Health Centre
Pitsmoor Surgery	Valley Medical Centre
Sheffield Medical Centre	Walkley House Medical Centre
Shiregreen Medical Centre	
Southey Green Medical Centre	
The Firth Park Surgery	
The Flowers Health Centre	
The Healthcare Surgery	
Upwell Street Surgery	
Wincobank Medical Centre	

1.6 Committee(s), including Audit Committee

The Governing Body has five directly reporting committees as follows:

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

Highlights from each of the committees are detailed in the Governance Statement at pages 62-67.

1.7 Audit and Integrated Governance Committee

Core members of the Audit and Integrated Governance Committee throughout 2018/19 include:

- Phil Taylor, Lay Member (Chair and Conflicts of Interest Guardian)
- Chris Neild, Lay Member
- Amanda Forrest, Lay Member (Deputy Chair)
- Dr Ngozi Anumba (05.04.18 only)
- Dr Kirsty Gillgrass (14.05.18 – 1.02.19)
- Dr Jennie Joyce (06.03.2018 to 31.10.18 to cover Dr Leigh Sorsbie's sabbatical)
- Dr L Sorsbie (from 01.11.18)
- GP Vacancy (from 01.01.19)

The Committee includes the following regular attendees:

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

Further details of the work of the Audit and Integrated Governance Committee may be found at pages 62-63 of the Governance Statement.

1.8 Register of Interests of Governing Body Members

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

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

1.9 Personal data related incidents

There were no Serious Untoward Incidents relating to data security breaches, including any that were reported to the Information Commissioner during 2018-19.

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.

Statement of Accountable Officer's Responsibilities

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

The responsibilities of an Accountable Officer 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.

Brian Hughes*

On behalf of

Maddy Ruff

Accountable Officer

23 May 2019

*Due to the sickness of the Accountable Officer, this statement is signed by Brian Hughes, Deputy Accountable Officer

Governance Statement

1 Introduction and context

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

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

As at 1 April 2018, 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 CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my CCG Accountable Officer Appointment Letter.

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

3 Governance arrangements and effectiveness

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

3.1 The Clinical Commissioning Group Governance Framework

The CCG Constitution states that in accordance with section 14L (2) (b) of the 2006 Act, 2014 the Group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:

- 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 standards of behaviour published by the Committee on Standards in Public Life (1995) known as the “Nolan Principles”
- The seven key principles of the NHS Constitution
- The Equality Act

NHS Sheffield is a clinically led, member organisation comprising 80 member practices and has a responsibility to ensure that robust corporate, clinical and financial governance arrangements are embedded within the organisation in accordance with best practice. Each practice has a registered key representative and who is appointed to vote on behalf of their practice. Each practice is aligned to one of four localities across the city. A full list of Member Practices is set out within the Accountability Report on pages 51-52.

The CCG has established a properly constituted Governing Body with the appropriate clinical, managerial and lay member skill mix, including: 4 locality nominated GPs, 4 elected GPs, a secondary care specialist doctor, a registered nurse, four independent lay members, the Accountable Officer, the Director of Finance, the Director of Delivery, Care Outside of Hospital and the Director of Commissioning and Performance. Details of the membership and the attendance of those members are set out on page 61.

Organisational structure and accountabilities are clear and well defined. Where capacity and/or capability gaps have been identified, actions are put in place with expected outcomes and timescales. Sheffield CCG clearly articulated its values to stakeholders through its Commissioning Intentions for 2018/19. Our organisational development strategy included an annual Staff Survey, 360 degree stakeholder survey and developing actions to address issues for development.

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

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

A full list of committees, including their responsibilities and membership, are set out at paragraph 3.2 of this Statement. In addition to governance, the Governing Body and its delegated committees place a clear focus on the services, performance and patient safety of its commissioned providers.

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

NHS Sheffield CCG adopted the initial model Constitution as recommended by NHS England as part of its authorisation back in January 2013 and has continued to maintain and update this document.

Our Constitution has been approved by Member practices and NHS England and reflects how the organisation operates. It sets out the CCG's powers and functions, describes our mission, values and aims and how these are delivered through the governance framework.

Our Constitution includes the following information:

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

During the summer of 2018, the Governing Body approved a number of small changes to the CCG's existing Constitution which would require consideration by Member Practices, followed by formal approval by NHS England. It was highlighted that none of these changes would impact on the CCG continuing to carry out its business and related more to a "tidying-up".

In September 2018, NHS England issued a revised model Constitution which took into account changes to legislation, CCG accountability frameworks and wider developments such as creation of Integrated Care Systems (ICS) which have taken place over the last few years. The revised model also looked to the future in an attempt to facilitate a greater degree of flexibility for CCGs, whilst maintaining high levels of transparency and accountability. Given publication of the revised model Constitution, our Governing Body agreed to hold in abeyance the minor identified changes and to adopt the revised model. It was therefore timely to undertake a full review of our Constitution and supporting governance documents against the new model and adopt a revised Constitution which will be presented to Governing Body on 2 May 2019 for consideration.

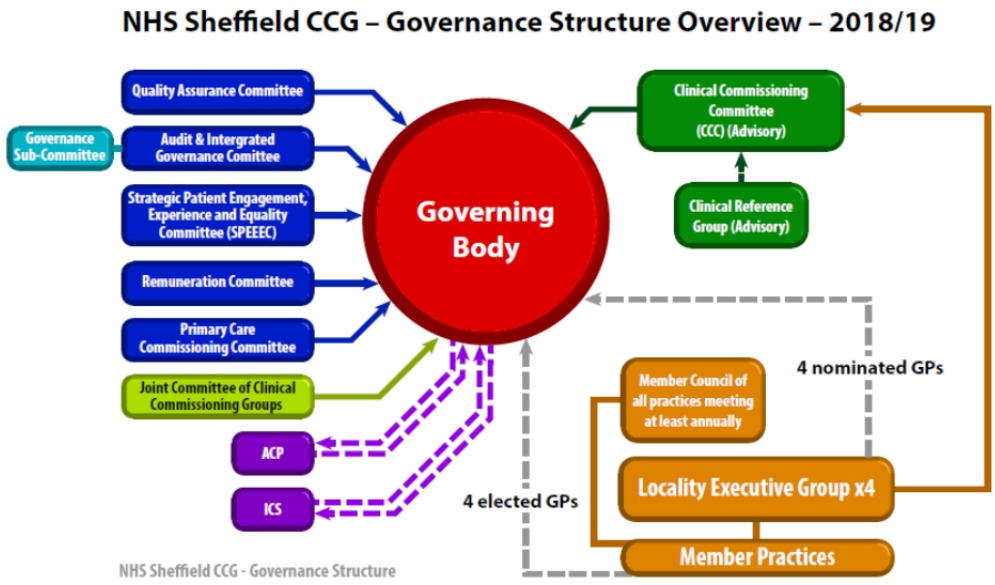
The Constitution, particularly through the Scheme of Reservation and Delegation, makes clear the respective responsibilities of the Members' Council (membership body), the Governing Body and its Committees. With the exception of changes to the Constitution, all powers and responsibilities have been delegated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

Our Constitution is available on the CCG's website www.sheffieldccg.nhs.uk

3.2 Governing Body, Committees, Sub-committee and Joint Committees of the Governing Body

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

Fig 1



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

3.2.1 Governing Body

The functions of the Governing Body are set out within 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 Governing Body has responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance. The

Governing Body met seven times in public during 2018-19. Its agendas have incorporated a comprehensive range of reports to support delivery of its key functions including the 2018-19 Operational Plan, Commissioning Intentions, Performance and Quality Reports.

The Governing Body has continued to evaluate its effectiveness, including full day development sessions throughout the year. NHS England commissioned an external 360 review of the CCG in late 2018. The Governing Body accepted the key findings of the review at its meeting on 7 March 2019 and is the process of developing an improvement plan which will include some specific actions for Governing Body during 2019/20.

Attendance at Governing Body Meetings

Membership	Role	Attendance	
		Actual	Possible
Dr Amir Afzal **(GB member from 1.11.18)**	CCG GP Locality representative - Central	3	3
Dr Ngozi Anumba **(GB member to 13.5.18)**	CCG GP Locality representative – Hallam and South	1	1
Dr Nikki Bates	CCG GP Elected City-wide Representative	6	7
Dr Gasan Chetty (**GB member to 31.7.18)**	CCG GP Locality representative - Central	3	3
Nicki Doherty	Director of Delivery – Care Outside of Hospital	6	7
Amanda Forrest	Lay Member	6	7
Mark Gamsu	Lay Member	7	7
Kirsty Gillgrass **(GB member from 14.5.18 to 1.2.19)**	CCG GP Locality representative – Hallam and South	4	5
Dr Terry Hudsen	CCG GP Elected City-wide Representative	5	7
Brian Hughes	Director of Commissioning and Performance	6	7
Dr Jennie Joyce **(Covering Dr Sorsbie sabbatical from 6.3.18 to 1.11.18)**	CCG GP Locality representative - North	4	5
Dr Annie Majoka	CCG GP Elected City-wide Representative	5	7
Dr Zak McMurray	Medical Director	0	7
Dr Tim Moorhead	CCG GP Locality representative - West CCG Chair	6	7
Julia Newton	Director of Finance	7	7
Chris Nield **(GB member from 1.7.18)**	Lay Member	5	5
Mandy Philbin **(Acting Chief Nurse 25.9.17**	Acting Chief Nurse / Chief Nurse	5	7

Membership	Role	Attendance	
		Actual	Possible
to 18.4.18; Chief Nurse from 19.4.18)			
Maddy Ruff	Accountable Officer	7	7
Dr Marion Sloan	CCG GP Elected City-wide Representative	5	7
Leigh Sorsbie **(returned from sabbatical 2 November 2019)**	CCG GP Locality representative - North	2	2
Phil Taylor	Lay Member and CCG Deputy Chair	7	7
Dr Chris Whale	Secondary Care Specialist Doctor	5	7

3.2.2 The remit of each committee is as follows:

AUDIT AND INTEGRATED GOVERNANCE COMMITTEE
Key Role and Responsibilities
The Committee is chaired by the Lay Member with responsibility for finance, governance and strategy and who is a qualified accountant. The AIGC has delegated responsibility for critically reviewing the CCG's financial reporting and internal control principles and for maintaining an appropriate relationship with internal and external audit and the CCG's Counter Fraud Service. A key responsibility of the Committee is to review the financial statements prior to submission to the Governing Body with recommendation for approval. The Committee also has delegated authority to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the CCG's activities. The AIGC is underpinned by the functions of both the Governance Sub-committee and the Quality Assurance Committee and on-going dialogue with internal and external auditors. It has met on five occasions during the year (this was due to the March 2018 meeting being moved to April), considering relevant issues in line with its annual work plan. During 2018/19, the AIGC undertook its annual assessment of effectiveness. This assessment was supported by our external auditors who were able to provide a report as to how Sheffield AIGC self-assessment compared with other CCG audit committees. The results of the self-assessment have been used to determine future actions eg additional training for committee members.

Key Performance Highlights

Key areas of the committee's work in 2018/19 included:

- Review of its annual self-assessment exercise using the KPMG audit committee guidance and agreement to additional training sessions
- Receiving and reviewing updates from external audit, following approval of annual plan
- 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, gifts and hospitality and sponsorship
- Reviewing the draft and final accounts, including the annual and quality reports and the CCG's Annual Governance Statement, prior to recommending approval by the CCG Governing Body
- Receipt and review of auditor's "ISA260" year-end report
- Receipt of the Head of Internal Audit's Annual Report and Opinion noting that significant assurance had been given
- Provision of a comprehensive training event for all AIGC Members and attendees
- Annual review of Terms of Reference and recommendation to Governing Body for approval
- Review and approval of Governance Sub-committee Terms of Reference
- Receiving quarterly updates on governance arrangements for the Accountable Care Partnership (ACP) and the Integrated Care System (ICS)
- Providing an annual report from the Chair of AIGC to Governing Body

PRIMARY CARE COMMISSIONING COMMITTEE

Key Role and Responsibilities

The CCG formally took over delegated co-commissioning responsibility for primary care medical services with effect from 1 April 2016. The Committee functions as a corporate decision making body for the management of the delegated functions and

the exercise of delegated powers. The Committee has been established in accordance with statutory provisions to enable its members to make collective decisions on the review, planning and procurement of primary care services in Sheffield under delegated authority from NHS England.

Key Performance Highlights

During 2018/19 key areas considered by the Committee included:

- Approval of a number of Locally Commissioned Services including the initiation of a Quality Contract to support the CCG's wider Out of Hospital Strategy
- Approval of a number of GP premises changes following the presentation of a Case for Change in keeping with the Sheffield Primary Care Estates Strategy
- Approval of plans and related spend in regard to Sheffield CCG GP Forward View (GPFV) strategy including the continued development of Primary Care Networks
- Monitoring and approval of actions related to the formal consultation on Urgent Primary Care
- Monitoring of developments with regard to GP digital / IT
- Approval of the re-procurement of Extended Access Hubs
- Approval of the recommendations regarding the re-procurement of CASES
- Approval of applications to the GP Retention Scheme

REMUNERATION COMMITTEE

Key Role and Responsibilities

The Remuneration Committee is chaired by a Lay Member. The Committee was established with delegated authority to determine the remuneration and conditions of service for all Governing Body Members, taking into account any national Directions or guidance on these matters. During 2018/19 updated national legal advice was issued to CCGs which indicated that Remuneration Committee's should make recommendations to Governing Body on these matters rather than approve. The CCG has moved to this position from January 2019 and will incorporate this revised guidance into its proposed new Constitution to be presented to Governing Body on 2 May 2019.

The Committee has the delegated authority to consider the outcome of any performance review of staff on Very Senior Manager contracts. In addition, the Committee has delegated authority to consider the severance payments of the Accountable Officer and of other senior staff.

The Committee advises the Governing Body on its determinations about allowances under any pension scheme it might establish as an alternative to the NHS pension scheme and on any other potential alternative remuneration and conditions of service for CCG employees outside of, or in place of, national Agenda for Change arrangements.

Key Performance Highlights

During 2018/19 key areas considered by the Committee included:

- Annual review of the Remuneration Committee Terms of Reference and recommendation to Governing Body for approval

- Review and approval of a redundancy business case
- 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

Remuneration Committee members attended a training session in June 2018 about their role.

QUALITY ASSURANCE COMMITTEE

Key Role and Responsibilities

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

During 2018 - 19 the committee has continued to develop and deliver its responsibilities. Specifically, the committee has:

Achieved good attendance from GP's and maintained effective clinical representation. It has:

- Filled the secondary care doctor representative vacancy
- Reviewed the reporting format to streamline exception reporting and highlight provider concerns
- Systematically reviewed provider's performance in relation all areas of quality, including not for profit organisations, Primary Care providers and Sheffield In-area providers that are not directly commissioned by the CCG
- Reviewed feedback relating to providers from the Care Quality Commission and other regulatory bodies and taken action with providers where appropriate
- Monitored patient safety issues, including Serious Incident, Never Events, targets and plans to reduce hospital and community acquired infection
- Monitored performance of providers relating to Clinical Quality and Innovation Schemes (CQUIN)
- Approved strategies and monitored action plans linking with the Commissioning for Quality strategy
- Monitored patient feedback from both provider and public websites
- Reviewed and approved clinical policies and procedures
- Received reviews from Internal Audit relating to the internal functions of the CCG's Quality Assurance systems
- Set up an extraordinary meeting to review an underperforming provider
- Undertaken a provider Committee to Committee meeting with a key provider
- Provided quarterly exception reports and recommendations to Governing Body

STRATEGIC PATIENT ENGAGEMENT, EXPERENCE AND EQUALITY COMMITTEE

Key Roles and Responsibilities

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

Key Performance Highlights

Key areas considered by the Committee included:

- Assurance that public engagement has been used to develop a Dementia Strategy for the City
- Assurance of the consultation process on the proposed changes to urgent care services
- Assurance on how the CCG met its equality duties in respect of the decision making for the urgent primary care consultation
- Assurance of engagement around adult short-break service and approval of plans for subsequent consultation
- Assurance of dementia strategy engagement
- Assurance of patient experience strategy and progress of action plan
- Assurance of volunteer policy
- Assurance of a plan in place to meet mandatory equality duties
- Assurance of engagement on future of community learning disability services to shape future options
- Assurance of over the counter medicine engagement and consultation
- Overview on mental health experience, engagement and equality

The committee has also discussed the CCG's Equality and Diversity Strategy and agreed the approach to the next iteration of this work.

GOVERNANCE SUB-COMMITTEE

Key Roles and Responsibilities

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

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

organisational risks and their associated risk scores. The Sub-committee also receives reports from a number of sub-groups including information governance and health and safety. Reports to the Sub-committee include quarterly updates in relation to workforce, Freedom of Information requests, legal claims and litigation and compliments and complaints. The Sub-committee also receives reports with regard to the review and implementation of CCG policies for which it has delegated responsibility for approval of both corporate and HR policies.

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

Key Performance Highlights

- Review of policies throughout the year with significant assurance that the process for review and management of policies is well managed.
- Significant improvement in the management of Freedom of Information (FOI) requests during the year which has been due in part to the team itself, but also from the support people have provided
- 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.
- Lessons learned to be key part of incident reporting process
- Investigations which are shared with staff where appropriate
- Significantly and efficiently implemented the new requirements of the General Data Protection Act 2018
- Operational risk register reviewed at each meeting and the scores of all new risks scrutinised
- Assurances received with regard to Information Governance systems and processes, including Data Security and Protection Toolkit, data quality and Freedom of Information requests, 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 and fire risk assessments
- Terms of Reference reviewed and updated to incorporate the Sub-committee's role with regard to its overview of data quality
- Received the Annual Health and Safety Report and organisational risk assessment
- Provided assurance to the AIGC that there are sound systems of control in place, highlighting any areas where further scrutiny is required
- Annual review of Terms of Reference with recommendation to AIGC for approval by Governing Body

3.2.3 Committee Membership and Attendance

The table below sets out details of membership and attendance at each of the CCG's committees during 2018/19. Each committee meets quarterly (unless stated otherwise) – all meetings were quorate throughout the year

Committee	Membership	Role	Attendance	
			Actual	Possible
Audit & Integrated Governance	Phil Taylor	Lay Member and Chair	5	5
	Chris Nield (**from 1.7.18)**	Lay Member	3	3
	Amanda Forrest	Lay Member and Vice Chair	5	5
	Mark Gamsu **(co-opted from 5.4.18 to 24.5.18)**	Lay Member	2	2
	Ngozi Anumba **(to 13.5.18)**	CCG GP Governing Body Member	1	1
	Kirstie Gillgrass **(from 14.5.18 to 1.2.19)**	CCG GP Governing Body Member	2	3
	Terry Hudsen **(co-opted on 13.12.18)**	CCG GP Governing Body Member	1	1
	Jennie Joyce **Covering Dr Sorsbie sabbatical from 6.3.18 to 1.11.18**	CCG GP Governing Body Member	3	3
	Leigh Sorsbie **(returned from sabbatical 1.11.18)**	CCG GP Governing Body Member	1	2
Quality Assurance Committee	Amanda Forrest	Lay Member and Chair	3	4
	Mandy Philbin **(Acting CN 25.9.17 to 18.4.18; CN from 19.4.18)**	Acting Chief Nurse / Chief Nurse and Vice Chair	4	4
	Mark Gamsu	Lay Member	3	4
	Jane Harriman (**voting rights from 3.5.18**)	Head of Quality	4	4
	Dr Terry Hudsen	CCG GP Lead for Quality	3	4
	Debbie Morton **(voting rights from 1.12.17 to 2.12.18)**	Interim Deputy Chief Nurse	0	3
	Zak McMurray	Medical Director	0	4
	Marion Sloan	CCG GP	4	4
	Dr Chris Whale	Secondary Care Doctor	1	4
	Alun Windle (**from 3.12.18)**	Deputy Chief Nurse	0	1

Committee	Membership	Role	Attendance	
			Actual	Possible
Primary Care Commissioning (*meets at least six times per year*)	Chris Nield **(from 1.07.18); (Chair from August 2018)**	Lay Member and Chair	6	6
	Nicki Doherty	Director of Delivery – Care Outside Hospital	8	9
	Amanda Forrest	Lay Member	9	9
	Mark Gamsu **(Chair from May to July 2018)**	Lay Member and Deputy Chair	7	9
	Julia Newton	Director of Finance	9	9
	Mandy Philbin **(Acting CN 25.9.17 to 18.4.18; CN from 19.4.18)**	Acting Chief Nurse / Chief Nurse	5	9
	Maddy Ruff	Accountable Officer	6	9
Remuneration Committee	Phil Taylor	Lay Member and Chair	4	4
	Amir Afzal **(from 1.11.18)**	CCG GP Governing Body Member	2	2
	Nikki Bates	CCG GP Governing Body Member	4	4
	Dr Gasan Chetty **(to 31.7.18)**	CCG GP Governing Body Member	0	0
	Amanda Forrest	Lay Member and Vice Chair	4	4
	Mark Gamsu	Lay Member	4	4
	Annie Majoka	CCG GP Governing Body Member	1	4
	Marion Sloan **(co-opted for 6.10.18 meeting)**	CCG GP Governing Body Member	1	1
Strategic Patient Engagement, Experience and Equality Committee (SPEEEC)	Mark Gamsu	Lay Member and Chair	8	9
	Parveen Ali **(from 22.5.18)**	Senior Lecturer in Nursing and Midwifery, with responsibility for equality at SHU	5	8
	Eleni Chambers	Public Representative	7	9
	Nicki Doherty	Director of Delivery – Care Outside of Hospital	6	9
	Lucy Ettridge (**from 3.7.18)**	Deputy Director of Communications. Engagement and Equality	5	7
	Amanda Forrest	Lay Member and Deputy Chair	7	9
	David Foster	Public Representative	9	9
	Susan Hird	Consultant in Public Health	0	3

Committee	Membership	Role	Attendance	
			Actual	Possible
	(**to 5.7.18)**			
	Phil Holmes / Simon Richards / Michelle Glossop	Sheffield City Council Representative	4	9
	Dr Terry Hudsen	CCG GP Governing Body Member with responsibility for engagement, equality and diversity	6	9
	Richard Kennedy / Helen Mulholland	Engagement and Equality and Diversity Managers	9	9
	Margaret Kilner / Guy Weston	Healthwatch Sheffield Representative	6	9
	Eleanor Nossiter **(to 22.3.18)**	Engagement, Communications and Equality Lead	2	2
	Mandy Philbin **(Acting CN 25.9.17 to 18.4.18; CN from 19.4.18)**	Acting Chief Nurse / Chief Nurse	4	9
	Sarah Neil	Patient Experience Manager	6	9
	Sarah Salway (**to 21.5.18)**	Health Equity and Inclusion Research Group, University of Sheffield	0	1
	Ed Sexton **(to 5.7.18)**	Engagement Development Manager, Sheffield City Council	0	3

3.3 Other Partnership Arrangements

Joint Clinical Commissioning Group Committee

In 2015 the CCG became a member of the Working Together Joint Committee of CCGs (JCCC) and as part of this jointly consulted with the public on proposals to change the way Hyper Acute Stroke Services and some out of hours Children's Surgery and Anaesthesia services that are provided across South and Mid Yorkshire, Bassetlaw and North Derbyshire. The Committee made the decision to make the changes in 2017 and throughout 2018/19 received updates on the progress towards implementation.

While the Committee currently has delegated authority to only make decisions on these two service areas, following a commissioning review in 2018, as part of the wider governance review for the South Yorkshire and Bassetlaw Integrated Care System, the JCCC is currently discussing proposals for its remit and revised terms of reference to operate in 2019/20. These are expected to be presented to individual CCG Governing Bodies for consideration in May or June 2019.

3.4 South Yorkshire and Bassetlaw Integrated Care System (ICS)

The CCG is a partner in the South Yorkshire and Bassetlaw Integrated Care System (ICS), which in June 2017 was named as one of the first in the country. ICSs are systems in which NHS commissioners and providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and health outcomes. They are expected to make faster progress than other health systems in transforming the way care is delivered, to the benefit of the population they serve. The ICS does not replace any legal, or statutory, responsibilities of any of the partner organisations.

During 2018/19, the following groups continued to meet:

The ICS Oversight and Assurance Group whose membership includes Chairs from CCGs, hospital trusts and health and wellbeing boards.

The ICS Collaborative Partnership Board includes chief executives and accountable officers from acute and mental health hospitals, primary care, commissioning groups, local authorities, umbrella Voluntary Action organisations, Healthwatch, NHS England and other arm's length bodies. Clinical chairs from CCGs are also represented on the board.

The ICS Executive Steering Group includes chief officers and chief executives, directors of strategy, transformation and delivery and directors of finance. There is also a range of programme boards responsible for delivering the workstreams. These are led by a chief executive and senior responsible officer (an accountable officer from a clinical commissioning group) and supported by a director of finance and a project manager/workstream lead.

The ICS has evolved from the establishment of a Sustainability and Transformation Partnership in January 2016, an Accountable Care System in April 2017, to then becoming one of the first and most advanced ICS systems in England and working arrangements have changed little over this time period. In September 2018 the Partnership supported a review of governance and ways of working and commissioned an independent expert to advise on matters and engage with system partners to develop a set of proposals for new partnership arrangements.

The ICS will continue to work with Local Authority partners to inform and shape how the system health and care partnership work including a revised Collaborative Partnership Board as set out in the NHS Long Term Plan. The next step for this will be a series of workshops led by local authority CEOs. The Collaborative Partnership Board will continue to meet on a bi monthly basis which will be reviewed in due course the light of the work above.

Arrangements in place to support the Partnership from 1 April 2019 for one year whilst the ICS continues to develop include:

- The System Health Oversight Board - is a joint forum between health providers, health commissioner, NHS England, 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

- The System Health Executive Group - comprising Chief Executive and Accountable Officer members from each health statutory organisations across the ICS and other partner organisation across Yorkshire and the Humber to plan and deliver strategic health priorities which require collaborative working across the ICS footprint

- An Integrated Assurance Committee - with non-executive and lay member representatives which brings together assurance across finance, operational delivery and quality matters

3.5 Sheffield Accountable Care Partnership (ACP)

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

The ACP vision, signed by the original 6 partners in September 2017 (with VCSE offered and accepting full membership in June 2018) is as follows:

"Improving the health and wellbeing of Sheffield's residents through the promotion of a health and wellbeing culture in all we do and the development and delivery of a world class health and care system"

The high level objectives of the ACP originally agreed are:

- Improve population health
- Improve care and quality
- Close the finance and sustainability gap
- Deliver a person-centred approach

The partnership works in the context of the general national move towards greater health and care integration set out in the NHS 5 Year Forward View and consolidated by the Long Term Plan as outlined above. In August 2018, the CEOs reviewed the ACP in a Time Out session, and alongside streamlining some architecture, agreed the following five priorities:

- Building community resilience through effective neighbourhood working
- Reducing smoking prevalence
- Reducing obesity and promoting physical activity
- Improving the experience of Older people in the care system
- Early years – developing more resilient families and communities

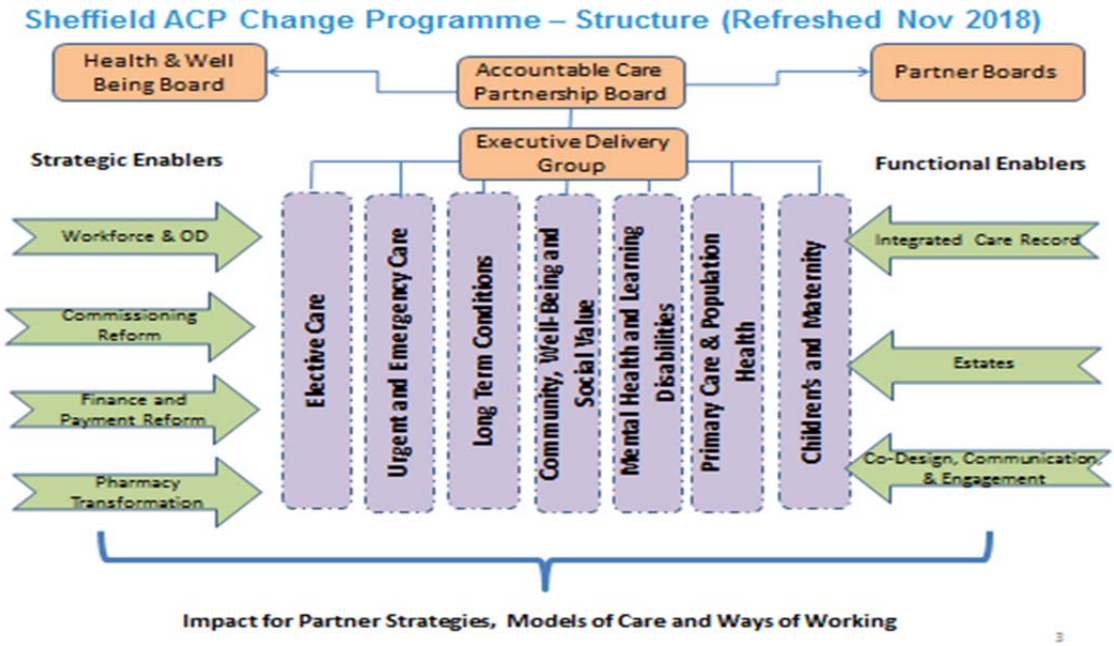
Healthwatch have been appointed as the **ACP VCSE partner on public and service user voice** and is funded to support the ACP on this work, whilst retaining that important independent focus. This arrangement commenced from November 2018 for a period of 12 months. This provides a great opportunity to build the public

and service user voice to the strategic and operational development of the ACP, alongside focusing on agreed priorities, such as Older People's experience.

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

Transformation Approach within the ACP

The ACP's transformation structure is as follows:



The ACP also coordinates the system wide response to **the CQC Local System Review** which reviewed care for Older People in the city in March 2018, with a report published in summer 2018 LINK.

There is considerable work taking place in response to this plan with a quarterly update coordinated by the ACP team provided to the ACP Board and ultimately the Health and Well-Being Board. Executive leads have been established for each partner organisation

The city has demonstrated significant outcomes through an ACP way of working across the city, which has been developing for a number of years. There are a number of excellent **models of commissioning and provision** which illustrate excellent partnership working, a population focus and more innovative payment and contracting models, underpinned by strong public and patient co-design and an outcomes focus. Examples and outcomes can be provided on request. The move towards integrated commissioning will be a crucial enabler for the ACP in 19/20.

4 UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance, however, compliance with relevant principles of the Code is considered to be

appropriate and good practice. This Annual Governance Statement is intended to demonstrate how the CCG has due regard to the principles set out in the Code and which are considered appropriate for CCGs. For the financial year ended 31 March 2019, and up to the date of signing this statement, we had regard to the provisions set out in the code, and applied the principles of the code.

5 Discharge of Statutory Functions

In light of recommendations of the 2013 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

6 Risk management arrangements and effectiveness

6.1 Risk Management Strategy

The CCG maintains a Risk Management Strategy which sets out its appetite for risk, together with the practical means through which risk is identified and evaluated as well as the control mechanisms through which it is managed. It creates a framework to achieve a culture that encourages staff to:

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

Fig 2

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

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

Leadership of the risk management process is given a high profile within the CCG and the Strategy sets out the roles of key personnel in handling and reporting risks. Risk management is built into the strategic planning process and managed operationally with the governance of decision making set out in the organisation's Scheme of Reservation and Delegation.

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

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

Risks are identified from a number of sources, including the Governing Body, Executive Directors, staff, Governing Body Assurance Framework (GBAF), internal

and external audit reports and risk assessments. Monitoring, evaluation and control have been further developed throughout the year and all identified risks are included on either the Corporate Risk Register, GBAF or individual team risk logs.

Risk management by the Governing Body is therefore underpinned by 6 interlocking systems of internal control:

- Governing Body Assurance Framework (GBAF)
- Corporate Risk Register (informed by team, directorate PMO, committee risk)
- Individual team risk logs
- Audit and Integrated Governance Committee
- Governance Sub-committee
- Annual Governance Statement

In addition, there are a range of controls in place within the CCG which include:

Control Type	Example
Risk Prevention	Scheme of Delegation and Reservation and financial authorisation and authorisation levels
Detection	Performance monitoring and quality reports to Governing Body
Internal	Statutory and mandatory training regime
Directive	Suite of policies and Standard Operating Procedures monitored by Governance Sub-committee and Quality Assurance Committee

Reports to Governing Body and committee meetings follow a recommended format including a standard front sheet that provides a clear summary of:

- Assurances that identified risks are being controlled
- Evidence of the CCG's compliance with the requirements of the Equality Act 2010
- How the paper supports involving patients, carers and the public in the preparation of the report

The Risk Management Strategy was reviewed and updated in February 2018 and approved by the AIGC at its meeting in April 2018.

All new or updated policies of the CCG are subject to Equality Impact Assessments which gauge and mitigate wider public risks.

6.2 Incident Reporting

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

6.3 Public Sector Equality Duty

We review compliance with the Public Sector Equality Duty annually and publish details on our website. We also publish data on the make-up of our workforce, those affected by our policies and procedures, as well as our objectives for improvements in equality across all areas of our work. Equality impact assessments are undertaken as a routine part of our commissioning. The Strategic Patient Engagement, Experience and Equality Committee is responsible for overseeing this important area of work.

6.4 Public Engagement

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

- The White Paper, '*Equity and Excellence: Liberating the NHS'*
- Health and Social Care Act 2012
- The NHS Constitution
- Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England

The CCG identifies impacts and risks of the decisions it makes through Equality and Quality Impact Assessment processes. These assessments provide insight into how certain communities may be impacted upon by potential changes. The insight of these assessments is used to target engagement with affected communities with a focus on how any impacts and risks can be negated or managed.

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

Supporting local people to have their say and genuinely influence our commissioning decisions is a priority for us. The CCG has a Volunteering Policy to ensure staff offer consistent and appropriate support to individuals who help our work.

Sharing the outcomes of our decision making with the public, and highlighting where public voice has impacted on our plans and decisions is vitally important to building trust with our communities and encouraging more involvement.

Our engagement activity is overseen and assured by our Strategic Public Engagement, Equality and Experience Committee whose members include local people, Governing Body lay members, Healthwatch Sheffield, the Local Authority and Sheffield University.

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

We consult with relevant Overview and Scrutiny Committees and NHS England as well as working in partnership with our local Healthwatch; and voluntary, community and faith sector in the City.

6.5 Equality and Diversity

Equality and Diversity is central to the work of NHS Sheffield CCG, as it is to the NHS Constitution. We want to ensure there is equality of access and treatment for all people to the services that we commission, both as a matter of fairness and as an essential part of our drive to reduce health inequalities and increase the health and wellbeing of all our population.

NHS Sheffield CCG is committed to embedding equality and diversity values into our policies, procedures, employment practice and the commissioning processes that secure health and social care for the people of Sheffield.

We are ensuring that all our staff are embedding equality and diversity in their work, and through our contracts and partnerships with providers we are supporting them to tackle inequities and barriers to services for patients. We monitor the performance of all providers in Sheffield.

The Governing Board has approved our equality objectives that have been developed and supported by underpinning actions that are linked to the four Equality Delivery System goals. The CCG has the following equality objectives:

- Ensure information and feedback from our patients, public and third sector partners is used to inform and influence our commissioning so that healthcare services meet the different needs of our local population
- Make measurable and continuous improvements in workforce equality, recognising the importance of a diverse workforce on improving the healthcare experience for all communities in Sheffield
- Ensure progress of actions are reported to the CCG Governing Body on a six monthly basis.

7 Capacity to Handle Risk

The CCG leads the risk management process in the following ways:

- Ensuring that effective governance structures are in place through the CCG Constitution, supporting policies and procedures, standing orders and standing financial instructions
- Ensuring that all directors and committees are clear in their remit and terms of reference including limits on their personal authority

- Having clear lines of reporting between the Governing Body, the Primary Care Committee and the high level committee and sub-committee structure, reviewed through the internal audit process
- Using a clear performance monitoring approach consisting of a triumvirate of the Corporate Risk Register, Governing Body Assurance Framework and monthly performance reports to ensure that risks are being identified and mitigated through the organisation
- Staff are trained and updated to ensure that they are aware of their responsibilities and authority, through providing regular update training sessions across a number of different areas of risk management including corporate risk, incident reporting, fraud, conflicts of interest and Information Governance

The Governing Body is responsible for ensuring that the CCG consistently follows the principles of good governance applicable to NHS organisations through its Governing Body Assurance Framework (GBAF) and other processes including the development of systems and processes for financial and organisational control, clinical governance and risk management. The Director of Finance is designated as the executive director lead for implementing the system of internal control, including the risk management process.

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

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

7.1 Risk Management Training

All members of staff are aware of their responsibilities in relation to the Risk Management Strategy. They have received training in relation to identifying, reporting, recording and managing risks, risk assessment, together with an overview of incident reporting within the organisation. This ensures that risk is seen as the responsibility of all members of staff and not just senior managers. Corporate induction includes an overview of the management of Conflicts of Interest within the CCG and reporting arrangements set out within the Standards of Business Conduct and Conflicts of Interest Policy and Procedure.

8 Risk Assessment

All risks to the CCG are assessed for their impact and likelihood to give an overall risk rating. The CCG's governance, risk management and internal control frameworks have been subject to review in-year to ensure that they remain fit for purpose. No significant risks to governance, risk management or internal control were identified during the year.

8.1 Assurance Framework

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 the achievement of its strategic objectives. Our Framework is built around the organisation's 5 strategic objectives, eight supporting goals and principle risks aligned to the Risk Register. It is a dynamic tool that maps key controls, highlighting any gaps in control and assurances to mitigate the risks identified, providing a mechanism to assure the Governing Body of its effectiveness of these controls. The Framework is part of the wider governance and assurance framework to ensure the CCG's performance across the full range of its commissioning activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for patients. Crucially, the GBAF provides the Governing Body with confidence that systems and processes are operating in a way that is safe and effective.

A meeting of the Executive Directors was held on 17 January 2018 to discuss the high level risks facing delivery of the organisations objectives. The meeting was attended by internal audit and discussion focussed on whether those risks identified remained relevant for the financial year ahead. This was followed by a 'Confirm and Challenge' session attended by Directors who reviewed and challenged the scores of all principal risks highlighted on the refreshed Framework. The Governing Body was provided with details of the refreshed GBAF at its meeting in March 2018 which included details of the changes to be taken forward for 2018/19. The Governing Body has received update reports throughout the year.

Management of the GBAF is the responsibility of the Corporate Services Risk and Governance Manager and is formally reviewed by each executive director risk lead on a quarterly basis. It is considered quarterly by the Senior Management Team (SMT) and by the Audit and Integrated Governance Committee (AIGC), providing the Governing Body with assurance that risks are being monitored and mitigated whilst highlighting any exceptions. The Committee 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 end of the monitoring period there remained 18 risks identified on the GBAF – the level of risk is set out below. One new risk was added during the year and no risks were closed. This is compared in the table below to the position in previous quarters.

Reporting Period	Critical	Very High	High	Medium	Low	Totals
Fourth	0	2	11	5	0	18
Third	0	3	12	3	0	18
Second	0	4	11	3	0	18
First	0	5	8	4	0	17

At 31 March 2019, the GBAF identified the following outstanding gaps in control, each of which have robust action plans and have been built into the 2019/20 Framework.

Risk Ref	Principal Risk	Identified Gap in Control
2.3	That the CCG commissioning activities fails to impact on the health inequalities and reduced life expectancy of its citizens who experience mental health conditions, as it is unable to influence the societal attitudes that prevail and lead to disparity of investment in mental health services when compared with physical health services. (Parity of Esteem)	This agenda is long term, and reflects the national health inequalities faced by the population with MH conditions. It will not be mitigated within year
5.2	Current commissioning support arrangements have been reviewed and have gone through significant change. New providers are delivering both IT and data management services and satisfactory delivery is as yet unproven.	Limited contractual mechanisms available via the LPF contract to drive performance improvement.

8.2 Corporate Risk Register

The CCG maintains a Corporate Risk Register through a web-based reporting system which is accessible to all staff via username and password and is reviewed on a 13 week cycle. All risks are reviewed by risk owners, senior managers and final reviewers (Directors). Risks are systematically reviewed by the Governance Sub-committee which includes a review of 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 both strategic and operational risks.

The Risk Register assesses the original and mitigated risks for their impact and likelihood and tracks the progress of individual risks over time through a standardised risk grading matrix. Risks that increase in score are subject to additional scrutiny and review.

A protocol in support of the risk register has been established and sets out the requirements of risk owners, together with reporting arrangements. The protocol is updated regularly and circulated to risk owners.

Each risk has three risk 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.

At the end of Quarter 4 2018/19 there were 31 risks on the risk register. There were no risks marked as 'serious' (scoring 15 or above) at this time.

Quarter	Critical (Black)	Very High (Red)	High (Amber)	Medium (Green)	Low (Light Green)	Total
1	0	3	14	5	1	23
2	0	2	19	6	1	28
3	0	3	23	7	0	33
4	0	0	23	5	3	31

The following risks were classified as Very High (Serious) during the course of the year, however the level of risk has since be reduced or the risk closed:

Risk Descriptor	Action Taken	Current Risk Score
Inability to deliver the objectives agreed pre-consultation for the Urgent Primary Care review. There is a significant risk that the findings of the public consultation will not support the preferred proposed option which could mean an alternate option has to be delivered or the maintenance of status quo. This could lead to the failure to deliver some or all of the objectives of the programme.	Risk reviewed by the team and subsequently closed during quarter 4 and now replaced by two further risks.	Risk Closed
Specific concerns regarding a Sheffield GP practice placed in special measures	Likelihood score has been slightly reduced due to a further	4x3(L)

following a Care Quality Commission (CQC) review	inspection from CQC (practice has shared draft report) which has taken the practice out of special measures though remains "requires improvement". The CCG continues to work intensively with the practice / practice leadership to improve the leadership model. A clear plan is in place and Primary Care Commissioning Committee (PCCC) continues to receive regular updates	
That the CCG will not be fully compliant or achieve the appropriate level within the Data Security and Protection Toolkit by the submission deadline of March 2019, due to new IT requirements not being implemented or embedded within time by our IT Provider. This will result in the CCG not being allowed vital activity information from Providers and GP practices as well as reputational damage as no organisation has failed to achieve the appropriate compliance level in order to receive information. Without the data flows and information, the CCG will not be able to deliver its function.	All IT elements that were required to be put in place for the Data Security and Protection Toolkit have now been completed. The CCG is on track to submit the toolkit submission at the end of March 2019	Risk Closed

9 Other sources of assurance

9.1 Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised 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 CCG procedural documents support the risk management and assurance processes and these include:

- Risk Management Strategy
- Serious Untoward Incident 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's Constitution incorporating the Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions
- Health and Safety Policy
- Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy

9.2 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** with only one low level recommendation highlighted:

- The start dates for all interests should be recorded accurately on the declaration forms and registers of interest

9.3 Data Quality

All reports received by Governing Body provide information on how they link to the GBAF. The Governing Body receives a monthly Performance, Quality and Outcomes Report which contains a significant range of data which officers' ensure is the most up to date available and from reliable sources such as contract data sets, nationally published data etc. (by local agreement local data is always noted as such to aid transparency). The Governing Body, as part of its monthly discussions on all reports, seeks reassurance on the accuracy and timeliness of the data and has found it acceptable. Any queries or feedback is sent back to the Information Team to investigate and the responsible Director (Director of Commissioning and Performance) presents back the answers and additional information. Periodic review of the contents / format helps ensure that processes reflect national changes in focus or monitoring. Joint working across the health economy and across South Yorkshire and Bassetlaw also exposes processes to review.

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

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

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

9.4 Information Governance

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

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

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

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

General Data Protection Regulations (GDPR) 2018 and the Data Protection Act 2018 were implemented throughout the CCG in 2018 which included various changes with regards to how the organisation handled confidential information. The changes were successfully communicated to all members of staff and incorporated within our routine practices. The CCG was audited on pre and post implementation of GDPR in which the post implementation resulted in an outcome of Significant Assurance.

The level of compliance demonstrated by completion of the 2018/19 Information Governance (IG) Toolkit is 66% with all standards at a score of at least two, which is deemed by NHS Digital to be satisfactory. Our IG Toolkit is also reviewed by our Internal Auditors and this audit resulted in an outcome of Significant Assurance. 2019/20 is the first year of the new Data Security and Protection Toolkit.

9.5 Business Critical Models

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

9.6 Third party assurances

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

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

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

- From NHS Shared Business Services for the provision of Finance and Accounting Services
- From NHS Digital regarding the processing of NHS payments and deductions to providers of general practice (“GP”) services
- From Capita for Primary Care Support 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 holds a contract for third party support with eMBED Health Consortium (eMBED) for the provision of IT Services. Assurance is received through the contract service delivery meetings and contract meetings which are held between the CCG and eMBED.

North East Commissioning Services (NECS) provides support relating to Data Management and Integration. Assurance is received through the contract which we hold with NECS and through the oversight of the flow of data by an Information Sharing Contract which we hold with NHS Digital and an Information Sharing Agreement.

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

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

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

10 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.

11 Review of economy, efficiency & effectiveness of the use of resources

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically. The ratings for the Quality of Leadership indicator of the CCG Improvement and Assessment Framework are published on MyNHS (www.nhs.uk/servicesearch/ performance/search). The latest data available is for Quarter 3 of 2018-19, and the CCG is rated as Good. The year end results for 2018-19 will be available from approximately July 2019. The overall rating will be based on categories of Outstanding, Good, Requires Improvement and Inadequate.

The CCG has developed and continues to refine systems and processes to effectively manage financial risks and to secure a stable financial position. The CCG's financial plan was developed for 2018-19, and budgets set within this plan, and signed off by Governing Body prior to the start of the financial year. These budgets were subsequently communicated to managers and budget holders within the organisation. The Director of Finance and management accountants have worked closely with managers to ensure robust annual budgets are prepared and delivered.

The CCG makes full use of both internal and external audit functions to ensure controls are operating effectively and to advise on areas for improvement. Audit reports, action plans and implementation of recommendations are discussed in detail at each meeting of the Audit and Integrated Governance Committee.

The CCG's annual accounts are reviewed by the Audit and Integrated Governance Committee prior to formal approval by the Governing Body.

The CCG also recognises the need to achieve cost reductions through improved efficiency and productivity and work is ongoing to develop schemes to achieve the QIPP targets and savings from whole system transformation which form part of future financial plans. A clear process has been developed to ensure monitoring and oversight of these schemes including the establishment of the Integrated QIPP Working Group.

12 Delegation of functions

The CCG currently contracts with a number of external organisations for the provision of back office services and functions, and as such has established an internal control system to gain assurance from these. These external services include:

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services. The use of NHS Shared Business Services is mandated by NHS England for all CCGs and is fundamental in producing NHS England group financial accounts through the use of an integrated financial ledger system
- The provision of Business Intelligence services from the North of England Commissioning Support Unit
- The provision of payroll services from Victoria Payroll Services, Sheffield Teaching Hospitals NHS Foundation Trust
- The provision of the ESR payroll systems support from McKesson
- The provision of Primary Care Support Services from Capita Business Services. The effectiveness of the controls is described under the Other Sources of Assurance section and the outcome of these audits is reported to AIGC.

We also have collaborative commissioning arrangements for 999 and 111 services across CCGs in the Yorkshire & Humber region. Assurance is provided via a Memorandum of Understanding and local representation at the Yorkshire and Humber Joint Strategic Commissioning Board. Limited delegation in respect of

quality and performance matters is in place to the coordinating commissioners for Yorkshire Ambulance Service (YAS) 999 (Wakefield CCG) and NHS 111 (Greater Huddersfield CCG) through the Memorandum of Understanding.

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

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

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

14 Head of Internal Audit Opinion

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

> In consideration of the above, I am providing a draft opinion of **Significant Assurance** that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

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

Area of Audit	Level of Assurance Given
General Data Protection Regulations	Significant
ACP Governance and Risk Management	Significant
Urgent Care in Primary Care	Limited

Better Care Fund	Extended Follow-up – N/A
Integrity of the General Ledger and Key Financial	Significant
Conflicts of Interest	Significant
Primary Care Quality Monitoring	Significant
Delegated Primary Medical Care Functions	Substantial
Data Security and Protection Toolkit	Significant

Urgent Care in Primary Care - Action Plan

The overall objective of the audit review was to provide independent assurance on the governance and project delivery arrangements which the CCG put in place during the consultation phase of the planned changes to the provision of urgent care services in Sheffield. The audit concluded that in the areas examined, the risk management activities and controls were not suitably designed, or were not operating with sufficient effectiveness, to provide reasonable assurance that the control environment was effectively managed during the period under review. An action plan has been agreed and implemented to address the issues raised.

There were eight major findings with 19 actions in the audit review which were all agreed by the CCG. This has now become the Project Assurance Action Plan, which has been agreed by the Urgent Care in Primary Care Programme Board to address the issues raised. All actions are now complete.

Progress has been made with 7 actions completed already and all others are in progress.

15 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 CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual management letter (ISA 260 report) and other reports.

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

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

- The Governing Body
- The Audit and Integrated Governance Committee

- The Quality Assurance Committee
- Strategic Patient Engagement, Equality and Experience Committee
- Governance Sub-committee
- Internal audit
- Other explicit review/assurance mechanisms.

The Governing Body develops, implements and delivers the strategic priorities of the CCG and receives assurances from the Audit and Integrated Governance Committee, the Quality Assurance Committee and the Strategic Patient Engagement, Equality and Experience Committee (via AIGC). Significant Assurance has also been received from the Head of Internal Audit. In addition to the assurances provided by management processes, the work of the Internal Auditors and External Auditors through their Annual Audit Letter and other reports and oversight of the Governing Body and CCG committees, the CCG is subject to the national assurance process through the NHS England Improvement and Assessment Framework. The CCG has regular dialogue with the NHS England local team and participates in the formal assurance process. An overall assessment is provided on an annual basis against the framework, including a rating for six clinical areas.

16 Conclusions

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.

Signed:

*Brian Hughes**

On behalf of:

Maddy Ruff
Accountable Officer
23 May 2019

*Due to the sickness of the Accountable Officer, this statement is signed by Brian Hughes, Deputy Accountable Officer

Remuneration and Staff Report

Remuneration Report

1. Remuneration Committee

Details of the membership of the Remuneration Committee can be found within the Annual Governance Statement (section 3.2.3 page 69). 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 the new GDPR rules all named individuals are required to give their consent to disclosure of information within the Remuneration Report and have done so. All such disclosures in the Remuneration Report will be consistent with identifiable information of those individuals in the Financial Statements.

Senior Managers' remuneration for 2018/19 was determined by the Remuneration Committee, taking account of national guidance, the prevailing economic climate, local market conditions and the requirement to obtain best value for money. The costs of all posts are met from within the notified CCG Running Cost Allowance.

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

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

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

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

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

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

comparative salary data, the labour market, and the financial circumstances of the organisation plus any national guidance.
The Accountable Officer, Director of Finance and the Director of Commissioning and Performance are entitled to performance related payments. However the Remuneration Committee agreed that due to the financial pressures faced by the CCG, performance related payments would not be made in relation to 2017/18.

3. Remuneration of Very Senior Managers

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

The table below details members of the Governing Body and the dates of their contract commencement and expiry.

Name	Title	*Contract Commencement	Contract Expiration
Dr Tim Moorhead	Chair	01-Nov-18	31-Oct-21
	Locality Appointed GP	01-Nov-14	30-Sep-20
Mrs Madeline Ruff	Accountable Officer	01-Sep-15	Substantive Post**
Mrs Mandy Philbin	Chief Nurse (Acting role from 25-Sept-17 to 19-4-18)	25-Sep-17	Substantive Post
Miss Julia Newton	Director of Finance	01-Apr-13	Substantive Post
Ms Nicola Doherty	Director of Delivery - Care Outside of Hospital	03-Nov-17	Substantive Post
Mr Brian Hughes	Director of Commissioning and Performance	29-May-17	Substantive Post
Dr Zak McMurray	Medical Director	01-Apr-13	Substantive Post
Dr Nikki Bates	GP Elected Member	01-Jan-17	31-Dec-19
Dr Terry Hudsen	GP Elected Member	01-Jan-17	31-Dec-19
Dr Annie Majoka	GP Elected Member	01-Jan-17	31-Dec-19
Dr Marion Sloan	GP Elected Member	01-Oct-13	30-Sept-19
Dr Jennie Joyce	Locality Appointed GP (cover for sabbatical)	06-Mar-18	01-Nov-18
Dr Gasan Chetty	Locality Appointed GP	01-Oct-17	31-Jul-18
Dr Amir Afzal	Locality Appointed GP	01-Nov-18	31-Oct-21
Dr Ngozi Anumba	Locality Appointed GP	14-May-15	13-May-18
Dr Kirsty Gillgrass	Locality Appointed GP	14-May-18	31-Jan-19
Dr Leigh Sorsbie	Locality Appointed GP (on sabbatical from 6-Mar-18 to 01-Nov-18)	01-Nov-14	31-Oct-20
Ms Chris Nield	Lay Member	01-Jul-18	30-June-21
Ms Amanda Forrest	Lay Member	01-Jul-13	30-June-20
Prof Mark Gamsu	Lay Member	01-Jul-13	30-June-20
Mr Phillip Taylor	Lay Member and Deputy Chair	01-Mar-16	31-Mar-19
Dr Christopher Whale	Secondary Care Doctor	01-Jul-17	30-June-20

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

** Maddy Ruff has confirmed her intention to resign on 7 June 2019 to take up a new post with a neighbouring Integrated Care System.

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 2017/18 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 2018/19.

8. Fair Pay disclosure (subject to audit)

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

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

The remuneration of the highest paid director or member of NHS Sheffield Clinical Commissioning Group in the financial year 2018/19 was £144,228 (£155,039 in 2017/18). This was 3.9 (4.36 times in 2017/18) times the median remuneration of the workforce which was £36,903 (£35,577 in 2017/18). The year-on year change to the remuneration of the highest paid member is as a result of the post being held by the Accountable Officer. The previous year the post was held by a Director who was paid on an off-payroll basis while a substantive appointment was progressed.

There has been a change in the composition of the workforce. The size of the total workforce headcount including temporary staff that worked during the 12 month period in 2018/19 rose from 410 employees in 2017/18 to 472 employees. The primary reason for the increase was the continued establishment of the South Yorkshire & Bassetlaw Integrated Care System (SY&BL ICS) for which Sheffield CCG is the host organisation as the ICS is not a separate statutory organisation. There were also smaller numbers of staff recruited within the Medicines Optimisation team and within the Sheffield Accountable Care Partnership for which the CCG also acts as host organisation.

There was a minimum 1.5% pay increase for all staff on Agenda for Change terms and conditions in 2018/19 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 5.5%

In 2018/19 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 2017/18) reflecting national guidance on the treatment of shared posts. Remuneration for CCG employees ranged from £10,401 to £144,228 where the salary is calculated on an annualised, full-time equivalent basis.

The South Yorkshire and Bassetlaw Integrated Care System (SY&BL 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&BL 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 2018/19 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. The remuneration relating to the two posts was £145,645 and £255,608.

Staff Report

1. Senior Managers

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

Pay Band	No. of Employees
Senior Managers	5
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 2018/19, 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	319	284	35
Net employee benefit costs In £'000s	17,172	14,184	2,988

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 2019.

	Female	Male
All Employees	283	79
Of which; Very Senior Managers (VSM)	2	1
Of which; Voting Members of the Governing Body	7	10

4. Sickness absence data

The table below provides an analysis of the staff sickness absence reported on a calendar year basis.

	2018 / 2019 Number	2017 / 2018 Number
Total Days Lost	2760	2,211
Total Staff Years	286	256
Average working Days Lost	9.7	8.6
Number of persons retiring on ill health grounds	2	0

Ill Health Retirement costs are met by the NHS Pension Scheme:

Sickness absence is managed in accordance with agreed policies and procedures which include employee wellbeing services of occupational health, counselling and physiotherapy.

5. 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 2018 to 31 March 2019 was as follows:

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent number*
3	**0.23**

Percentage of pay bill spent on facility time: The percentage of the total paybill spent on paying employees who were relevant union officials for facility time during 2018/19 was as follows:

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

Percentage of pay bill spent on facility time: The percentage of the total paybill spent on paying employees who were relevant union officials for facility time during 2018/19 was as follows:

Total cost of facility time	**£8,070**
Total pay bill - £000	**£12,058,000**
Percentage of the total paybill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) × 100	**0.07%**

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

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: *(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) × 100*	**15.07%**

Staff policies applied during the financial year: To ensure that all our staff members are treated fairly and without discrimination, harassment or victimisation we have a range of policies;

- Alcohol, Drug/Substance Misuse and Smoke free Policy
- Annual Leave and General Public Bank Holidays Policy
- Clinical Supervision Policy
- Dignity at Work (Prevention of Bullying and Harassment) Policy
- Disciplinary Policy
- Domestic Abuse Policy
- Employee Leaver, Notice Period and Exit Interview Policy
- Equality and Diversity Policy

- Expenses Policy
- Flexible Working Policy
- Freedom To Speak Up (Whistleblowing) Policy
- Gender Reassignment Support in the Workplace Policy
- Grading Review Policy
- Grievance Policy
- Hours of Work Policy
- Induction, Mandatory and Statutory Training Policy
- Learning and Development Policy
- Management of Performance Policy
- Management of Stress Policy
- Maternity, Adoption, Maternity Support (Paternity) and Parental Leave Policy
- Off Payroll Arrangements Policy
- Organisational Change, Redundancy and Pay Protection Policy
- Pay Progression Policy
- Recognition Agreement
- Recruitment and Selection Policy
- Retirement Policy
- Secondment Policy
- Sickness Absence Management Policy
- Social Media Policy
- Special Leave Policy
- Work Experience Policy

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

In line with the requirements of the Equality Act, we are committed to making sure that equality and diversity are a priority when planning and commissioning local healthcare. To help us do this we work closely with local communities to understand their needs and how best to commission the most appropriate services to meet those needs. This is equally important in the way we recruit, involve and develop our staff. We recognise that in order to remove the barriers experienced by individuals with a disability, we need to make reasonable adjustments for our disabled employees. We do this on a case by case basis and involve occupational health services as appropriate. The principle of reasonable adjustments is embedded throughout all policies as described above.

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

The commitments are as follows:

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

NHS Sheffield CCG has discharged its responsibility to calculate and publish the organisation's gender pay gap. This has been reported nationally on the government website and published locally on our website; http://www.sheffieldccg.nhs.uk/our-information/equality.htm

7. Other Employee Matters

Joint Staff Consultative Forum (JSCF)

The JSCF was established at the start of the CCG 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

National Staff Survey 2018

The National Staff Survey 2018 was sent via email to all directly employed staff of the organisation at 31st August 2018. The survey is designed to provide insight into opinion on many aspects of staff experience and engagement. The organisation received an overall 88% response rate, the results of which will inform the action plan that is formulated with staff engagement and input.

Health and Wellbeing

The CCG takes an active interest in the health and wellbeing of its employees. A number of initiatives have taken place throughout the year as detailed below:

- The organisation has 19 trained Mental Health First Aiders (MHFAs) trained across the CCG's directorates offering support to all staff. 2018 / 2019 saw increased support in relation to positive mental health including Mental Health Awareness Week, learning resources and the promotion of the support available from the MHFAs. Refresher training has also take place in 2018 to ensure the MHFAs have up to date knowledge and skills to undertake the role.
- Bullying and Harassment Prevention Training was delivered throughout 2018/2019 and has been attended by a total of 156 staff. The training is mandatory for all staff.
- Employee events and promotional material in relation to health and wellbeing services have been undertaken e.g. the CCG Mental Health Week, Self-Care week and the CCGs 'Time to Talk' day was well attended by staff.
- Wellbeing and resilience training for staff was developed and delivered. Line managers were trained in 'Managing for Wellbeing training' and Directorate Wellbeing Champions delivered 'Wellbeing and Resilience Training' to their teams in December and January 2019.
- Promotional sessions were held throughout 2018 / 2019 to increase awareness of employee wellbeing services. This included events hosted by the Employee Assistance Programme provider, HR training sessions and the staff induction. The Physiotherapy team has hosted monthly sessions for staff throughout 2018. Both the Physiotherapy service and the Employee Assistance Programme are interventions that are available to staff through self-referral.

8. Expenditure on consultancy

NHS Sheffield Clinical Commissioning Group spent £1,626k in total on consultancy services in 2018/19. Of this, £1,517k related to consultancy services commissioned by the South Yorkshire & Bassetlaw Integrated Care System (ICS) which the CCG hosts, mainly in relation to the Hospital Services Review and transformation projects.

9. Off-payroll engagements

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

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

Table 1: Off-payroll engagements longer than 6 months

The off payroll engagements as of 31 March 2019 for more than £245 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2019	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: New off-payroll engagements

New off-payroll engagements or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than 6 months are as follows:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	15
Of which:	
Number assessed as falling within the scope of IR35	11
Number assessed as not falling within the scope of IR35	4

Number engaged directly (via PSC contracted to department) and are on the departmental payroll	4
Number of engagements reassessed for consistency / assurance purposes during the year	15
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 2018 and 31 March 2019.

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).	22

10. Exit Packages (subject to audit)

The table below details the number and value of the exit packages agreed in 2018/19 (2017/18 £29k).

Table 1: Exit Packages

Exit package cost band (inc. 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	1	23,699			1	23,699		
£25,001 - £50,000								
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 – £200,000								
>£200,000								
TOTALS	**1**	**23,699**	**0**	**0**	**1**	**23,699**	**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 is not a Governing Body member. The total cost of the redundancy was £99,940. An agreement was made with partner organisations that the liability for this cost would be shared between the Working Together Commissioning organisations of: NHS Sheffield CCG, NHS Rotherham CCG, NHS Barnsley CCG, NHS Doncaster CCG, NHS Bassetlaw CCG, NHS Wakefield CCG, NHS North Derbyshire CCG and NHS Hardwick CCG. The redundancy was approved at the CCG Accountable Officers meeting on 5 November 2018.

Analysis of Other Departures

There were no other departures in 2018/19.

*Brian Hughes**
On behalf of

Maddy Ruff

Accountable Officer

23 May 2019

*Due to the sickness of the Accountable Officer, this statement is signed by Brian Hughes, Deputy Accountable Officer

Appendix A – Register of interests, Governing Body 2018/19

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 2018/19

Appendix Bi

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

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

Notes

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

**The Accountable Officer M Ruff is employed by Sheffield CCG and as part of this role works within the South Yorkshire & Bassetlaw Integrated Care System (SY&B ICS) on a 0.4 whole time 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.

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

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

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

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

Remuneration Report: Senior Managers: Salaries and Allowances 2017/18

Appendix Bii

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

	2017-18					
Name and Title	**Salary** (bands of £5k) £000	**Expense Payments (taxable)** (rounded to the nearest £100) £00	**Performance pay and bonuses** (bands of £5k) £000	**Long term Performance pay and bonuses** (bands of £5k) £000	**All Pension Related Benefits** (bands of £2.5k) £000	**TOTAL** (bands of £5k) £000
T Moorhead Chair of the Governing Body	100 - 105	0	0	0	17.5 - 20.0	115 - 120
M Ruff Accountable Officer	140 - 145	52	0 - 5	0	20.0 - 22.5	170 - 175
P Brooks Chief Nurse (voting rights ceased 24 September 2017)	25 - 30	0	0	0	0	25 - 30
M Philbin Acting Chief Nurse (from 25 September 2017)	40 - 45	1	0	0	120.0 - 122.5	160 - 165
N Doherty Director of Delivery - Care Outside of Hospital	80 - 85	1	0	0	37.5 - 40.0	120 - 125
B Hughes Director of Commissioning and Performance (from 29 May 2017)	90 - 95	1	0	0	197.5 - 200.0	290 - 295
Z McMurray Medical Director	110 - 115	0	0	0	0	110 - 115
*P Moore Director of Strategy & Integration (to 30 September 2017)	50 - 55	1	0	0	20.0 - 22.5	70 - 75
J Newton Director of Finance	110 - 115	1	0 - 5	0	52.5 - 55.0	170 - 175
*M Powls Director of Commissioning and Performance (interim) (to 19 May 2017)	10 - 15	0	0	0	0	10 - 15
N Bates GP Elected Member	10 - 15	0	0	0	0 - 2.5	10 - 15
T Hudsen GP Elected Member	10 - 15	0	0	0	0 - 2.5	15 - 20
A Majoka GP Elected Member	10 - 15	0	0	0	160.0 - 162.5	170 - 175
M Sloan GP Elected Member	10 - 15	0	0	0	0	10 - 15
A Afzal Locality Appointed GP (to 30 September 2017)	5 - 10	0	0	0	0	5 - 10
N Anumba Locality appointed GP	10 - 15	0	0	0	160.0 - 162.5	175 - 180
G Chetty Locality Appointed GP (from 1 October 2017)	5 - 10	0	0	0	0	5 - 10
L Sorsbie (voting rights ceased 5 March 2018) Locality appointed GP	10 - 15	0	0	0	2.5 - 5.0	15 - 20
J Joyce Locality Appointed GP (from 6 March 2018)	0 - 5	0	0	0	12.5 - 15.0	15 - 20
C Whale Secondary Care Doctor (from 01 July 2017)	5 - 10	0	0	0	0	5 - 10
J Boyington CBE Vice Chair and Lay Member (to 31 May 2017)	0 - 5	0	0	0	0	0 - 5
A Forrest Lay Member	10 - 15	0	0	0	0	10 - 15
M Gamsu Lay Member	10 - 15	0	0	0	0	10 - 15
P Taylor Lay Member (Deputy Chair from 9 November 2017)	10 - 15	0	0	0	0	10 - 15
JA Williams Lay Member (from 1 September 2017 to 26 February 2018)	5 - 10	0	0	0	0	5 - 10

Notes

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

Pension related benefits is the increase in the annual pension entitlement determined in accordance with the HMRC method. This compares the accrued pension and the lump sum at age 60 at the end of the financial year against the same figures at the beginning of the financial year. 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 and their performance bonus paid in 2017/18 relates to the 2016/17 financial year. The Director of Commissioning and Performance was not eligible for a performance bonus relating to 2016/17 as he was not in post until 2017/18.

Two of the Governing Body members were paid on an off-payroll basis during the year. One of the payments was for a clinician who carried out ad-hoc clinical engagement work outside of their Governing Body role, the other was for the interim Director of Commissioning and Performance (M Powls) who was paid via an Agency. To ensure the salary of M Powls is comparable to the salaries of employees the value shown is exclusive of VAT, agency fees and employers national insurance costs.

*The salary relating to P Moore is a joint post with Sheffield City Council and 50% of the stated salary is recharged to that organisation.

Pension Benefits - 2018-19 **Appendix Biii**

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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's Contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
*T Moorhead Chair of the Governing Body	0	0	0	0	0	0	0	0
M Ruff Accountable Officer	0 - 2.5	0 - 2.5	50 - 55	145 - 150	976	111	1137	0
N Doherty Director of Delivery - Care Outside of Hospital	2.5 - 5.0	2.5 - 5.0	15 - 20	30 - 35	166	49	233	0
B Hughes Director of Commissioning and Performance	2.5 - 5.0	(0 - 2.5)	30 - 35	70 - 75	433	91	552	0
*Z McMurray Medical Director	0	0	0	0	0	0	0	0
J Newton Director of Finance	0 - 2.5	2.5 - 5.0	35 - 40	115 - 120	740	86	865	0
M Philbin Chief Nurse	2.5 - 5.0	7.5 - 10.0	30 - 35	85 - 90	494	122	642	0
N Bates GP Elected Member	0 - 2.5	0 - 2.5	5 - 10	25 - 30	158	27	191	0
T Hudsen GP Elected Member	7.5 - 10.0	27.5 - 30.0	10 - 15	35 - 40	44	149	197	0
A Majoka GP Elected Member	0 - 2.5	0 - 2.5	10 - 15	25 - 30	145	26	178	0
*M Sloan GP Elected Member	0	0	0	0	0	0	0	0
*A Afzal Locality Appointed GP (from 1 November 2018)	0	0	0	0	0	0	0	0
N Anumba Locality appointed GP (to 13 May 2018)	(0 - 2.5)	(0 - 2.5)	5 - 10	20 - 25	171	0	176	0
*G Chetty Locality Appointed GP (to 31 July 2018)	0	0	0	0	0	0	0	0
K Gilgrass Locality Appointed GP (from 14 May 2018 to 31 January 2019)	0 - 2.5	0 - 2.5	5 - 10	20 - 25	85	24	123	0
J Joyce Locality Appointed GP (to 1 November 2018)	5.0 - 7.5	15.0 - 17.5	10 - 15	35 - 40	51	85	199	0
L Sorsbie Locality appointed GP (from 2 November 2018)	0 - 2.5	0 - 2.5	10 - 15	30 - 35	215	12	255	0
**C Whale Secondary Care Doctor	0	0	0	0	0	0	0	0

* Dr McMurray, Dr Moorhead, Dr Sloan, Dr Afzal and Dr Chetty do not make contributions to the NHS Pension Scheme and hence no information is available to the CCG.
**Dr Whale makes contributions to the NHS Pension Scheme in his full time substantive clinical post and hence this is a nil return.

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 19 against the accrued pension/lump sum at 31 March 18 which is then adjusted by a factor of 3% to account for inflation (3% is a figure quoted in the Business Services Authority guidance on the Remuneration Report and is based on the Consumer Price Index). Where the result is a decrease in the pension or lump sum this reflects the fact that the previous years nominally inflated pension/lump sum is higher than the pension/lump sum value as at March 2019 and/or that the remuneration of the individual has decreased in the current financial year compared to the previous financial year.

The closing CETV value for 2017/18 is different in some cases to the opening CETV value for 2018/19. This is unusual and it has been confirmed that NHS Pensions has implemented a series of new calculation factors (as determined by Government Actuary Dept.), which has resulted in some of these differences.

Parliamentary Accountability and Audit Report

Sheffield CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingency liabilities, losses and special payments, gifts, and fees and charges are included as notes to in the financial statements (annual accounts) of this report. An audit certificate and report is also included in this Annual Report at 112.

ANNUAL ACCOUNTS

*Brian Hughes**
On behalf of

Maddy Ruff

Accountable Officer

23 May 2019

*Due to the sickness of the Accountable Officer, this statement is signed by Brian Hughes, Deputy Accountable Officer

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Sheffield Clinical Commissioning Group ("the CCG") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2018/19.

Basis for opinion

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

Going concern

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

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

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

Other information in the Annual Report

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

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the

other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

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

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

Accountable Officer's responsibilities[1]

As explained more fully in the statement set out on page 57, the Accountable Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

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

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

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

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

We have nothing to report in this respect.

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

As explained more fully in the statement set out on page 56, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability

Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

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

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

We have nothing to report in these respects.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

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

Clare Partridge
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA
24th May 2019

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Annual Accounts for the Period

1st April 2018

to 31st March 2019

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 2019 have been prepared by NHS Sheffield Clinical Commissioning Group under section 17 of schedule 1A of the National Health Service Act 2006 (as amended by the Health & Social Care Act 2012) in the form which the Secretary of State has, with the approval of the Treasury, directed.

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

NHS Sheffield Clinical Commissioning Group - Annual Accounts 2018-19

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	(2,659)	(2,880)
Other operating income	2	(463)	(2,383)
Total operating income		**(3,122)**	**(5,263)**
Staff costs	4	17,213	15,184
Purchase of goods and services	5	862,051	837,498
Depreciation and impairment charges	5	59	35
Provision expense	5	(5)	5
Other Operating Expenditure	5	733	493
Total operating expenditure		**880,051**	**853,215**
Net Operating Expenditure		**876,929**	**847,952**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**876,929**	**847,952**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**876,929**	**847,952**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**876,929**	**847,952**

The notes on pages 5 to 27 form part of this statement.

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets:			
Property, plant and equipment	8	321	260
Total non-current assets		**321**	**260**
Current assets:			
Trade and other receivables	9	11,432	5,655
Cash and cash equivalents	10	139	180
Total current assets		**11,571**	**5,835**
Total assets		**11,892**	**6,095**
Current liabilities			
Trade and other payables	11	(48,875)	(42,501)
Provisions	12	-	(5)
Total current liabilities		**(48,875)**	**(42,506)**
Assets less Liabilities		**(36,983)**	**(36,411)**
Financed by taxpayers' equity			
General fund		(36,983)	(36,411)
Total taxpayers' equity:		**(36,983)**	**(36,411)**

The notes on pages 5 to 27 form part of this statement.

The financial statements on pages 1 to 4 were approved by the Governing Body on 23rd May 2019 and signed on its behalf by:

Accountable Officer
Maddy Ruff

*Due to sickness of the Accountable Officer, this statement is signed by Brian Hughes, Deputy Accountable Office.

Statement of Changes In Taxpayers Equity for the year ended 31 March 2019

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(36,411)	-	-	**(36,411)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	-	-	**-**
Impact of applying IFRS 9 to Opening Balances	(2)			**(2)**
Impact of applying IFRS 15 to Opening Balances	-	-	-	**-**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(36,413)**	**-**	**-**	**(36,413)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating expenditure for the financial year	(876,929)			**(876,929)**
Net gain/(loss) on revaluation of property, plant and equipment		-		**-**
Net gain/(loss) on revaluation of intangible assets		-		**-**
Net gain/(loss) on revaluation of financial assets		-		**-**
Total revaluations against revaluation reserve		**-**		**-**
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(876,929)**	**-**	**-**	**(876,929)**
Net funding	876,359	-	-	**876,359**
Balance at 31 March 2019	**(36,983)**	**-**	**-**	**(36,973)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(37,067)	-	-	**(37,067)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	**-**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(37,067)**	**-**	**-**	**(37,067)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating costs for the financial year	(847,952)			(847,952)
Net gain/(loss) on revaluation of property, plant and equipment		-		**-**
Net gain/(loss) on revaluation of intangible assets		-		**-**
Net gain/(loss) on revaluation of financial assets		-		**-**
Total revaluations against revaluation reserve		**-**		**-**
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(847,952)**	**-**	**-**	**(847,952)**
Net funding	848,608	-	-	848,608
Balance at 31 March 2018	**(36,411)**	**-**	**-**	**(36,411)**

The notes on pages 5 to 27 form part of this statement.

Statement of Cash Flows for the year ended
31 March 2019

	Note	**2018-19** **£'000**	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(876,929)	(847,952)
Depreciation and amortisation	5	59	35
Impairments and reversals	5	-	-
Non-cash movements arising on application of new accounting standards		(2)	-
Movement due to transfer by Modified Absorption		-	-
Other gains (losses) on foreign exchange		-	-
Donated assets received credited to revenue but non-cash		-	-
Government granted assets received credited to revenue but non-cash		-	-
Interest paid		-	-
Release of PFI deferred credit		-	-
Other Gains & Losses		-	-
Finance Costs		-	-
Unwinding of Discounts		-	-
(Increase)/decrease in inventories		-	-
(Increase)/decrease in trade & other receivables	9	(5,777)	1,977
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade & other payables	11	6,348	(2,518)
Increase/(decrease) in other current liabilities		-	-
Provisions utilised	12	-	-
Increase/(decrease) in provisions	12	(5)	5
Net Cash Inflow (Outflow) from Operating Activities		**(876,306)**	(848,453)
Cash Flows from Investing Activities			
Interest received		-	-
(Payments) for property, plant and equipment		(94)	(116)
(Payments) for intangible assets		-	-
(Payments) for investments with the Department of Health		-	-
(Payments) for other financial assets		-	-
(Payments) for financial assets (LIFT)		-	-
Proceeds from disposal of assets held for sale: property, plant and equipment		-	-
Proceeds from disposal of assets held for sale: intangible assets		-	-
Proceeds from disposal of investments with the Department of Health		-	-
Proceeds from disposal of other financial assets		-	-
Proceeds from disposal of financial assets (LIFT)		-	-
Non-cash movements arising on application of new accounting standards		-	-
Loans made in respect of LIFT		-	-
Loans repaid in respect of LIFT		-	-
Rental revenue		-	-
Net Cash Inflow (Outflow) from Investing Activities		**(94)**	(116)
Net Cash Inflow (Outflow) before Financing		**(876,400)**	(848,569)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		876,359	848,608
Other loans received		-	-
Other loans repaid		-	-
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		-	-
Capital grants and other capital receipts		-	-
Capital receipts surrendered		-	-
Non-cash movements arising on application of new accounting standards		-	-
Net Cash Inflow (Outflow) from Financing Activities		**876,359**	848,608
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(41)**	39
Cash & Cash Equivalents at the Beginning of the Financial Year		**180**	141
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**139**	180

The notes on pages 5 to 27 form part of this statement.

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2018-19 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis**.**

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

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 **Accounting Convention**

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

1.3 **Joint arrangements**

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the clinical commissioning group is a joint operator it recognises its share of assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.4 **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 assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.5 **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.

1.6 **Revenue**

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
NHS Sheffield Clinical Commissioning Group are the host for several admin and clinical service functions including Procurement, HR, Individual Funding Requests and Working Together. The provision of these services to other local clinical commissioning groups is the main source of income for NHS Sheffield Clinical Commissioning Group.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

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

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

1.7.2 **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.

1.8 **Other Expenses**

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

1.9 **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.

1.10 **Property, Plant & 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,
· The item has a cost of at least £5,000; or,
· Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
· Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

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

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

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

1.10.3 **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 & Impairments**

Assets held for sale are not depreciated.

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

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

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

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

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

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

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

1.12.2 **The Clinical Commissioning Group as Lessor**

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

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

1.13 **Cash & Cash Equivalents**

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

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

1.14 **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 rate as follows:

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

• A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) 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% (2017-18: negative 1.56% in real terms) 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% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

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

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

1.15 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with 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 the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.17 **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.

1.18 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

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

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

1.18.3 **Financial assets at fair value through profit and loss**

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

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

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

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

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

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

1.19.1 **Financial Guarantee Contract Liabilities**
Financial guarantee contract liabilities are subsequently measured at the higher of:
· The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
· The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.19.2 **Financial Liabilities at Fair Value Through Profit and Loss**

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

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

1.2 **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.

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

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

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

1.23 **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.

1.23.1 **Critical accounting judgements in applying accounting policies**

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

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

1.23.2 **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.

1.24 **Accounting 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 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

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

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

The application of the Standards as revised would not have a material impact on the accounts for 2018-19, were they applied in that year.

2 Operating income

	2018-19 Total £'000	2017-18 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**329**	29
Non-patient care services to other bodies	**1,265**	2,401
Other Contract income	**1,025**	-
Recoveries in respect of employee benefits	**40**	450
Total Income from sale of goods and services	**2,659**	**2,880**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	**448**	268
Non cash apprenticeship training grants revenue	**15**	5
Other non contract revenue	**-**	2,110
Total Other operating income	**463**	**2,383**
Total Operating Income	**3,122**	**5,263**

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 2018/19, revenue shown under 'Other Contract income' includes £260k income for Accountable Care Partnership services, £213k income in relation to the provision of healthcare to refugees, £154k income for Better Care Fund services, £150k income for learning disability transforming care programme, £130k income for the transformation of estates and technology, £50k income for the provision of procurement services, £35k income for facilities services and £33k income for provision of other admin services.

For 2017/18, revenue shown under 'Other non contract revenue' includes £1m income received from Sheffield City Council (SCC) for the recharge of prescribing costs for the services that SCC commission and £0.6m relates to pharmaceutical rebate schemes. As a result of the implementation of IFRS 15, these recharges are now coded as negative expenditure to offset the original cost and therefore not recorded as revenue. Other revenue included £0.2m income for Resettlement programmes, £0.2m was income for staffing and associated costs for hosted services.

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

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue				
NHS	-	1,206	345	-
Non NHS	329	59	680	40
Total	**329**	**1,265**	**1,025**	**40**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue				
Point in time	6	40	73	-
Over time	323	1,225	952	40
Total	**329**	**1,265**	**1,025**	**40**

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

	2018-19		
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	11,418	2,570	13,988
Social security costs	1,197	217	1,414
Employer Contributions to NHS Pension scheme	1,538	201	1,739
Other pension costs	3	-	3
Apprenticeship Levy	45	-	45
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	24	-	24
Gross employee benefits expenditure	**14,225**	**2,988**	**17,213**
Less recoveries in respect of employee benefits (note 4.1.2)	(40)	-	(40)
Total - Net admin employee benefits including capitalised costs	**14,185**	**2,988**	**17,173**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**14,185**	**2,988**	**17,173**

4.1.1 Employee benefits

	2017-18		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	10,623	1,805	12,428
Social security costs	1,121	78	1,199
Employer Contributions to NHS Pension scheme	1,409	78	1,487
Other pension costs	2	-	2
Apprenticeship Levy	39	-	39
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	29	-	29
Gross employee benefits expenditure	**13,223**	**1,961**	**15,184**
Less recoveries in respect of employee benefits (note 4.1.2)	(450)	-	(450)
Total - Net admin employee benefits including capitalised costs	**12,773**	**1,961**	**14,734**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**12,773**	**1,961**	**14,734**

4.1.2 Recoveries in respect of employee benefits

	2018-19			2017-18
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(32)	-	(32)	(329)
Social security costs	(4)	-	(4)	(54)
Employer contributions to the NHS Pension Scheme	(4)	-	(4)	(67)
Total recoveries in respect of employee benefits	**(40)**	**-**	**(40)**	**(450)**

4.2 Average number of people employed

	2018-19			2017-18		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**284.44**	**34.56**	**319.00**	254.43	15.15	**269.58**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

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

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	2,525	-	-	1	2,525
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	1	26,683	-	-	1	26,683
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**29,208**	**-**	**-**	**2**	**29,208**

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 the entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

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

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

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the 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. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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

5. Operating expenses

	2018-19 Total £'000	2017-18 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	463	760
Services from foundation trusts	556,400	533,854
Services from other NHS trusts	28,308	25,972
Purchase of healthcare from non-NHS bodies	63,473	63,893
Purchase of social care	22,085	22,225
Prescribing costs	88,806	94,589
Pharmaceutical services	308	376
General Ophthalmic services	320	320
GPMS/APMS and PCTMS	91,647	86,118
Supplies and services – general	3,030	2,370
Consultancy services	1,626	1,633
Establishment	1,070	1,281
Transport	65	46
Premises	3,554	3,327
Audit fees	47	49
Other non statutory audit expenditure		
· Other services	10	-
Other professional fees	204	54
Legal fees	433	450
Education, training and conferences	202	181
Total Purchase of goods and services	**862,051**	**837,498**
Depreciation and impairment charges		
Depreciation	59	35
Total Depreciation and impairment charges	**59**	**35**
Provision expense		
Provisions	(5)	5
Total Provision expense	**(5)**	**5**
Other Operating Expenditure		
Chair and Non Executive Members	294	294
Research and development (excluding staff costs)	381	139
Expected credit loss on receivables	2	-
Non cash apprenticeship training grants	15	5
Other expenditure	41	55
Total Other Operating Expenditure	**733**	**493**
Total operating expenditure	**862,838**	**838,031**

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 £1,626k in total on consultancy services in 2018/19. Of this, £1,517k related to consultancy services commissioned by the South Yorkshire & Bassetlaw Integrated Care System (ICS) which the CCG hosts, mainly in relation to the Hospital Services Review and transformation projects.

NHS Sheffield Clinical Commissioning Group will be required to obtain assurance from the external auditors over reported compliance with the requirements of the Mental Health Investment Standard. The CCG has received £10,000 of resource allocation in relation to this work. The final fee is not yet confirmed.

6.1 Better Payment Practice Code

Measure of compliance	2018-19 Number	2018-19 £'000	2017-18 Number	2017-18 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	17,016	200,008	16,011	190,223
Total Non-NHS Trade Invoices paid within target	16,818	199,588	15,778	189,536
Percentage of Non-NHS Trade invoices paid within target	**98.84%**	**99.79%**	**98.54%**	**99.64%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,141	634,773	4,227	581,696
Total NHS Trade Invoices Paid within target	4,083	634,260	4,200	580,841
Percentage of NHS Trade Invoices paid within target	**98.60%**	**99.92%**	**99.36%**	**99.85%**

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense

				2018-19				2017-18
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
Payments recognised as an expense	**£'000**	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Minimum lease payments	-	2,865	9	**2,874**	-	2,937	13	**2,950**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**2,865**	**9**	**2,874**	**-**	**2,937**	**13**	**2,950**

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 2018-19 is £1,107k (2017-18 £1,127k).

Clinical commissioning groups are required to pay for void space in primary and community care buildings that predecessor organisations had responsibility for or commissioned services within. This arrangement with Community Health Partnerships Limited falls within the definition of operating leases but 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 2018-19 is £1,622k (2017-18 £1,710k).

7.1.2 Future minimum lease payments

				2018-19				2017-18
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payable:								
No later than one year	-	-	35	**35**	-	-	11	**11**
Between one and five years	-	-	9	**9**	-	-	109	**109**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**44**	**44**	**-**	**-**	**120**	**120**

8 Property, plant and equipment

2018-19	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2018	295	205	500
Addition of assets under construction and payments on account	-	-	-
Additions purchased	120	-	120
Additions donated	-	-	-
Additions government granted	-	-	-
Additions leased	-	-	-
Reclassifications	-	-	-
Reclassified as held for sale and reversals	-	-	-
Disposals other than by sale	-	-	-
Upward revaluation gains	-	-	-
Impairments charged	-	-	-
Reversal of impairments	-	-	-
Transfer (to)/from other public sector body	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-
Cost/Valuation at 31 March 2019	**415**	**205**	**620**
Depreciation 01 April 2018	35	205	240
Reclassifications	-	-	-
Reclassified as held for sale and reversals	-	-	-
Disposals other than by sale	-	-	-
Upward revaluation gains	-	-	-
Impairments charged	-	-	-
Reversal of impairments	-	-	-
Charged during the year	59	-	59
Transfer (to)/from other public sector body	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-
Depreciation at 31 March 2019	**94**	**205**	**299**
Net Book Value at 31 March 2019	**321**	**-**	**321**
Purchased	321	-	321
Donated	-	-	-
Government Granted	-	-	-
Total at 31 March 2019	**321**	**-**	**321**
Asset financing:			
Owned	321	-	321
Held on finance lease	-	-	-
On-SOFP Lift contracts	-	-	-
PFI residual: interests	-	-	-
Total at 31 March 2019	**321**	**-**	**321**

Revaluation Reserve Balance for Property, Plant & Equipment

	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2018	-	-	-
Revaluation gains	-	-	-
Impairments	-	-	-
Release to general fund	-	-	-
Other movements	-	-	-
Balance at 31 March 2019	**-**	**-**	**-**

8 Property, plant and equipment cont'd

8.1 Cost or valuation of fully depreciated assets

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

	2018-19 £'000	2017-18 £'000
Information technology	-	-
Furniture & fittings	205	205
Total	**205**	**205**

8.2 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Information technology	5	5
Furniture & fittings	-	-

9 Trade and other receivables	**Current 2018-19 £'000**	Current 2017-18 £'000
NHS receivables: Revenue	139	576
NHS prepayments	3,350	3,249
NHS accrued income	4,185	288
NHS Non Contract trade receivable (i.e. pass through funding)	1,196	-
Non-NHS and Other WGA receivables: Revenue	161	265
Non-NHS and Other WGA prepayments	109	154
Non-NHS and Other WGA accrued income	495	844
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	403	-
Non-NHS and Other WGA Non Contract trade receivable (i.e. pass through funding)	1,229	-
Expected credit loss allowance-receivables	(4)	-
VAT	111	98
Other receivables and accruals	58	181
Total Trade & other receivables	**11,432**	**5,655**
Included above:		
Prepaid pensions contributions	-	-

9 Trade and other receivables cont'd

9.1 Receivables past their due date but not impaired

	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000	2017-18 DHSC Group Bodies £'000	2017-18 Non DHSC Group Bodies £'000
By up to three months	402	-	17	14
By three to six months	-	-	103	8
By more than six months	-	-	20	6
Total	**402**	**-**	**140**	**28**

£245k of the amount above has subsequently been recovered post the statement of financial position date.

NHS Sheffield Clinical Commissioning Group did not hold any collateral against receivables outstanding as at 31 March 2019.

9.2 Impact of Application of IFRS 9 on financial assets at 1 April 2018

	Trade and other receivables - NHSE bodies	Trade and other receivables - other DHSC group bodies	Trade and other receivables - external	Other financial assets	Cash and cash equivalents	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Classification under IAS 39 as at 31st March 2018						
Financial Assets held at Fair Value Through Profit and Loss (FVTPL)	-	-	-	-	-	-
Financial Assets held at Amortised cost	312	552	1,109	181	180	**2,334**
Financial assets held at Fair Value Through Other Comprehensive Income (FVOCI)	-	-	-	-	-	-
Total at 31st March 2018	**312**	**552**	**1,109**	**181**	**180**	**2,334**
Classification under IFRS 9 as at 1st April 2018						
Financial Assets designated to FVTPL	-	-	-	-	-	-
Financial Assets mandated to FVTPL	-	-	-	-	-	-
Financial Assets measured at amortised cost	312	552	1,109	181	180	**2,334**
Financial Assets measured at FVOCI	-	-	-	-	-	-
Total at 1st April 2018	312	552	1,109	181	180	**2,334**
Changes due to change in measurement attribute	-	-	-	-	-	-
Other changes	-	-	-	-	-	-
Change in carrying amount	-	-	-	-	-	-

9.3 Movement in loss allowances due to application of IFRS 9

	Trade and other receivables - NHSE bodies	Trade and other receivables - other DHSC group bodies	Trade and other receivables - external	Other financial assets	Cash and cash equivalents	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Impairment and provisions allowances under IAS 39 as at 31st March 2018						
Financial Assets held at Amortised cost						
(i.e. the 1718 Closing Provision)	-	-	-	-	-	-
Financial assets held at FVOCI	-	-	-	-	-	-
Total at 31st March 2018	-	-	-	-	-	-
Loss allowance under IFRS 9 as at 1st April 2018						
Financial Assets measured at amortised cost	-	-	(2)	-	-	**(2)**
Financial Assets measured at FVOCI	-	-	-	-	-	-
Total at 1st April 2018	-	-	**(2)**	-	-	**(2)**
Change in loss allowance arising from application of IFRS 9	-	-	**(2)**	-	-	**(2)**

9 Trade and other receivables cont'd

9.4 Loss allowance on asset classes

	Trade and other receivables - external £000s
Balance at 1st April 2018	
Allowance for credit losses at 1st April 2018	-
Recognition of loss allowance on application of IFRS9 (2018-19 only)	(2)
Lifetime expected credit losses on trade and other receivables-Stage 2	(2)
Allowance for credit losses at 31 March 2019	**(4)**

9.5 Provision Matrix on lifetime credit loss

	31-Mar-19 % Lifetime expected credit loss rate	31-Mar-19 £'000 Gross Carrying Amount	31-Mar-19 £'000 Lifetime expected credit loss	31-Mar-18 £'000 Lifetime expected credit loss
Non NHS Debt				
Current	0.1	1,312	1	-
1 - 30 days	1.0	27	-	-
31 - 60 days	2.0	3	-	-
61 - 90 days	5.0	46	2	-
Greater than 90 days	10.0	3	1	2
			4	**2**

10 Cash and cash equivalents

	2018-19 £'000	2017-18 £'000
Balance at 01 April 2018	180	141
Net change in year	(41)	39
Balance at 31 March 2019	**139**	**180**
Made up of:		
Cash with the Government Banking Service	139	180
Cash with Commercial banks	-	-
Cash in hand	0	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**139**	**180**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2019	**139**	**180**

11 Trade and other payables	Current 2018-19 £'000	Current 2017-18 £'000
NHS payables: Revenue	11,740	2,376
NHS accruals	2,911	4,920
Non-NHS and Other WGA payables: Revenue	3,804	5,747
Non-NHS and Other WGA payables: Capital	57	31
Non-NHS and Other WGA accruals	29,202	27,948
Social security costs	191	171
Tax	173	139
Payments received on account	-	10
Other payables and accruals	797	1,159
Total Trade & Other Payables	**48,875**	**42,501**

Non-NHS and Other WGA accruals includes £15.1m Prescribing accrual, £5.6m in relation to Primary Care, £5.2m Continuing Healthcare accruals and £1.2m in relation to Non-NHS contracts (31 March 2018: £15.6m Prescribing accrual, £4.8m in relation to Primary Care, £5.2m Continuing Healthcare accruals and £1.1m in relation to Non-NHS contracts).

Other payables include £238k outstanding pension contributions at 31 March 2019 (31 March 2018: £221k).

11.1 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018

	Trade and other payables - NHSE bodies	Trade and other payables - other DHSC group bodies	Trade and other payables - external	Total
	£000s	£000s	£000s	£000s
Classification under IAS 39 as at 31st March 2018				
Financial Liabilities held at Fair Value Through Profit and Loss (FVTPL)	-	-	-	**-**
Financial Liabilities held at Amortised cost	440	7,776	33,965	**42,181**
Total at 31st March 2018	**440**	**7,776**	**33,965**	**42,181**
Classification under IFRS 9 as at 1st April 2018				
Financial Liabilities designated to FVTPL	-	-	-	**-**
Financial Liabilities mandated to FVTPL	-	-	-	**-**
Financial Liabilities measured at amortised cost	440	7,776	33,965	**42,181**
Financial Liabilities measured at Fair Value Through Other Comprehensive Income (FVOCI)	-	-	-	**-**
Total at 1st April 2018	440	7,776	33,965	**42,181**
Changes due to change in measurement attribute	-	-	-	**-**
Other changes	-	-	-	**-**
Change in carrying amount	-	-	-	**-**

12 Provisions

	Current 2018-19 £'000	Current 2017-18 £'000
Legal claims	-	5
Total	**-**	**5**

	Legal Claims £'000	**Total £'000**
Balance at 01 April 2018	**5**	**5**
Arising during the year	-	**-**
Utilised during the year	-	**-**
Reversed unused	(5)	**(5)**
Unwinding of discount	-	**-**
Change in discount rate	-	**-**
Transfer (to) from other public sector body	-	**-**
Transfer (to) from other public sector body under absorption	-	**-**
Balance at 31 March 2019	**-**	**-**

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them.

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 2019 is £100k (31 March 2018: £505k).

13 Contingencies

	2018-19 £'000	2017-18 £'000
13.1 Contingent liabilities		
NHS Resolution employee liability claim	-	1
HMRC review	-	3
Net value of contingent liabilities	**-**	**4**

14 Commitments

14.1 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:

	2018-19 £'000	2017-18 £'000
In not more than one year	1,266	1,339
In more than one year but not more than five years	-	1,266
In more than five years	-	-
Total	**1,266**	**2,605**

The NHS Sheffield Clinical Commissioning Group has one non-cancellable contract whose full cost exceeds £1m and is with eMBED Health Consortium to provide IT support and Business Intelligence services. The financial commitment at 31 March 2019 is £1,187k (31 March 2018: £2,413k).

15 Financial instruments

15.1 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 NHS Sheffield Clinical Commissioning Group and internal auditors.

15.1.1 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.

15.1.2 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.

15.1.3 Credit risk

As the majority of the NHS Sheffield Clinical Commissioning Group's revenue comes parliamentary funding it 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.

15.1.4 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 and is not, therefore, exposed to significant liquidity risks.

15 Financial instruments cont'd

15.2 Financial assets

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

For 2017-18 comparatives please refer to note 9.2.

15.3 Financial liabilities

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

16 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	880,051	(3,122)	**876,929**	11,892	(48,875)	**(36,983)**

During the year NHS Sheffield Clinical Commissioning Group paid £416,052k, approx. 47% of total expenditure, (2017-18: £401,900k approx. 47%) to Sheffield Teaching Hospitals NHS Foundation Trust for the purchase of healthcare and other services provided.

17 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 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 the joint commissioning of Mental Health Activity. During 2018-19 a Memorandum of Agreement has been in place to enter into a tripartite risk share including Sheffield Health and Social Care NHSFT.

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:

	2018/19			2017/18		
	NHS Sheffield CCG	Sheffield City Council	Total	NHS Sheffield CCG	Sheffield City Council	Total
	£'000	£'000	£'000	£'000	£'000	£'000
The Better Care Fund	266,273	181,890	**448,163**	256,921	169,830	**426,751**

The CCG net contribution to the Better Care Fund for 2018/19 shown above is included within the expenditure recorded in note 5 to these accounts (Services from foundation trusts £187.7m; Purchase of healthcare from non-NHS bodies £57.2m; GPMS/APMS and PCTMS £1.0m; Services from other CCGs and NHS England £0.11m; Purchase of Social Care £20.2m; and Employee Benefits £0.02m).

The memorandum account for the pooled budget is:

The Better Care Fund	**2018-19**	2017-18
Income	**£'000**	£'000
NHS Sheffield Clinical Commissioning Group	266,273	256,921
Sheffield City Council	181,890	169,830
	448,163	**426,751**
Allocation of expenditure		
Theme 1 - People Keeping Well in their Local Community	(11,283)	(9,033)
Theme 2 - Active Support and Recovery	(58,548)	(51,458)
Theme 3 - Independent Living Solutions	(8,249)	(6,303)
Theme 4 - Ongoing Care	(186,738)	(186,410)
Theme 5 - Adult inpatient Medical Emergency Admissions	(69,306)	(65,177)
Theme 6 - Mental Health	(110,497)	(105,637)
Theme 7 - Capital Grants	(3,542)	(2,733)
	(448,163)	**(426,751)**

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

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 Department is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, NHS Sheffield Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Sheffield City Council.

18 Related party transactions cont'd

Prior Year Comparator 2017-18:

Name & Role of Individual	Related Parties for which transactions made & Role of Individua	Purpose of Payment/Receipt	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
A Afzal, Locality Appointed GP (to 30 September 2017)	Duke Medical Centre - Senior Partner	Contract Payments/Locality Reimbursement	796	0	62	0
	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	3,908	(37)	147	0
N Anumba, Locality Appointed GP	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	3,908	(37)	147	0
	Woodhouse Health Centre - GP Partner	Contract Payments/Locality Reimbursement	1,484	(0)	119	0
	Woodhouse Healthcare Services Ltd - Director	Contract Payments	5	0	0	0
N Bates, GP Elected Member	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	3,908	(37)	147	0
	Porterbrook Medical Centre - GP Partner	Contract Payments/Locality Reimbursement	2,132	(1)	132	0
	Sheffield Hallam University - Practice is the provider of Occupational Health Services	Mentorship/Scoping Work/Contract Payment	16	0	0	0
	Rivelin Healthcare Ltd - Minority Stakeholder	Contract Payments	44	0	5	0
G Chetty, Locality Appointed GP (from 1 October 2017)	The Mathews Practice - GP Partner & provides Minor Surgery for Sheffield surgeries	Contract Payments/Locality Reimbursement	1,063	0	68	0
M Gamsu, Lay Member	Sheffield Citizens Advice - Chair	Contract Payments	185	0	0	0
	Darnall Wellbeing - Committee Member	Contract Payments	127	0	111	0
	Leeds Beckett University - Professor, Institute for Health Development	Tuition fees for member of staff	1	0	0	0
	Voluntary Action Sheffield - Trustee	Contract Payments	79	0	0	0
T Hudsen, GP Elected Member	University Health Service - GP Principal	Contract Payments	2,076	0	72	0
J Joyce, Locality Appointed GP (from 6 March 2018)	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	3,908	(37)	147	0
	Pitsmoor Surgery - GP Partner	Contract Payments/Locality Reimbursement	1,322	0	83	0
	Foundry Medical Group - Board & Executive Member	Matched funding support - GPN Ready Scheme	24	0	0	0
A Majoka, GP Elected Member	Primary Care Sheffield - Practice is a Shareholder in PCS and GP for Cardiology & Gynaecology	Contract Payments	3,908	(37)	147	0
	Abbey Lane Surgery - GP Principal	Contract Payments/Locality Reimbursement	283	0	15	0
Z McMurray, Medical Director	Woodhouse Healthcare Services Ltd - Shareholder	Contract Payments	5	0	0	0
T Moorhead, Chair of the Governing Body	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	3,908	(37)	147	0
	Oughtibridge Surgery - Senior Partner	Contract Payments/Locality Reimbursement	798	0	40	0
	Rivelin Healthcare Ltd - Minority Shareholder	Contract Payments	44	0	5	0
	Sheffield Local Medical Committee - Executive Member	Statutory & Voluntary Levy	242	0	0	0
	Baslow Road Surgery - Sibling is GP Partner	Contract Payments/Locality Reimbursement	1,453	0	104	0
M Ruff, Accountable Officer	Worklife Company - Occasionally see Director	OD Services	47	0	0	0
M Sloan, GP Elected Member	Primary Care Sheffield - Practice is a Shareholder in PCS	Contract Payments	3,908	(37)	147	0
	Sloan Medical Centre - GP Principal and Lead GP Gastroenterology Community Service	Contract Payments/Locality Reimbursement	1,441	0	88	0
L Sorsbie, Locality Appointed GP (to 05 March 2018 - on sabbatical)	Firth Park Surgery - GP Partner & Salaried GP	Contract Payments/Locality Reimbursement	1,015	0	69	0
P Taylor, Lay Member (Deputy Chair from 10 November 2017)	HFMA - Honorary Fellow and Non Executive Director and Lay Member Faculty Chair	HFMA Conference Fees	3	0	0	0

19 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 2018-19 Number	**Total Value of Cases 2018-19 £'000**	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Administrative write-offs	-	-	-	-
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**-**	**-**	**-**	**-**

Special payments

	Total Number of Cases 2018-19 Number	**Total Value of Cases 2018-19 £'000**	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Compensation payments	-	-	-	-
Compensation payments Treasury Approved	-	-	-	-
Extra Contractual Payments	-	-	-	-
Extra Contractual Payments Treasury Approved	-	-	-	-
Ex Gratia Payments	2	1	1	2
Ex Gratia Payments Treasury Approved	-	-	-	-
Extra Statutory Extra Regulatory Payments	-	-	-	-
Extra Statutory Extra Regulatory Payments Treasury Approved	-	-	-	-
Special Severance Payments Treasury Approved	-	-	-	-
Total	**2**	**1**	**1**	**2**

20 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:

	2018-19 Target	**2018-19 Performance**	2017-18 Target	2017-18 Performance
Expenditure not to exceed income	880,187	880,171	859,715	853,335
Capital resource use does not exceed the amount specified in Directions	120	120	120	120
Revenue resource use does not exceed the amount specified in Directions	876,945	876,929	854,332	847,952
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	12,778	10,011	12,722	10,372

21 Effect of application of IFRS 15 on current year closing balances

There has been no material impact on the application of IFRS 15 on current year closing balances.