NHS Sheffield
Clinical Commissioning Group

70 YEARS OF THE NHS 1948 - 2018

NHS Sheffield Clinical Commissioning Group
Annual Report and Accounts 2017-2018

NHS Sheffield Clinical Commissioning Group Annual Report 2017/18

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PERFORMANCE REPORT

Maddy Ruff

Accountable Officer

24 May 2018

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, our Accountable Officer

This is a special year for the NHS as it marks its 70th anniversary and we thought it would be a great opportunity to celebrate the many good things going on with our partner organisations for the people of 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. I believe through working with our partners over the last 12 months we are bringing about real benefits for local people.

Developing services in local communities is still a key priority for us. We are continuing to develop our neighbourhood model, whereby GP practices have joined together to form 16 groups across the city in order to make the best and most effective use of our local services.

Primary care services such as your GP practice, community pharmacist and optician(s) are your first point of call. 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. GP receptionists are being trained as Care Navigators helping to steer patients towards the best services to meet their needs. The pilot has been very well received by patients and is currently being rolled out across the city. You can read many examples of this in the report.

Our Active Support and Recovery Programme aims to provide joined-up services in the heart of each Sheffield community, aiming to prevent avoidable hospital admissions, making sure those patients with ongoing complex health care needs can be supported to live at home and maintain their independence for as long as possible.

In December last year I was proud to open the Sheffield cancer information hub which is a service provided from a market stall in the Moor Market. The aim of the hub is to offer a ‘front door’ into local cancer services to people who might not access traditional health care services.

The cancer hub is a place where people can pick up information and talk to a friendly, knowledgeable person. It is a non-clinical environment that does not duplicate the support they can get from their GP or clinical team, but instead offers a place to go to for advice and to speak to someone who understands the impact of a

cancer diagnosis. It can help the person navigate their way through the different services they might benefit from.

In mental health, the council, CCG and Sheffield Health and Social Care NHS Foundation Trust have started to work in an integrated way, breaking down the traditional commissioner and provider split to work together to plan and deliver services, which is what we are aiming to achieve with the Accountable Care Partnership.

This year we've worked with our partners to provide more support for young people in our city schools, through an innovative approach to emotional wellbeing and mental health. We also worked together to develop a new suicide prevention strategy for young people and we are delivering more treatment at home for people with mental health problems, instead of in hospital.

I'm proud to say that we are also among the best performers in England, meaning that people in Sheffield have some of the lowest waiting times in the country for elective (planned) treatment.

The main measure of performance for elective (non-urgent) treatment is the incomplete waiting list which measures the numbers of people still waiting for treatment and the length of time they have waited from the date they were referred. At the end of February 2018, 95.6% of Sheffield CCG patients still waiting for treatment had waited less than 18 weeks. This is the best performance in England, with Sheffield patients also having the second lowest average (median) waiting time at 4.6 weeks. You can read more about our performance in the performance analysis section of this report.

Of course, this has been a challenging year financially mainly due to the rising costs of healthcare, an ageing population and we are also seeing a rise in people with long term conditions. We need to make sure we spend every penny wisely and don't spend more than we have available - and this means having to make some difficult decisions.

This makes us work even harder to see how we can continue to reduce waste and be more efficient, as well as looking at different ways of working with some other organisations in the city.

We hope the city will soon start to see the benefits of stronger partnership working and a true team effort to further improve health and wellbeing for all the people of Sheffield.

Maddy Ruff

Looking back at general practice - Message from our Chair

To celebrate the NHS 70th birthday this year our Chair Dr Tim Moorhead talks about the developments he has seen in general practice since he started 20 years ago and how working as a GP has changed over the years. Tim is a GP and Senior Partner at Oughtibridge Surgery.

"When I first started it was remarkable to have a patient reaching 100, but it is not that unusual now."

I think many GPs would agree that the most overwhelming difference to being a GP in 2018 compared to 20 years ago is how much busier it is now. When I first started, a typical day would be doing a morning surgery, finishing at 11am and making my house calls. Then I would go home to spend some time with the children and be back at the practice for evening surgery.

Now we start at 8.30am and usually do straight 12-hour day. More people are living longer now but often with one or more long-term conditions - there are more interventions we can make now and more medications, some which require intense monitoring.

Over the years the illnesses and conditions I have seen have also changed. In the early days we used to see a lot of emergency cases such as heart attacks but people know now to call an ambulance.

These days it is also common to see diagnosis of attention deficit hyperactivity disorder (ADHD) in children, whereas when I first started there wasn't any diagnosis of this. One theory is that ADHD itself is not becoming more common, but that we are just more aware of it now and have the skills to recognise it.

When I first started it was remarkable to have a patient reaching 100, but it is not that unusual now. Due to the ageing population, and other lifestyle factors, we are seeing more cancer now but as people are more likely to talk about symptoms and go and see a doctor and with more advanced detection and treatment we are seeing an improvement in cancer survival rates.

Mental health diagnosis and treatment has also improved over the years with more talking therapies and effective medication with fewer side effects available. It has always been a feature of general practice but people spoke less about it, particularly men. We still have a way to go and it will be a challenge for us over the coming years.

We've also seen a big change when it comes to smoking. When I first started it was not unusual for some doctors to smoke during consultations! People are much more

aware of the health risks of smoking now so it is less prevalent and one of the reasons why people are living longer.

When I started we had more of an extended primary health care team working with health visitors, district nurses, midwives and psychiatric nurses. Because of reorganisations and how fragmented health services have become a lot of this has become lost and is more distant from primary care now. This is one of the reasons why we have launched our 'neighbourhoods' way of working as it will help us rebuild our teams, as well as addressing the increase in workload.

The single biggest innovation in my time as a GP is the computer which has changed everything we do in primary care including patient records, prescribing and contractual arrangements such as how we are paid. All of this now depends on IT.

Also when I first started, practice management was in its infancy. Now it's essential to have a good practice manager as they oversee everything from running the practice, preparing us for Care Quality Commission inspections to employment law.

For most people the GP practice is their first port of call, and this has always been the same. It's a well-established, trusted model that patients like and rely on and it has been a great success in Sheffield. It's now important that we build on and invest in this.

Finally, there's a much greater awareness now of the cost of care to the tax payer. It's not just doctors and nurses who are aware but patients too. Even though there is more money going into the NHS now than when I started, compared to the increase in need and the additional services we provide, there is just not enough to go round. Because of this we have to keep examining how we spend the money we have to make sure we spend it in the most effective way.

Dr Tim Moorhead

"The single biggest innovation in my time as a GP is the computer which has changed everything we do."

"Mental health has always been a feature of general practice but people spoke less about it, particularly men. We still have a way to go and it will be a challenge for us over the coming years."

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 82 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 aims

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

Our organisational objectives 2017/18

- 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 Accountable Care System to develop sustainable integrated care models and be recognized as a system leader for public sector reform. To find out more about us and our work, please visit www.sheffieldccg.nhs.uk

Key Risks

Our Governing Body Assurance Framework (GBAF) enables the organisation to have a clear view of the risks and issues affecting the achievement of our aims and strategic goals, how those risks are being mitigated, the likelihood of occurrence and their potential impact. As at March 2018, there were 17 risks identified on the GBAF (1 very high risk, 6 high risks and 10 medium risks). No new risks were added during the year and no risks closed. More information on our Governing Body Assurance Framework is provided in the Governance Statement as part of this annual report.

Finance at a glance

Despite the increasing financial constraints and demands placed upon the local healthcare system, we have again achieved our statutory financial duties as an NHS commissioning organisation, ending the year with our required financial surplus of **£6.4m** (£18m if the brought forward surplus of £11.6m is included). This is made up of:

- In year planned surplus **£1.6m**
- Additional savings **£1.1m** associated with national pharmaceutical pricing changes (which NHS England require CCGs to add to the year-end surplus)
- As set out in the 2017/18 NHS Planning Guidance, CCGs were required to hold a 0.5 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means. In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 0.5% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Sheffield CCG has released its 0.5% reserve to the bottom line, resulting in an additional surplus for the year of **£3.7m**. This additional surplus will be carried forward for drawdown in future years.

CCGs are expected to hold a 1% cumulative surplus (£7.7m for NHS Sheffield CCG). Any amount in excess of this should become available for use in future years, subject to NHS England planning rules.

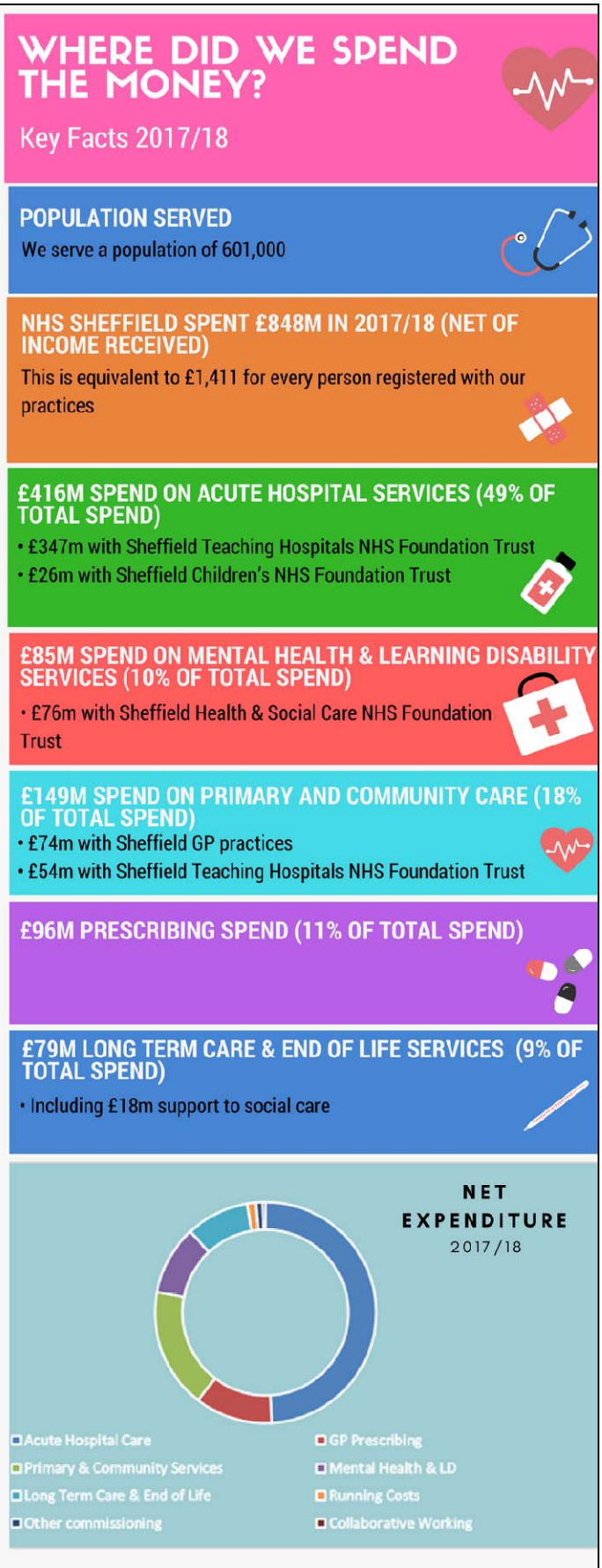
Financial Performance

Our programme allocation, which we use to commission health care services for the people of Sheffield, was £853m. Our actual spend was £837m (an underspend of £16m).

Overall, we spent an average of £1,411 on health care for the people of Sheffield (compared to £1,388 per person for 2016/17). 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 £12.7m. This is used to fund the commissioning and governance costs and clinical engagement activities of the CCG and its Localities. In 2017/18, our actual spend was £10.5m (an underspend of £2.2m). This equates to £17.50 per head of population (compared to £19.79 per head in 2016/17).

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



A quick lookback 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 lookback at some of the achievements of 2017/18.

Sheffield's Springboard Cafés

"I was made very welcome. I love it; it feels like a new start for me, the people are fantastic and make me feel welcome." Café user from the Parsons Cross Learning Zone

In collaboration with Sheffield City Council, we supported the launch of three 'Springboard Cafés' across the city. They are designed to help people who are feeling low, isolated, anxious or struggling to manage their mental wellbeing.

They provide a place for people to come along, have a chat about their situation and find out what support is available to help them move forward. The café-style setting aims to create a friendly atmosphere, where people can meet, receive advice, and feel encouraged to try new things.

David Luck, Mental Health Commissioning Officer for Sheffield City Council, said: Our 'Springboard Cafés' offer a safe and positive place for people with low level mental health conditions to access friendship and support. At the heart of the cafes are trained, volunteer recovery coaches, often with lived experience. Sean is one of these recovery coaches – the cafés moved him from severe depression (which led him to consider suicide), to a place of hope for his future."

Reducing social isolation

We have been working closely with the 'Age Better Programme' in Sheffield, a National Lottery funded initiative, which is helping to reduce social isolation and loneliness for thousands of older people in the city.

Social isolation and loneliness are two of the biggest public health challenges facing our society. The National Lottery funded 'Age Better in Sheffield' Programme, led by South Yorkshire Housing Association, has been set up to reduce this. Local volunteers are working with isolated and lonely people over the age of 50 and by 2021 we aim to empower over 25,000 people to reduce their social isolation and loneliness.

By intervening early, people will be less isolated and more actively involved in their communities. They also won't have to depend on other services that may not be the right service to help them. Visit the Age Better in Sheffield website www.agebettersheff.co.uk/

Putting patients at the heart of decisions

There is a lot of work going on in Sheffield to promote Person Centred Care, which sees patients as equal partners in planning and developing their care. It involves

putting patients and their families at the heart of all decisions to make sure the care is the best it can be and fits individual's needs.

We encourage people to think about what really matters to them and using a questionnaire called the 'Patient Activation Measure' we help people to identify their own knowledge, skills and confidence to manage their own health and wellbeing. This helps us to tailor and adapt our support to meet their individual needs - moving away from a 'one size fits all' approach.

Last year 69 out of the city's 86 practices took part in the local scheme aimed at developing this approach. Working with colleagues from across the NHS, voluntary services and social care 17,000 people have benefitted from this approach. 12,000 Patient Activation Measure questionnaires were captured in the year.

Empowering patients

A new telephone service puts patients through to fully-trained receptionists, who are able to point them towards the best and quickest service for their specific health needs.

Chapelgreen Practice (Burncross Surgery and High Green Health Centre) introduced the new care navigation system for 2017. We provided both online and face-to-face training citywide for staff, with the aim of rolling out the service further across the city.

Through the new system, receptionists are able to advise whether patients can access healthcare directly (through opticians, pharmacies, nurses, family services, support groups etc.) without having to see a GP first. This means that as well as patients receiving the care they need more quickly, the care navigation system aims to reduce GP waiting times, for when seeing a GP is the appropriate course of action.

Kathy Peasegood, Deputy Manager of Chapelgreen Practice, said: "We've received a positive response from patients and we are passionate about improving the service based on patient and staff comments as we move forward. One of the most positive outcomes has been building better relationships with patients, who no longer see receptionists as a barrier to accessing healthcare, but as facilitators."

A new point of contact for families

Just over a year ago we commissioned a new service for children called a rapid access clinic. The clinic at the Sheffield Children's Hospital is a point of contact for GPs when they are concerned about a child, and would like the opportunity for them to be seen by a team that includes a senior general paediatrician.

The rapid access clinic is for conditions that might otherwise have needed seeing on the acute assessment unit, and would have possibly led to a short stay in hospital. GPs have welcomed the new service where children can be assessed and monitored. The types of illnesses and conditions they are referred for include non-surgical stomach pain, persistent diarrhoea with weight loss, faints and funny turns. It

ensures that children are seen in the right place at the right time by the right health professional.

In many cases, children referred to the clinic do not need to be admitted after they have been assessed and monitored - but it gives their families the reassurance they need. It also helps avoid adding extra pressure onto A&E and also avoid unnecessary admissions into hospital.

Advanced Nurse Practitioners

Julie Lingard is one of the new Advanced Nurse Practitioners in the city. They are trained to determine exactly what a patient needs (a process called triage), and have the skills and expertise to diagnose and provide treatment where appropriate. They can also refer patients to GP and other services if necessary.

The result of having more Advanced Nurse Practitioners is that people can get the care they need as quickly as possible, often without having to wait to see a doctor. This also frees up doctors, so they can spend more time with patients who need a greater level of support.

Julie splits her work between Dovercourt Group Practice and Handsworth Medical Practice, making sure her time is well spent and that she helps as many patients as possible. She talked to us about the best bits of being an Advanced Nurse Practitioner: “Every day is different - I’ve been nursing a long time, but I’m learning something new every day. A lot of the time, the patients I see I can treat myself, rather than referring on to a GP.”

Supporting our practices

Dhaval Shah is one of 16 new Practice Pharmacists in Sheffield. Patients can now get expert advice on taking medication quickly and easily from these Practice Pharmacists, instead of doctors. This is making sure patients get one-to-one support with their medication, with the added benefit of reducing GP waiting room times.

The Practice Pharmacists are based in the GP practices themselves, and can help with all medication queries. They can also keep in touch with patients who have a long term illness or a regular need for advice and information.

Dhaval is passionate about sharing his skills to benefit both patients and GPs: “Before I started at Sothall Medical Centre, the GPs often didn’t go home until 10pm. Introducing Practice Pharmacists like me has increased the variety of skills available, and now doctors are able to go home at a normal time. I think that’s a big benefit for everyone in the surgery, as well as for patients.

“Freeing up doctors time for more complex appointments is how we see the future.”

Developing inspirational mentors

Dawn Russell is one of 20 new Nurse Mentors in the city. The Mentor role involves teaching and supporting student nurses, ensuring that the next generation feel

confident in supporting GP practices and delivering excellent patient care. Their role is vital to the future of nursing.

Bringing students into GP practices, Nurse Mentors help them to translate theory into practice, and turn what is learned in the classroom into reality. They are required to create great relationships with student nurses, empower their learning, and provide a positive space for feedback.

Dawn has found becoming a Nurse Mentor a rewarding and natural addition to her everyday role: “I do a lot of practical work, and students used to sit in with me anyway. I thought that I might as well become a mentor - I’m already teaching, I’m encouraging, I’m supporting, so I did it.”

Thanks to Dawn and her colleagues, GP practices are helping to make sure future nurses are confident in their skills and feel encouraged to get involved in general practice when they graduate.

In your neighbourhoods

The healthcare services in Sheffield are linked to 16 separate neighbourhoods, responsible for developing tailored services to meet the specific needs of the population living within them.

The GP practices in a neighbourhood are the key coordinators of primary health and care needs, and will develop services in partnership with community nursing, social work and voluntary sector groups.

Some of the services developed so far include enhanced case management in the community, promoting Digital Literacy for people with long term conditions, social prescribing and the ‘Dance to Health’ scheme, that supports people who are at risk of falling.

There is evidence that these partnerships between primary, community, social and voluntary care groups are creating a year-on-year reduction in inappropriate admissions to hospital. The amount of care delivered comfortably in people’s homes is increasing.

Dancing to health

‘Dance to Health’ is a new health and fitness programme for older people, with sessions led by fully trained professionals and tailored to the needs and requirements of those taking part.

Falls are extremely traumatic for older people and the ‘Dance to Health’ programme helps to prevent the risk of falling by improving participants’ balance and flexibility. Combining evidence based exercise with the creativity and energy of dance, these gentle exercise classes also aim to provide an engaging, sociable way of staying fit and mobile.

After each session there is an opportunity to relax and catch up with other members over a cup of tea. Developed by Aesop, an arts charity and social enterprise, ‘Dance to Health’ is working in partnership with our CCG and Yorkshire Dance.

DNA Man combats missed appointments

Is it a bird? Is it a plane? No it's DNA Man - Sheffield's very own superhero sent to combat people not turning up for their GP appointments.

Missed appointments cost the NHS money and drive up waiting times for other patients. Staff from Chapelgreen GP practice, together with children from Ecclesfield School, came up with DNA Man as a fun campaign to raise awareness about this important problem that affects all practices from time to time.

Early signs show that DNA Man's message of 'Can't make it? Cancel it!' is already having a positive impact so much so that the campaign has gone citywide. Sharing Chapelgreen's hard work to tackle these challenges across all Sheffield practices saves money and means all patients can benefit from better access to local care.

Supporting young people

We have helped develop a suicide prevention ‘pathway’ for young people this year, which establishes better links between child and adolescent mental health services and schools. The pathway has also introduced training for schools, support for those affected, tools for practitioners and a one-stop-shop for advice and counselling service for young people up to the age of 25.

Dr Steve Thomas, Clinical Director of the Mental Health, Learning Disabilities and Dementia said: “We recognise how important it is to promote good mental health early in peoples’ lives. Providing an easily accessible, safe place to talk and to get help is a vital part of our work with young people.”

Keeping patients in their communities

A simple new system has meant around 2,500 patients have been treated in their local community, instead of having to go to hospital.

In seven areas of care, the elective care team introduced a process where, if a GP feels a patient needs to be referred to hospital or a specialist clinic, the patient’s case is reviewed by a GP with particular interest in that area. It’s known as CASES - Clinical Assessment, Services, Education and Support.

Because of their knowledge and interest, the second GP may be able to suggest an alternative treatment, further investigation or confirm that the referral is the best way forward, helping patients get the most appropriate care as quickly as possible. The best thing about this is that it is clinically led, designed by doctors for doctors, and gives GPs feedback they can use next time they see someone with the same problem.

The benefits we are seeing so far include avoiding unnecessary hospital appointments and reducing avoidable referrals to hospital - so better care for patients and resources better used for your NHS.

‘Pop-up’ cancer information hub

This new hub brings together a host of the city’s best loved good causes including Age UK Sheffield, Cavendish Cancer Care and the Cancer Support Centre to provide much needed information to customers.

Maddy Ruff, our Accountable Officer said: “We are delighted to be supporting the pop up cancer information hub. By having it in this busy area of the city centre we hope it will raise awareness of the services available to people affected by cancer amongst communities that would not typically access them but who face some of the worst experiences of cancer.”

The Moor Market innovation was the brainchild of Macmillan Nurse Louise Metcalfe: “Having the shop at the Moor Market is an ideal place for people to talk about cancer and find out about some of the fantastic services available across Sheffield. People can feel intimidated walking into a GP surgery or hospital setting and asking for help. Our shop is completely informal and we just want people to pop in for a chat with us while they’re picking up their shopping.

Funded by a Macmillan Cancer Bid, the cancer hub aims to empower all patients across the city to live the best lives possible at all stages of their cancer journey.

Coordinating services closer to home

The virtual ward is a team of health, care and community professionals linked to a specific group of GP practices who work together to coordinate care for people in their local community. The core team includes a GP, service coordinator (ward manager), community nursing, community support workers and the voluntary sector.

The team works together to identify the patients in their local community who will benefit from the virtual ward way of working and then identifies the level of care they need for their needs. The work started as a pilot at Dovercourt Practice off City Road, and has been rolled out to another 21 practices in central Sheffield. Working together to support these patients with complex care needs means we can help ensure that they are supported to stay at home wherever possible and avoid the distress of hospital admissions again and again and often for long periods of time.

For a person with complex health conditions, a virtual ward is about better self-care, self-awareness and confidence to handle common flare ups at home. For GP practices, a virtual ward provides a consistent, active approach to caring for people with the most complex medical and social needs in the community, rather than reacting to problems when they have happen and at a point where it could lead to multiple hospital admissions. This is good for the patients and good for the NHS.

Did you know? Sheffield Hallam University and The University of Sheffield medical centres are working in partnership to hold a bi-monthly clinic for students with type 1 diabetes. The clinics bring essential check-ups and tests into the student neighbourhood, making these services easier to get to.

Performance Analysis

How we performed

Key successes in 2017/18

- We continue to deliver the 18 week waiting time from referral to first treatment standard, as required by the NHS Constitution.
- We are delivering more treatment at home for people with mental health problems than the target we had planned for (as an alternative to a hospital setting).
- We continue to deliver the standards around the two week wait for suspected cancer (wait from referrals to first appointment).
- NHS England assessed us as a "Good" CCG, based on our performance in the previous year (2016/17).
- There have been no cases of MRSA attributable to the CCG in year, and Sheffield Teaching Hospitals NHS Foundation Trust has maintained a very low number of cases, as well as significantly reducing the number of cases of Clostridium Difficile in the hospital.
- In line with national requirements, we have made significant progress on carrying out assessments for Continuing Health Care outside a hospital setting (evidence shows 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).

Delivering on our performance standards

We are responsible for ensuring that that the services we commission (plan, buy and monitor) meet local needs and national standards around quality, safety and access (how long patients wait to be seen and treated). We make sure that we work within the frameworks set out by NHS England, for example the priorities set out for us in the annual Planning Guidance, and the national standards set out in the NHS Constitution.

Quality standards are written into our service specifications and we monitor our providers against these, using our contract processes which follow a nationally agreed format. Our Intelligence and Performance Assurance teams use national and local data sets to monitor activity, achievement of targets and to highlight quality issues. Any concerns regarding performance are addressed with the provider and actions to ensure improvements are agreed and monitored.

Our organisational performance: The CCG Improvement and Assessment Framework (IAF)

CCGs are assessed annually by NHS England and rated for how well they are fulfilling their function of commissioning safe, good quality, sustainable services and compassionate care. NHS England uses the CCG Improvement and Assessment Framework (IAF) – which rates CCGs as either *Outstanding, Good, Requires Improvement* or *Inadequate*.

The framework covers three domains - better health and healthcare; quality of leadership; and financial sustainability. There are 51 indicators which cover a wide range of areas, including: Injuries from falls in older people, appropriate prescribing of antibiotics, access to primary care, and one-year survival from cancers. The framework also examines how the CCG is run, looking at corporate governance and relationships with local partners.

NHS Sheffield CCG was awarded a rating of "Good" for the year 2016/17. The CCG was assessed as in the top 25% of performers for a number of indicators, including education support for people newly diagnosed with diabetes, diagnosis of dementia in primary care, providing local care for people with complex mental health problems, patient experience of cancer care, waiting times for hospital treatment and the quality of our leadership.

Our year-end assessment for the year 2017/18 is expected to be published in July 2018 and will be announced on our website.

Our performance against the full range of indicators is expected to be available to the public on the My NHS website at www.nhs.uk/service-search/Performance/Search.

How did we perform in 2017/18?

1) NHS Constitution core rights and pledges

The NHS Constitution sets out a number of pledges to patients about their care. We hold our providers to account on their delivery of these pledges and we work with them to create remedial plans when there are shortfalls.

This is the position as at April 2018 - full data is not expected to be available until July. The CCG reports each month on the Constitutional standards and other key performance indicators every month in the "Performance, Quality and Outcomes Report" which can be found with the Governing Body papers, published on our website.

NHS Constitution Rights and Pledges overview for 2017/18	Did we meet the standard?	Comparison with how we performed in 2016/17	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 Foundation Trust (STH NHS FT) continues to be our most challenging issue (in common with many other communities). The winter period saw high numbers of seriously ill patients presenting at A&E, with complex needs. The CCG has worked closely with the Trust, with primary care and colleagues in the City Council to find "whole system" solutions to ensure patients can access unscheduled care in other settings as alternatives to hospital (eg the primary care "hubs"), as well improving the flow of patients into the hospital from A&E, and timely discharge, which frees up beds for further admissions. Sheffield Children's NHS Foundation Trust has delivered the four hour standard in 2017/18.
Waiting times for elective treatment • 92% of all patients should wait less than 18 weeks for their treatment to start	✓	=	We remain in a strong position on delivery of this target.
• No patients wait more than 52 weeks for treatment to start	☒	=	A very small number of Sheffield patients (fewer than 10) waited longer than 52 weeks for their treatment; in some cases this 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 have been issues with a small number of diagnostics tests at STH NHS FT which have led to some patients waiting longer than the six-week standard. Some of these problems relate to national staff shortages. We have been working with the Trust to remedy this.
Waiting time for Cancer treatments & diagnostic tests • There are nine separate waiting time pledges for cancer which address how long patients should wait for various parts of their treatment journey	✓	=	We continue to deliver well on seven out of the nine standards, as per the previous year. There continue to be challenges around the 62 day pathways, which often reflect more complex cases and transfer between providers. We are working with partner CCGs and neighbouring Trusts in South Yorkshire and Bassetlaw to improve performance in this area.

Mental Health • 95% of patients discharged from psychiatric inpatient care followed up by Mental Health Services within seven days, to ensure that they have appropriate care and support. IN ADDITION TO THE STANDARD ON SEVEN DAY FOLLOW UP, WE ALSO MONITOR FOUR OTHER KEY INDICATORS IN MENTAL HEALTH SERVICES	☒	⇩	Year to date performance in February 2018 was 92.79% compared to the standard of 95%. The CCG's mental health team and Clinical Director are working with Sheffield Health and Social Care NHS Foundation Trust to explore how this can be improved.
• 50% of people referred to the Early Intervention in Psychosis Services should be seen within two weeks	☒	⇩	This target has not been met consistently every month this year. Additional investment has been made by the Trust and this will be continued by the CCG in 2018/19, in order to boost capacity in this service. New posts have been created.
• Proportion of Sheffield's population who are accessing local Improving Access to Psychological Therapies (IAPT) i.e. talking treatments. This is about the expected number of our local residents experiencing conditions such as depression and who could benefit from IAPT.	✓	=	Sheffield remains in a strong position on this indicator.
• 75% of people referred to IAPT should wait six weeks or less until their first appointment; 95% of people should be seen within 12 weeks.	✓	=	Sheffield remains in a strong position on these indicators.
• 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

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

- **Mixed sex accommodation**: There have been a small number of occasions (eight breaches as at March 2018) where patients were cared for in a mixed sex environment. At times this was due to significant bed pressures associated with the peak winter period. Each case is investigated and a remedial plan required.

- **Operation cancelled on or after the date of admission, for non-clinical reasons to be offered another date within 28 days**: There 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 and handover times are also covered in the NHS Constitution. In common with many other ambulance services, our provider Yorkshire Ambulance Service (YAS) has not delivered these standards consistently.

The NHS is now moving to a new way of prioritising calls and measuring performance. Following an extensive review of the way ambulance services in England assess 999 calls and allocate a response, in July 2017 the Secretary of State for Health approved a number of changes, which are designed to ensure that the sickest patients receive the fastest response, and patients get the response they need first time.

The previous Red 1 and Red 2 national standards have been replaced by a new call prioritisation system which sets standards for all 999 calls to ambulance services, including those requiring an ambulance intervention passed to ambulance services via NHS 111. These two sets of standards are not comparable. In the new financial year (2018/19), CCGs will be reporting on a new indicator set which looks at a wider range of quality measures for ambulances.

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.

Commissioning services for the people of Sheffield

In 2017/18 the city continued to develop an Accountable Care Partnership 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. 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.

The strategic direction of travel and strategic priorities of the CCG reflects the recognition that services need to be sustainable and meet the needs of local people.

Through our neighbourhood development approach, we continue to work in partnership with primary care, community care, social care and other commissioning partners and providers to actively promote the development of sustainable care closer to patients' homes, reducing the need to travel to hospital where this is not necessary.

Within our planned care workstream we continued to implement a model of care that aims to support people to access care closer to home, self-care where possible, hospital where appropriate and specialist when needed in a specialist centre for best outcome.

Our Operational Plan for 2017–2019 sets out further details of these commissioning priorities and plans and how these were being developed in 2017/19 http://www.sheffieldccg.nhs.uk/our-information/documents-and-policies.htm

Others initiatives:

- Medicines management waste campaign
- Supporting Greener General Practice Initiative in primary care

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 2017/18 have included:

- Social value is included as a key requirement in tender documentation and specifications, maximising the influence we can achieve as a commissioner of services.

- Joint procurement of patient transport for renal services across South Yorkshire and Bassetlaw – the provider is using a fleet of new vehicles and a fleet management system to reduce carbon emissions and new approaches to reduce “did not attends” reducing wasted journeys.

- 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.

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 2017/18 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.

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:

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

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.

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 2017/18 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 court and hopefully promotes active means of transport for social and business travel over car journeys.

Facilities Management

NHS Property Services (NHSPS) manages our lease for the building from which we operate, as well as the utility costs, on our behalf.

We have been working with NHSPS to obtain our baseline position for electricity, gas, waste and water. The following tables indicate our estimated utilisation carbon footprint for gas, electricity, water and waste for 2017/18. Where the full year's data was not available a forecast based on performance this year has been applied.

Unfortunately, as the premises occupied by the CCG are part of a leasehold building NHSPS has not been able to obtain fully disaggregated data from the landlord of the building. After a discussion with the NHS Sustainable Development Unit, a calculated estimate performance information per meter squared has been applied.

Total Tenant Area (m2)	Consumption			Cost		
	Electricity (kWh)	Gas (kWh)	Water (m3)	Electricity (£)	Gas (£)	Water (£)
2,850	268,379	606,745	2,308	34,353	14,562	6,510

We will work further with NHSPS to obtain more accurate data of our utilities usage to establish a baseline for developing targets to reduce out carbon footprint during 2018/19. However steps that have been taken to reduce energy consumption within our offices include: Fitting presence/absence (PIR) detection to lighting systems and on-site recycling facilities.

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 2017 we recycled:

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

This reduced our carbon footprint by eight metric tonnes and saved 71 average sized trees.

We intend to use this data to set a baseline for reducing our carbon footprint and improving our resource utilization and recycling in future years.

Next steps

- Develop energy, water and waste baselines and reduction targets
- Develop a Good Corporate Citizen action plan
- 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

Ensuring high quality care is at the very heart of what we do. We want our city's residents to have a positive experience of care when they need it.

I became a nurse in the mid-1980s and throughout our training it was emphasised how important it was to listen to the patient's needs and to offer appropriate care and support as it was needed.

We collect lots of information to understand the quality of care we deliver but the patient voice has to be paramount. Hearing their experiences, both good and bad, helps us address individual needs and also to plan, buy and monitor high quality services for the city's residents.

We bring the voice to life at our Governing Body meetings which now start with a patient story – an opportunity for us to reflect on the journey some of our residents have experienced during their care. It also helps us continually focus on the patient as we make decisions as a group on behalf of the city.

And as we work more closely in partnership with other organisations, we can collectively look at an individual's needs and understand how we can jointly support them in their lives.

To do this we also need a skilled and knowledgeable workforce both within the CCG and across the wider system. Education and development continues to be an important part of this, supported by the use of research and best practice identified at a national level, to design high quality services for Sheffield.

Mandy Philbin, Acting Chief Nurse

For Pete's Sake

'For Pete's Sake!' is a new campaign that reminds all NHS staff, no matter what they do, to put themselves in the patient's shoes every step of the way.

Our Continuing Heath Care team was inspired to develop the campaign by listening to the experiences of Pete, a father and husband who sadly died in 2016. Pete had multiple sclerosis and in the later stages of his illness used a wide range of local health and care services.

His experiences helped him to identify some simple, small actions that can make significant differences to patients' quality of life. He was passionate about improving experiences for other people and his wife Sue is now campaigning to make this his legacy.

In every care setting '*For Pete's Sake!'* calls on health care professionals, commissioners and business support teams to take steps to make sure they're delivering the highest quality of support. Taking the time to listen to patients, thinking about the small things which can make a difference to each individual and using this information to improve experience for patients and carers to make a great difference.

Tackling antibiotic resistance

Health services in Sheffield have reduced the number of antibiotics prescriptions by nearly 12%. The reduction is an effort to combat antibiotics losing their effectiveness, which is happening at an increasing rate.

It is estimated that at least 5,000 deaths are caused every year in England because antibiotics no longer work for some infections, and this figure is set to rise. Experts predict that failure to take care of this problem will mean that in 30 years' time, antibiotic resistance will kill more people than cancer and diabetes combined.

Ian Hutchinson, NHS Sheffield Clinical Commissioning Group Medicines Management Pharmacist said: "To tackle antibiotic resistance, we've worked very hard to minimise the prescribing of antibiotics in situations where the use of them is likely to be of no or limited value. The number of prescribed antibiotic courses has been reduced by over 12% since 2012. This is a healthy reduction, which is in line with overall progress across the rest of the country."

Enhancing Care Homes

As part of our vision to know more and do more to support the health and wellbeing of older people living in care homes, we are working with care homes to develop a digital service to measure the health and wellbeing of elderly residents.

Using the new service, care home staff will be able to record a resident's nutrition, hydration, mobility, social activity and mental health. They will then be able to use the data at an individual level to monitor a resident's health and wellbeing. For example, we know that being dehydrated can lead to falls so this is a way of helping prevent that from happening. By preventing falls or other health problems it can also avoid residents having to go to hospital.

We also plan to use the data to monitor the health and wellbeing of whole care homes across the city, as well as helping plan for future care home services.

Overall this will improve the quality of residents' lives by keeping them well in their own home, standardise monitoring of residents' health and wellbeing across care homes and prevent admissions to hospital.

Did you know? We have been helping the city's care homes tackle infection prevention and control for their residents. We began to visit independent care homes in Sheffield in 2016, to audit practice and provide the support they needed to make improvements.

Continuing Health Care

In line with national requirements, we have made significant progress on carrying out assessments for Continuing Health Care (CHC) outside 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 since September 2017 no assessments have taken place in hospital.

This year the CHC team has also restructured the clinical workforce to ensure that assessments are completed within 28 days, which is also in line with national requirements. This ensures that patients are assessed and receive their eligibility outcome in a timely manner making a positive impact on patient experience.

Did you know? Our dietitians support care home staff to improve the treatment of malnutrition in care homes and to help staff provide appropriate texture modified diets to those who need them.

Electronic bed system

Working with the council, hospitals and care homes we have developed a new care home bed capacity portal - an online system where care homes can share their bed vacancies with social care teams and hospital discharge teams at the touch of a button.

In the past these teams had to call round care homes asking for bed availability. Now they have the information at their fingertips and can search for the most appropriate bed for the individual. This means that people can get out of hospital quicker, ensuring they get the care they need in the community and freeing up hospital beds for people who need them more.

It will also save staff time, cutting down on unnecessary calls to care homes so the staff can focus on caring for residents instead.

Did you know? With the support of our patients, this year we have achieved £2.3million in prescribing savings to be invested back in local healthcare provision.

Did you know? The Primary Care Development Nurse team worked with practices to optimise management of patients with diabetes. This helped to improve blood pressure, cholesterol and blood sugar control. This was part of a national project run by NHS England. The project included the general population and various community groups including taxi drivers.

Did you know? Our medicines management team was highly commended in national awards for their patient safety work ensuring the correct use of new blood thinning medication.

Support and advice over the phone

Our Prescription Order Line has expanded this year, and now offers a centralised telephone line for patients registered at 14 GP practices across Sheffield – serving around 130,000 patients. This telephone line allows people to order their repeat prescriptions over the phone, and aims to reduce the amount of unwanted medicines, improve patients' safety and promote health across Sheffield. A recent patient satisfaction survey highlighted that 93% of patients would recommend the service to friends and family.

Patients using the service have commented on its convenience and welcomed the chance to discuss any queries, with one even commenting that it was "the best idea the NHS has had in ages!"

In October, the team achieved another milestone for the service by managing over 125,000 calls since the service started in April 2016. Support Assistant Lizzie Hilbert said: "As a team we feel really proud to have achieved this milestone, and to have given all these patients a quality service."

Safeguarding

It can be a difficult topic to talk about, but our safeguarding team undertakes the important task of ensuring standards of care are met throughout the group and the wider health community.

They advise colleagues and safeguarding boards around child and adult protection, and have also expanded their support into the areas of domestic abuse, Prevent

(safeguarding people and communities from the threat of terrorism), modern slavery and human trafficking.

The team have also trained lots of staff, running two hugely successful events with over 400 colleagues from GP practices attending. They've provided advice and support to manage cases, both within the organisation and outside – including working with banks.

We assess and monitor performance of key quality issues in Sheffield against local and national standards and these are reported to our Governing Body.

This includes patient feedback, infection rates, serious incidents and safeguarding concerns. Our Quality Assurance Committee oversees this work on behalf of the Governing Body and monitors progress on any areas identified for improvement. You can find out more by visiting our website www.sheffieldccg.nhs.uk

A team effort for Sheffield

Accountable Care Partnership

Partnership working is developing well in Sheffield across the six organisations involved in providing and commissioning health and care services. In 2017 this was further enhanced through the establishment of the Accountable Care Partnership Programme Board and the appointment of the Accountable Care Partnership Programme Director, Rebecca Joyce, who started in post in January 2018. All partners have signed up to a vision of:

"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 care system"

The Accountable Care Partnership for Sheffield aims to deliver improved health and care outcomes, improved health and well-being and close the financial and efficiency gap across the Sheffield system. Underpinning these aims are the following ambitions:

- To support tangible improvements in local health and wellbeing
- To tackle persistent health inequalities
- To ensure the sustainability of the Sheffield care economy
- To support a happy, motivated and high-performing workforce
- To improve public engagement and empowerment

Within the ACP there are seven priority workstreams:

- Elective Care
- Urgent and Emergency Care
- Long term conditions
- Children's services

- Community, Well-Being and Social Value
- Primary Care
- Mental Health and Learning Disabilities

Key enabling work streams for the ACP, including finance, workforce, organisational development and digital, are currently under development. The ACP governance arrangements have been refreshed for 2018/19 in light of feedback. The ACP Board is moving to pursue the transformational agenda with greater pace. The vision, work and change approach of the ACP will be further developed for 2018/19.

Accountable Care System

We are a partner in Health and Care Working Together in South Yorkshire and Bassetlaw, developed from the previous Sustainability and Transformation Partnership (STP), which in June 2017 was named as one of the first Accountable Care Systems (ACS) in the country. As a partnership of 25 organisations, we are responsible for looking after the health and care of the 1.5 million people living in Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

Working together, the local ambition is to be better able to join up GPs and hospitals, physical and mental healthcare, social care and the NHS to give patients seamless care. Through partnership working, we all aim to make real and long-lasting improvements to the health of local people which individuals and organisations working alone would not be able to achieve.

In 2017/18 the governance of the ACS was strengthened. Whilst the ACS does not replace any legal, or statutory, responsibilities of any of the partner organisations, a number of groups discuss regional issues and agree how best to take things forward in collaboration.

From April 2018 the newly named Integrated Care System will begin to operate as a Shadow ICS, which means taking on additional responsibilities from NHS England and NHS Improvement around local system performance and transformation indicators.

Getting hospital patients home

We have worked with partners in the city to tackle the issue of delayed transfers of care - this is when patients are still in hospital when they don't need to be, but can't get home or into social care for a variety of reasons. This isn't good for the patient, their family or for the NHS. Jointly, the CCG has looked at the reasons behind the delays and developed systems to make sure big improvements are made. This has moved everyone away from working as separate teams in organisations, and towards working as a single team to get the right solutions for patients.

It is thanks to many dedicated staff from across the CCG, Sheffield City Council, Sheffield Teaching Hospitals NHS Foundation Trust, and Sheffield Health and Social Care NHS Foundation Trust that this important work has begun, and is ongoing: there's still more to do.

Our staff

Keeping healthy and well

We are committed to staff health and wellbeing and run a number of activities to support this, including a lunchtime pilates class, mental health first aiders, mindfulness sessions and an annual health and wellbeing week, organised by our Staff Forum.

Did you know? We have a Staff Forum that acts as a bridge between staff and senior management - a sounding board for ideas and developments

What our staff say

The latest results from our annual staff survey highlighted a number of areas where staff thought we were performing well as an employer, including recommending us as a place to work, having opportunities for staff to show initiative and being able to make suggestions to improve the work of their department. The areas where we didn't score as highly as we would have liked include having enough staff to carry out the work required and staff reporting musculoskeletal issues. HR and our Staff Forum are already working together to look at how we can improve these areas.

Did you know? 165 of our staff had their annual flu jab this winter protecting themselves, their families and their patients against the illness. The HR team worked with occupational health to encourage staff to have the jab as part of the national seasonal flu campaign for NHS staff. It is important that as many staff as possible are protected against the virus, to reduce staff sickness and to make us as productive – and protect others.

Supporting Student Nurses

NHS Sheffield CCG's Continuing Health Care Team Leader Diane Holley and her colleagues have received awards for inspirational mentoring this year. As part of their Annual Mentor Conference, Sheffield Hallam University asked current students and academics to nominate inspirational, outstanding and supportive mentors from within their placements and departments.

Diane was selected as Inspirational Mentor for her work creating great relationships with student nurses, encouraging their learning and providing good feedback and leadership. The Continuing Health care team also received an Inspirational Award for their work mentoring students as a whole.

Nurse Practitioner at Birley Health Centre, Sarah Newton, has won the 2018 Yorkshire and the Humber Nurse Mentor of the Year award. Presented by NHS England, the award recognises the vital contributions of practice nurses to training and educating the future workforce.

Nominated by a return to nursing student, Sarah's work is recognised as being invaluable to the development of the next generation of nurses, helping students to translate what is learned in the classroom into reality. This prestigious award acknowledges her commitment to going above and beyond for her students.

Celebrating staff on the front line

Infection, Prevention and Control Nurse Lisa Renshaw was invited down to Buckingham Palace in March. The reception, held in the presence of HRH The Prince of Wales, celebrated and recognised the everyday work of nursing staff.

The Prince of Wales praised the "unsung and unseen" hard work of Lisa and her colleagues who are engaged in front line nursing across the country.

Developing innovation for Primary Care

The NHS Sheffield CCG Prescription Order Line (POL) team received accolades for their work at The Association of Pharmacy Technicians National Conference in July. The conference offers the opportunity for hospital trusts, community pharmacies and CCG pharmacy technicians to display new, innovative ideas that they have implemented.

The POL team presented information on the telephone line's success in reducing the amount of medicines waste across the city and in supporting patients to get the best outcomes from their medicines. Their display was judged for the Katherine Miles Award, an award that celebrates best practice and innovation, and came second out of 23 entrants from across the UK. This recognition at the Conference celebrates the excellent service that the Prescription Order Line provides to patients in Sheffield.

Engaging people and communities

Working with patients and local people is a central part of the way we commission services and essential to make sure we understand and meet the needs of everyone living in Sheffield. Patient involvement has been central to many of the achievements featured in this report and we use a wide variety of ways to work with our local communities and make sure they have chance to influence our work.

During the year, we established a new committee of our governing body to strengthen our approach to engagement and demonstrate our commitment to ensuring the voice of patients, carers and the public is integral to our decision-making. The Strategic Patient Engagement, Experience and Equality Committee (SPEEEC) is responsible for overseeing work in these important areas and assuring not only that we are carrying out our statutory duties to a high standard but that we are responding effectively to the feedback we receive and using this to inform and influence our commissioning. As well as senior executives and governing body

members, the committee includes representatives from Healthwatch, Sheffield Council and two members of the public.

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 engagement with local people
Renal patient transport procurement	NHS Sheffield led this work on behalf of the five South Yorkshire & Bassetlaw CCGs and ensured patients played a key role. Two members of the public were trained and supported to take part in the procurement, including assessing the bids from possible providers and being part of the decision making team. This made sure that the views of patients and the public were well-represented throughout the process.
Delivering our priorities under financial pressure	In August, we engaged people in discussions around the financial challenges the CCG is facing and approaches to managing them. This provided valuable information to help governing body members decide on the best approach to take and contributed to our commissioning decisions.
Children's short-breaks (respite)	Extensive work was carried out with families of children with complex healthcare needs during the year to understand their needs and consider how we could improve services. Their views informed the development of options to make services fairer, easier to access and more flexible, which were consulted on during February and March.
Hospital Services Review	We have supported engagement work for the South Yorkshire & Bassetlaw hospital services review, facilitating involvement of Sheffield representatives in the process. This has ensured that people in Sheffield have the opportunity to give their views and help shape plans for the future delivery of the region's hospital services.More information about this can be found at http://www.healthandcaretogethersyb.co.uk/
Adult short breaks	Throughout the year, the CCG and Sheffield Council have been working with families and carers of patients using short break services to develop a clear and consistent approach to allocating short breaks and make sure that we are using the resources we have in the best way to meet people's needs. Feedback from families is being used to develop a city-wide policy and consider any improvements that could be made to the services offered.
Cancer services	We have received numerous requests for information through the recently opened cancer awareness hub at the Moor Market carers due to a lack of information associated with palliative/end of life services. As a result we are initiating an end of life baseline assessment with Macmillan to identify the gaps and remove inequalities. The hub has also had requests from the homeless which has led to us working with the Archer Project to identify accommodation for the homeless who are undergoing palliative treatment. Work with the 'hard to reach' groups has led to the setting up of a social movement project in Sheffield where we are trying to recruit 3,500 volunteers from those hard to reach communities to educate communities on screening and early warning signs.

	We are responding to patients needs to have follow ups closer to home by implementing monitoring of prostate, breast and colorectal cancer in the community so that they do not need to attend hospital. Sheffield's demographic data has shown significant inequalities across different communities particularly in relation to late presentation with cancer symptoms and low uptake of screening services. In order to rectify this, a range of events have been organised to raise awareness of cancer (including the risk factors, signs, symptoms, investigations and procedures) and to support people and carers living with and beyond cancer to try to engage those communities most at risk, such as hard to reach groups, BME and learning disabilities. We have also engaged and formed a partnership with Sheffield international venues in order to reach as wide an audience as possible. A wide range of professionals are now engaged and able to actively promote a positive message on cancer awareness at a range of leisure and community centres.
Commissioning For Outcomes	The Commissioning for Outcomes policy updates 32 existing procedures that have thresholds or are not routinely commissioned to ensure they reflect the latest evidence. Engagement with the public and clinicians highlighted a number of points that we have acted on in the development of the policy. • We will not use age as criteria for access to treatment (with the exception of IVF). • Making sure that the treatments offered to patients are proven to be effective for patients like them. • There will be clear information on the process and outcomes for patients. • There will be no delays to treatment as a result of the new policy, making sure that GPs know about the changes, with support from NHS partners as well as changing practice systems to make referrals to be made efficiently.
Care Navigation	Views from previous engagement work on GP services were used to inform the planning and roll-out of Care Navigation in practices across Sheffield. This is a new approach where receptionists are trained to be able to signpost people to services that can help them get the care they need as quickly as possible, reducing both patient waiting times and pressure on GPs. For example, patients with back pain can be directed straight to the Musculoskeletal service rather than needing to see a GP for referral.

Consultations

Where we have looked at making changes to services, we have run formal consultations to get people's views on the proposals and make sure we fully understand the impact any changes would have on different communities.

Urgent care

We consulted on proposals to improve urgent care services in the city between 26 September and 31 January. A wide range of activities took place to give people opportunity to contribute their views, including public meetings, drop in sessions at local libraries and we reviewed response rates on a weekly basis to identify and target any communities that we weren't hearing from.

The consultation succeeded in generating an excellent response rate of over 4,000 responses. All the feedback has been independently analysed to identify key themes and is being carefully considered to ensure that we find the best solution for delivering urgent care services in Sheffield.

Gluten-free prescribing

The CCG ran a public consultation on proposed guidelines to suspend the prescribing of gluten-free products for adults. There were mixed views from respondents, with strong opposition from those with coeliac disease. All the feedback received was carefully considered and the proposals were eventually approved. In response to comments about improving availability of advice and information for people with coeliac disease, a number of actions were also identified and agreed to ensure that people with coeliac disease and those newly diagnosed have access to a range of advice and support. The report and further details are available on our website.

Children's short-breaks (respite)

From 14 February to 28 March 2018, we consulted on proposals to improve short break services for children with complex heath needs. This was primarily targeting those currently using the services and those who might be eligible to use them in the future and we worked with the carer's forum to help get families' views on the proposals. At the time of writing, feedback was being analysed and will be used to inform the decision as to whether the proposals should go ahead.

Helping to give people a voice

- **Hearing from all our communities**

A key focus of our engagement work this year has been reaching diverse groups across Sheffield to ensure that the voices of our most vulnerable communities are heard in our commissioning. This has been made possible by working with specialist groups across the city, including The Cathedral Archer Project, the Deaf Advice team, Sheffield Talking News, Roshni Sheffield, the Chinese Community Centre and the Refugee Council. We are very grateful for their support and for helping us make sure that people from all our communities have the opportunity to give their views, which has helped make a number of improvements to services we commission and to make sure we have a better

understanding of people's needs across the city.

> *"Thank you for the opportunity to get voices and needs of refugees heard and reflected in your commissioning process, it feels like a real privilege to have that access for these clients" The Refugee Council*

- **Patient Participation Groups (PPG) network**

We have continued to run our network for members of GP patient groups to help them to share learning and ideas for supporting their practices. Meetings also focus on work the CCG is doing and gives PPGs an opportunity to be more involved. Topics discussed have included the GP Forward View, practices working together as 'neighbourhoods' and follow-up hospital appointments.

- **Our amazing volunteers**

We have a number of volunteers, who kindly give their time to work on specific projects or serve on committees. During the year, they contributed over 250 hours of their time to making sure the views of local people are represented – an amazing contribution, which we really appreciate.

- **Community conversation group**

The 'conversation' group we set up with graduates from the Introduction to Community Development and Health course run by Sheffield Council has continued to meet to share their experiences of how other aspects of life have impacted on their health and discuss key topics affecting healthcare services in Sheffield. The group provides a direct link with many of Sheffield's communities to help facilitate discussions on health and local health services. Topics discussed have included the proposals for urgent care services and delivering the CCG's priorities under financial pressure so that members could contribute to these important areas of work and help spread the word in their local communities.

- **The voice of our youth!**

Our annual public meeting focused on children and young people – 'the future of Sheffield' and students from Sheffield College and Chilypep (The Children and Young People's Empowerment Project) grilled our governing body about key issues for them. We also heard directly from Chilypep about some of the work they are doing with the CCG and what they feel is important for young people in Sheffield as we look at the future of healthcare for our next generation. And of course older members of the audience also got the chance to ask questions about the work we do too!

- **Supporting volunteers**

The CCG has continued to work closely with Voluntary Action Sheffield and other partners to influence the development of the city-wide volunteering strategy. This aims to provide a platform to encourage individuals, communities and organisations to realise the benefits of volunteering and strengthen the approach across Sheffield.

And finally…. a big thank you to all of our patient and public participants
We really appreciate the time people have given to find out about our work and give us their views. Hopefully the information in this section shows what a difference your involvement makes and how it's helping us to get services right for people in Sheffield.

If you would like to find out more about what the CCG does or get involved in our work, we'd love to hear from you. Our Involve Me network has over 700 members; some choose just to receive our electronic newsletters and updates; others play a more active role, such as representing patient views on a particular group or committee. We also have a Readers' Panel who review documents and information we produce to help make sure it is clear and easy to understand.
Contact us at sheccg.engagementactivity@nhs.net to join or find out more.

Taking different needs into account
Equality and diversity considerations form a key part of our commissioning. We want to ensure there is equality of access and treatment for all the services that we commission, both as a matter of fairness and as part of our commitment to reducing health inequalities.

We carry out equality impact assessments on our plans and policies to make sure all communities and groups of people have been considered. This also informs our engagement work, helping us to tailor our activities to hear from all communities across Sheffield, including those most likely to be impacted by specific plans.

We also provide training for our staff to help make sure everyone understands our equality duties and the diversity of our local population, and chair the Sheffield Equality Engagement Group, which supports local NHS organisations to meet their equality duties.

In line with our statutory duties, we publish equality information annually, demonstrating how we have met our duties in regard to both our staff and the Sheffield population. This is available on our website, along with the equality objectives that we are working towards. www.sheffieldccg.nhs.uk/our-information/equality.htm

Tell us about it!
When we do something well or could do something better, we want to hear about it. If something has gone wrong or you are unhappy about your care, you can contact us to raise you concerns or to make a formal complaint. Equally, please do let us know when things go really well so we can learn from your good experiences too to help us commission services that meet your needs.

Reducing health inequality - Bridging the divide

Health inequalities

Health inequalities are the unfair differences in health between different populations or individuals that are caused by differences in where people live and their social and economic conditions. These factors have a huge impact on people's health and wellbeing, as well as affecting how they use services, with people who are worst off 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.

Tackling this challenge drives our commissioning approach, and we also work on a range of specific initiatives that aim to reduce health inequalities, in close partnership with the Public Health team at Sheffield Council. Some of our key achievements in 2017/18 include:

- Significant progress in developing person-centred approaches and asset-based conversations in practice
- The development and maturity of our 16 neighbourhoods enables a more targeted local approach according to need and is helping to shape local inequalities agendas
- Continued investment in social prescribing across the city to support wellbeing
- Significant investment for Improving Access to Psychological Therapies (talking therapies) leading to a new health and wellbeing service helping people manage their long terms conditions or ongoing physical symptoms, alongside stress, anxiety and depression. It's provided in primary care clinics in areas of high prevalence and demand and people can self-refer to the service.

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.

Emergency Planning

The South Yorkshire and Bassetlaw CCGs work in collaboration on emergency preparedness and business continuity matters, with, for example, a common policy for both issues being agreed and submitted to Governing Bodies for approval.

Sheffield CCG works 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. The responsibilities for emergency planning are set out in the Civil Contingencies Act 2004, Section 46 of the Health and Social Care Act 2012 and the NHS England Emergency Preparedness, Resilience and Response Framework 2015.

Sheffield CCG is part of the South Yorkshire Local Resilience Forum and the Local Health Resilience Partnership (LHRP) that covers South Yorkshire and Bassetlaw. There is a Health Resilience Sub-group which sits under the LHRP and chaired by NHS England. Planning is coordinated through the LHRP and the CCG has been an active member of both the executive and tactical steering groups through its South Yorkshire collaboration arrangements. The CCG has worked in partnership with NHS England during 2017/18 to ensure there was a coordinated response to escalation pressures and emergency planning by health services in South Yorkshire and Bassetlaw.

We confirm that the CCG has emergency response plans in place, which are fully compliant with the NHS England Emergency Preparedness, Resilience and Response Framework (EPRR) 2015. The CCG regularly reviews and makes improvements to its incident response and business continuity plans and has a programme for regularly testing these plans, the results of which are reported to the Governance Sub-committee and Governing Body.

The CCG carried out a self-assessment assurance process with NHS England to assess the CCG plans and the CCG also met with its three key providers to review their plans. The CCG and the three providers were assessed as being substantially compliant.

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.

The Local Government Ombudsman and Parliamentary and Health Service Ombudsman have introduced a new process for investigating complaints about both health and social care services. These complaints are now investigated by a single team based in the Local Government Ombudsman's office, acting on behalf of both Ombudsmen. The Local Government Ombudsman and Parliamentary and Health Service Ombudsman have provided a joint final report back to the CCG on one complaint this year. This was upheld and the Ombudsmen identified actions for the CCG, local authority and service provider to follow up on.

The joint report was provided at the end of the financial year and the Ombudsmen have requested the CCG complete the actions identified within two months.

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

Maddy Ruff

Accountable Officer

24 May 2018

Corporate Governance Report

1. Members Report

1.1 Member profiles

Members of our Governing Body during 2017/18 were as follows. If no dates are shown, this means the Member was in post all year:

Dr Tim Moorhead - Chair and West Locality Nominated GP Representative

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

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

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

Maddy Ruff - Accountable Officer

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

Maddy is passionate about delivering high quality healthcare services to improve the health of everyone in the city. Over the past 12 months Maddy has had a key role in supporting system transformation through the development of the South Yorkshire and Bassetlaw Integrated Care System (ICS) and Sheffield Accountable Care Partnership (ACP). She is committed to achieving organisational success and drives improvement through her own passion and energy, engaging and inspiring others. She is dedicated to developing staff, both within the CCG and across health and social care, to allow them to provide the best possible care for patients.

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

Julia Newton - 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 & corporate governance. During 2017/18 she provided the lead finance representation for all CCGs across South Yorkshire and Bassetlaw on the Joint Committee of CCGs and on the Executive Delivery Group of the Accountable Care System.

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

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 Royal Derby Hospital, where he also has a leadership role as Deputy 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.

Brian Hughes, Director of Commissioning and Performance (from 30.05.17)

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.

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 has also 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, Acting Chief Nurse (from 25.09.17)

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.

Dr Marion Sloan - Elected GP Member

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 gynecology 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.

Dr Nikki Bates - Elected GP Member

Dr Nikki Bates has been a GP for 27 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 - Elected GP Member (from 1 January 2017)

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.

Dr Hudsen 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 lives.

Dr Annie Majoka - Elected GP Member (from 1 January 2017)

Dr 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 Ngozi Anumba – Hallam and South Locality Nominated GP Representative

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 include pediatrics, particularly child safeguarding and women's health. Ngozi is a member of the Audit and Integrated Governance Committee.

Dr Gonapragasan Chetty – Central Locality Nominated GP Representative (from 1 September 2017)

Dr Gasan Chetty has been working 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 (from 6 March 2018)

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.

Amanda Forrest - Lay Member

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 Quality Assurance Committee and 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. Amanda is Trustee of Sheffield Carers Centre.

Mark Gamsu - Lay Member

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. He 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.

Phil Taylor - Lay Member

Phil was appointed as a lay member in March 2016 with responsibility for audit, governance and 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 currently the chair 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.

Nicki Doherty Director of Delivery - Care Outside of Hospital (interim up to 02.11.17, substantive from 03.11.17)

Nicki is responsible for the Transformation and Delivery Directorate, her areas of responsibility include: Primary Care; Active Support & Recovery; Active Ageing, Long Term Conditions and End of Life Care; Communications and Engagement; Equality & Diversity and Emergency Preparedness Planning & Resilience. Nicki worked with partners across Sheffield to produce the Sheffield Place Based plan. 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 the NHS and designing services that work for both people who need them as well as people who deliver them.

Profiles for those who ceased to be Members of Governing Body during 2016/17

Tony Williams – Lay Member (1.09.17 – 26.02.18)

Tony was appointed as a Lay Member in September 2017 with responsibility for systems and leadership. Given his previous experience in this field, Tony was the lead Lay member for Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity. His career spanned over 30 years working in local government, more recently as Chief Executive at Bournemouth Borough Council, where he worked in close partnership with healthcare organisations. Through his public sector roles, he was involved in major service transformation and integration, Tony is committed to addressing health inequalities. He is an experienced Chair and Chair of the Primary Care Commissioning Committee. He has been a Governor at Wakefield College since July 2017.

Post note: Tony resigned from his post due to ill health on 26th February 2018 and sadly died on 18th March 2018.

Dr Amir Afzal - Locality Nominated GP (Central Locality to 30.09.17)

Amir is a Sheffield GP and has worked at Duke Medical Centre as a partner since 1994 working with some of the most vulnerable people in the city. He is now senior partner at the practice. Amir was also the Central Locality representative on the CCG Board. 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.

John Boyington CBE - Lay Member (up to 31.05.17)

John worked for over 40 years in health services, both in the NHS and civil service. He originally trained as a nurse in Sheffield and has held chief executive posts in NHS Trusts and a PCT. He received the CBE in 2007 for leading national prisoner health care reforms. He was Director of the World Health Organisation (WHO) Collaborating Centre for prisons and public health for five years. John was Deputy Chair of the CCG Governing Body and Chair of the Primary Care Commissioning Committee and Remuneration Committee. He is passionate about change in the NHS to ensure that services deliver what people need in a way that is easily accessible.

Penny Brooks - Chief Nurse (from 1.09.16 – 31.12.17)

Penny started her nursing career in the NHS in 1976 as a Nursing Cadet before qualifying as a Registered Nurse and District Nurse. She has experience in both acute, primary and community services before becoming Chief Nurse and Executive Director in 2001 in Doncaster West PCT. Penny has worked as Chief Nurse with wide portfolios of responsibilities in both Barnsley and Sheffield and as Chief Nurse for South Yorkshire and Bassetlaw cluster before the dissolution of PCTs. Latterly she was the Clinical Director for Primary and Community Services Care Group within Sheffield NHS Teaching Hospitals Foundation Trust responsible for a wide range of services and staff. Penny is also a Trustee of Ashgate Hospice Care in North Derbyshire

Peter Moore - Director of Strategy and Integration (1.11.16 – 30.09.17)

Peter Moore was jointly funded by Sheffield City Council to lead our Integration agenda across the City. His remit included executive director leadership of urgent care, mental health and children's agendas as these require cross organisational delivery. Peter also led the Transforming Sheffield Programme and the Sheffield Place Based Plan.

Peter has worked at Board level within the NHS since 2010 and prior to that worked within Nissan and Toyota Manufacturing where he led a number of key model changes, he has a detailed knowledge of Lean and is keen on applying this thinking to making sure our patients receive the best service possible from our providers.

Matt Powls - Interim Director of Commissioning and Performance (1.11.16 – 19.05.17)

Matt was responsible for a number of areas within the CCG including: commissioning of elective care, commissioning of cancer care, contracting and procurement, provider performance, business intelligence and IM&T and QIPP Delivery (Quality, Innovation, Productivity and Prevention).

Matt worked at executive level for a variety of provider and commissioning organisations over the last 20 years.

Dr Leigh Sorsbie - Locality Nominated GP (North Locality)

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

She is passionate about ensuring high-quality evidenced-based clinical care is available for everyone within the city, regardless of postcode or background. Her work in Firth Park has enabled her to experience the challenges faced by communities in ethnically diverse areas of high deprivation, 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. Leigh also works as a GP appraiser, providing ongoing support to practicing GPs throughout Sheffield.

Dr Sorsbie is currently on 6 month sabbatical leave and Dr Jennie Joyce has taken over from Dr Sorsbie during this period (wef 6.03.18).

1.2 Member Practices

The following is a list of all of NHS Sheffield CCG's 82 GP member practices listed by locality.

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

Heeley Green Surgery Manor Park Medical Centre Norfolk Park Health Centre Park Health Centre Sharrow Lane Medical Centre The Sloan Medical Centre The Matthews Practice The Medical Centre Veritas Health Centre The White House Surgery Woodseats Medical Centre	Mosborough Health Centre Nethergreen Surgery Owlthorpe Surgery Richmond Medical Centre Rustlings Road Medical Centre Selbourne Road Medical Centre Sothall Medical Centre Stonecroft Medical Centre The Avenue Medical Centre The Hollies Medical Centre Totley Rise Medical Centre Woodhouse Health Centre
North Locality (23)	**West Locality (15)**
Barnsley Road Surgery Buchanan Road Surgery Burngreave Surgery Chapelgreen Practice Crookes Valley Medical Centre Dunninc Road Surgery Ecclesfield Group Practice Elm Lane Surgery Foxhill Medical Centre Grenoside Surgery Mill Road Surgery Norwood Medical Centre Page Hall Medical Centre Pitsmoor Surgery Sheffield Medical Centre Shiregreen Medical Centre Southey Green Medical Centre The Firth Park Surgery The Flowers Health Centre The Healthcare Surgery Upperthorpe Medical Centre Upwell Street Surgery Wincobank Medical Centre	Broomhill and Lodge Moor Surgeries Deepcar Medical Centre Devonshire Green and Hanover Medical Centres Dykes Hall Medical Centre Far Lane Medical Centre Harold Street Medical Centre Oughtibridge Surgery Porterbrook Medical Centre Stannington Medical Centre The Crookes Practice Dr Milner and Partners Tramways Medical Centre (O'Connell) University Health Service Health Centre Valley Medical Centre Walkley House Medical Centre

1.3 Composition of Governing Body

The CCG Governing Body is responsible for NHS clinical commissioning decisions across Sheffield and for the long term success of the CCG. Membership of the Governing Body is set out in the CCG's Constitution.

Our Member Practices and NHS England approved changes to the membership of the Governing Body which came into effect from November 2017. These changes included a review of the composition of the Governing Body at executive officer level at the end of the secondment of the Director of Strategy and Integration. Roles and responsibilities for this post were reallocated to existing directors portfolios.

Mr Brian Hughes was appointed to the post of Director of Commissioning and Performance in May 2017.

Our Chief Nurse Penny Brookes, resigned in December 2017 following a period of sickness absence, the vacancy was filled in an acting capacity from September 2017 by Mrs Mandy Philbin prior to a formal recruitment process being undertaken to fill the vacancy on a substantive basis.

At 30 September 2017, three of the four locality nominated GP Members' terms of office came to conclusion following their three year period and requests for nominations from the relevant localities were sought. In accordance with the CCG's Constitution, candidates were formally assessed against a list of essential and desirable competencies. Where more than one candidate in the relevant locality met the specified competencies, an election by a simple majority of votes cast, with one vote per member practice within each locality took place. Where only one candidate met the specified competencies, that candidate was appointed to the post. The CCG received four applications, Dr Sorsbie, and Dr Moorhead were appointed uncontested to North and West Localities respectively. Following a vote by Member Practices Dr Chetty was appointed to the Central Locality.

A further recruitment process was undertaken in February 2018 in line with the CCG's Constitution to cover Dr Sorsbie's leave of absence; Dr Jennie Joyce was appointed to this post for a period of 6 months.

Mr Phil Taylor Lay Member, took up the role of Acting Deputy Chair of Governing Body from 3 July 2017 and substantively Deputy Chair from 9 November 2017. Phil was also Acting Chair of the Remuneration Committee from 3 July 2017 and then substantively also from 9 November 2017. Phil's period of acting-up was as a result of the changes needed to our Constitution which required approval by both Members and NHS England before the appointments could be made substantive.

Governing Body Members (i.e. voting Members) with effect from 1 November 2017 included:

- CCG Chair (who is also a locality appointed GP Member)
- Accountable Officer
- Director of Finance
- Medical Director
- Chief Nurse
- Four elected GP Members

- Four Locality appointed GP Members (one of which is the Chair of the Governing Body)
- Four Lay members (one of which is the Deputy Chair of the Governing Body)
- Secondary Care Specialist Doctor
- Director of Delivery – Care Outside of Hospital
- Director of Commissioning and Performance

1.4 Committee(s), including Audit Committee

The Governing Body has five directly reporting committees: The Primary Care Commissioning Committee, Audit and Integrated Governance Committee, Quality Assurance Committee, Remuneration Committee and the Strategic Patient Engagement, Experience and Equality Committee. The Governance Sub-committee reports to the Audit and Integrated Governance Committee. Highlights from each of the committees are detailed in the Governance Statement at page 62.

Audit and Integrated Governance Committee

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

• Phil Taylor, Lay Member (Chair and Conflicts of Interest Guardian)

• Vacancy, Lay Member

• Amanda Forrest, Lay Member (Deputy Chair)

• Dr Ngozi Anumba, CCG GP

• Dr Jennie Joyce (from 06.03.2018 to cover Dr Leigh Sorsbie's sabbatical)

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

1.5 Register of Interests of Governing Body Members

The CCG maintains a number of Registers of Interests. An extract of the Register giving the position for Governing Body Members at 31 March 2018 can be found at Appendix A on pages 101 to 108 of this Accountability Report. 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 which was reviewed and updated in September 2017 in line with NHS England's: *Managing Conflicts of Interest Statutory Guidance for CCGs*

1.6 Personal data related incidents

A Serious Untoward Incident was identified in 2017/18 relating to personal identifiable data which occurred in 2016/17. The incident has been formally reported to the Information Commissioner's Office who are currently investigating this case.

1.7 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 clinical commissioning group's external auditors, and members of the Governing Body take all necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.

1.8 Modern Slavery Act

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

1.9 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 financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

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

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

- Assess the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- Use the going concern basis of accounting unless informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as 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 the CCG's auditors are aware of that information.
- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Maddy Ruff
Accountable Officer

24 May 2018

Governance Statement

1 INTRODUCTION

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

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

As at 1 April 2017, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

2 SCOPE OF RESPONSIBILITY

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

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

3 GOVERNANCE ARRANGEMENTS AND EFFECTIVENESS

The main function of the governing body is to ensure that the 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 82 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. The CCG Governing Body takes overall responsibility for governance throughout the organisation but discharges some of its responsibilities to a number of committees, primarily the Audit and Integrated Governance Committee, Quality Assurance Committee, Primary Care Commissioning Committee, Remuneration Committee, Strategic Patient, Engagement, Experience and Equality Committee, and Governance Sub-committee. A full list of committees, including their responsibilities and membership, are set out at paragraph 3.3 of this Statement. In addition to governance, the Governing Body and its delegated committees place a clear focus on the services, performance and patient safety of its commissioned providers.

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.

The Constitution was reviewed and updated once during 2017/18 and followed a review of governance arrangements by the Governing Body. The following key changes were proposed and agreed by our Governing Body, Member practices and NHS England:

- Changes to the Executive Directors including some responsibilities
- Changes throughout to reflect the establishment of the Strategic Patient Public Engagement Experience and Equality Committee (SPEEEC)
- Clarity with regard to the process for the appointment of the Deputy Chair of Governing Body
- Changes to practice information

- Updated references to the Standards of Business Conduct and Conflicts of Interest Policy and Procedures
- Updated to reflect changes to the Membership
- Changes to Scheme of Reservation and Delegation
- General changes throughout the document to provide clarity and ensure consistency

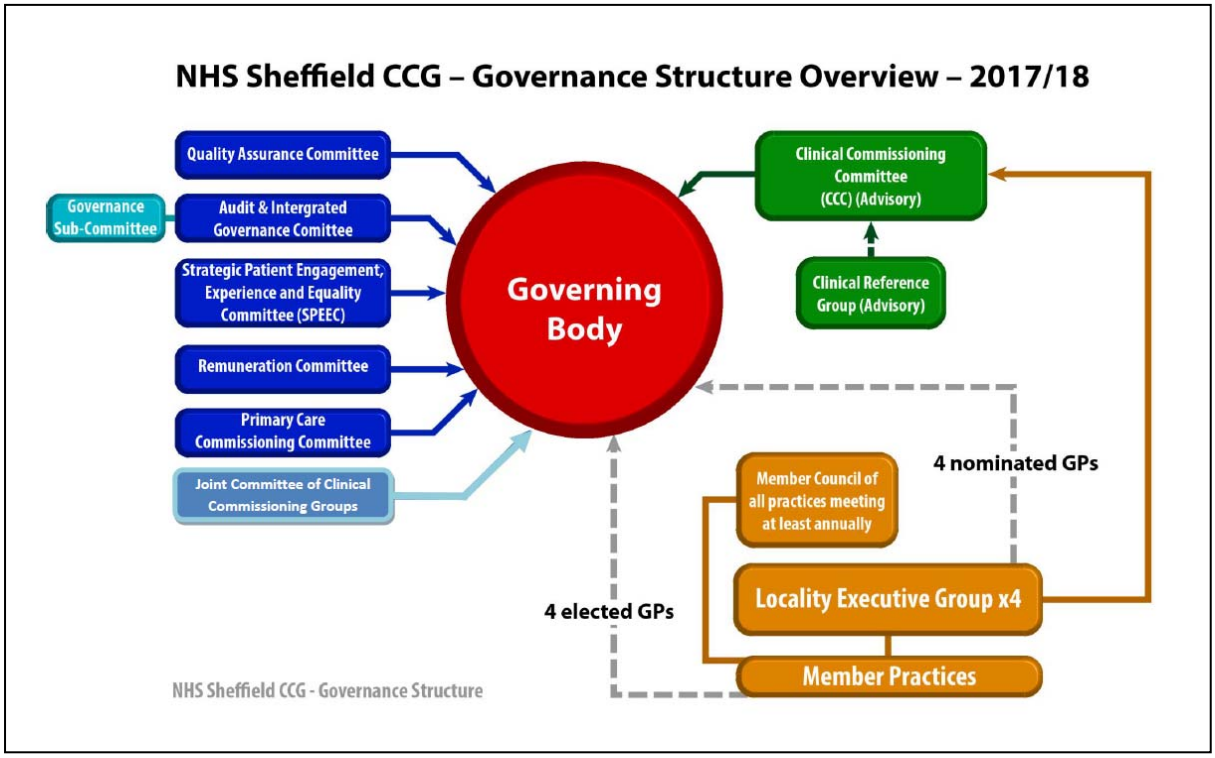
The Constitution, particularly through the Scheme of Reservation and Delegation, makes clear the respective responsibilities of the Members' Council (membership body), the Governing Body and its Committees. With the exception of changes to the Constitution, all powers and responsibilities have been delegated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

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

3.3 Governing Body, Committees, Sub-committee and Joint Committees of Governing Body

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

Fig 1



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

3.3.1 Governing Body

The Governing Body comprises a diverse range of skills from executive, clinical and lay members. There is a clear division of the responsibilities of individual's with no one individual having unfettered powers of decision. The CCG Scheme of Delegation details how key CCG functions have been discharged through the organisation as agreed by its member practices in the CCG Constitution.

The CCG's governance arrangements agreed by Member practices are set out within our Constitution giving the Governing Body the power to lead and manage the CCG on the Members' behalf.

The CCG Chair is responsible for leadership of the Governing Body, ensuring its effectiveness and that executives have access to relevant information to assist them in the delivery of their duties. Lay members have actively provided scrutiny and challenge at Governing Body and at committee level. The Governing Body and its committees draw their membership from a broad pool of NHS clinicians, staff and lay members, providing the appropriate balance of skills, experience, independence and knowledge of the organisation to enable them to discharge their respective duties and responsibilities effectively.

The Governing Body is collectively responsible for the long term success of the CCG and its composition is set out in section 1.3 of the members report (page 50)

Responsibility

The Governing Body has a responsibility to ensure there are appropriate healthcare services for the people of Sheffield. The CCG aspires to be a strong and forward thinking organisation. Its success depends on strong partnerships with constituent practices, local communities and external organisations. Members of the Governing Body have proactively sought strong relationships collectively and individually through:

- Joint working through Partnership Boards in Sheffield with the Local Authority and local NHS Foundation Trusts including the Sheffield Accountable Care Partnership arrangements set up during 2017/18 as part of the wider South Yorkshire and Bassetlaw Accountable Care System (ACS) arrangements.
- As part of the ACS arrangements, the Clinical Commissioning Groups from South Yorkshire and Bassetlaw, have continued with their commissioner working together arrangements covering a wide range of issues and also including the formal Joint Committee of CCGs which has formal delegated authority for a limited range of commissioning decisions.
- Joint working with NHS England at both national and local area team levels
- Informal collaboration and networking with neighbouring CCGs and Core City CCGs, including strategic commissioning for ambulance and 111 services across Yorkshire & Humber.

The Governing Body is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. During

2017/18 it has maintained sound risk management and internal control systems as described in the Risk Management and Internal Control Framework sections.

Key Performance Highlights

A range of governance and strategic reports have been considered by the Governing Body including assurances on quality, finance and performance. Meetings are held in public and agendas, papers and minutes are published on the website at www.sheffieldccg.nhs.uk

All Governing Body agendas include the requirement for declarations of interest. The Governing Body receives information in a timely manner in a form and of a quality appropriate to enable it to discharge its duties.

The Governing Body has maintained a clear focus on delivery of the CCG's financial plan for 2017/18 with a range of discussions in public and private sessions on the actions to be taken to ensure financial sustainability and management of risks. This has involved detailed evidence based debate on ceasing investment in particular areas and has included regular progress reports against the CCG's Quality, Innovation, Prevention and Productivity (QIPP) plan. Governing Body has at each meeting considered delivery against a wide range of national performance and quality indicators, seeking assurance on actions where the CCG has not been on target to deliver against these indicators. The Governing Body has balanced its requirement to monitor performance against national requirements with considering development of key strategies to address our local priorities, in areas such as out of hospital care, mental health and urgent care.

The Governing Body continued to conduct the majority of its business in public, meeting on ten occasions in 2017/18.

Executive directors, clinical leads and lay members are subject to formal assessment and appraisal processes. There is a comprehensive induction and bespoke development programme in place for all Governing Body members.

Risk Framework

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

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

Each committee has formal terms of reference and provides summary reports to the Governing Body. The Terms of Reference for each of these committees have been reviewed during the year, ensuring they remained fit-for-purpose and offered stringent governance assurance. Terms of Reference of each of the Committees and the Governance Sub-committee are available on the CCG's website.

Attendance at Governing Body Meetings

Membership	Role	Attendance	
		Actual	Poss
Dr Amir Afzal **(to 30.9.17)**	CCG GP Locality representative	3	5
Ngozi Anumba	CCG GP Locality representative	7	10
Dr Nikki Bates	CCG GP Elected City-wide Representative	9	10
John Boyington **(to 31.05.17)**	Lay Member	2	3
Penny Brooks[1] **(to 31.12.17)**	Chief Nurse	3	7
Dr Gasan Chetty **(from 1.10.17)**	CCG GP Locality representative	5	5
Nicki Doherty[2]	Director of Delivery – Care Outside of Hospital	9	10
Amanda Forrest	Lay Member	8	10
Mark Gamsu	Lay Member	7	10
Dr Terry Hudsen	CCG GP Elected City-wide Representative	8	10
Brian Hughes **(from 30.5.17)**	Director of Commissioning and Performance	7	7
Dr Jennie Joyce[6] **(from 6.04.18)**	CCG GP Locality representative	n/a	n/a
Dr Annie Majoka	CCG GP Elected City-wide Representative	5	10
Dr Zak McMurray	Medical Director	8	10
Peter Moore **(to 30.9.17)**	Director of Strategy & Integration	3	5
Dr Tim Moorhead	CCG GP Locality representative CCG Chair	10	10
Julia Newton	Director of Finance	10	10
Matt Powls **(to 19.5.17)**	Interim Director of Commissioning & Performance	2	2
Mandy Philbin[3] **(from 25.9.17)**	Acting Chief Nurse	5	5
Maddy Ruff	Accountable Officer	7	10
Dr Marion Sloan	CCG GP Elected City-wide Representative	7	10
Leigh Sorsbie[4]	CCG GP Governing Body Member	8	10
Phil Taylor[5]	Lay Member	10	10
Dr Chris Whale **(from 1.7.17)**	Secondary Care Specialist Doctor	6	7
Tony Williams **(from 1.9.17 – 26.02.18)**	Lay Member	5	5

[1] Penny Brooks Governing Body voting rights to 24 September 2017
[2] Nicki Doherty – Interim appointment to 2 November 2017, substantive wef 3 November 2017
[3] Mandy Philbin voting rights wef 25 September 2017
[4] Dr Leigh Sorsbie up to 5 March 2018
[5] Phil Taylor – Acting Deputy Chair wef 3 July 2017, substantive wef 9 November 2017
[6] Dr Jennie Joyce – to cover Dr Leigh Sorsbie sabbatical wef 6 March 2018

3.3.2 Audit and Integrated Governance Committee

Responsibility

This Committee is chaired by the Lay Member with responsibility for financial strategy and governance. The Chair of this committee is also the Conflicts of Interest Guardian. 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 before 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 three occasions during the year, considering relevant issues in line with its annual work plan.

During 2017/18, 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 2017/18 included:

- Approval of the annual programme of work to be undertaken
- Receiving and reviewing updates from external audit
- Review of Internal Audit and Counter Fraud Services; in year monitoring and delivery against plans
- Review of policies against NHS Protect Standards for Bribery and Corruption against the Bribery Act 2010
- 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
- Receiving and noting updates on guidance on conflicts of interest
- Review of Registers of Interests, procurement and registers of interests

- 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
- Appointment of a new lay member who took up post 1 September 2017 as a member of the Committee, who is a qualified accountant with extensive experience of NHS finance, including chairing Finance and Audit Committees.
- 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 of Governance Sub-committee Terms of Reference for recommendation and approval to Governing Body
- Receiving updates from the Chair on the development of governance for the ACS from meetings of Audit Chairs from across the patch.

3.3.3 Quality Assurance Committee

Responsibility

The Quality Assurance 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 met quarterly during the year and an Extraordinary Meeting was held on 4 January 2018 and has provided exception reporting to Governing Body on quality concerns and good practice. During the year it has streamlined reporting and focused on specific clinical issues or service areas.

Key Performance Highlights

During 2017/18 the committee has continued to develop and deliver its responsibilities. Specifically, the committee has:

- Secured increased clinical representation, via a second GP Quality Lead.
- Systematically reviewed provider's performance in relation all areas of quality including performance against national reviews and priorities.
- Reviewed feedback relating to providers from the Care Quality Commission and other regulatory bodies and taken action with providers where appropriate.
- Monitored patient safety issues, including Serious Incident, Never Events, targets and plans to reduce hospital and community acquired infection.
- Monitored performance of providers relating to Clinical Quality and Innovation Schemes (CQUIN).

- Approved strategies for Commissioning for Quality and Patient Experience, and monitored delivery of the action plans.
- 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.
- Provided feedback to Governing Body on a quarterly basis.
- Annual review of Terms of Reference and recommendation to Governing Body for approval

3.3.4 Remuneration Committee

Responsibility

The Remuneration Committee is chaired by a Lay Member. The Committee has delegated authority to determine the remuneration and conditions of service for all Governing Body Members, taking into account any national Directions or guidance on these matters. The Committee has the delegated authority to consider the outcome of any performance review of the Accountable Officer and other senior CCG employees. In addition, the Committee has delegated authority to consider the severance payments of the Accountable Officer and of other senior staff. The Committee advises the Governing Body on its determinations about allowances under any pension scheme it might establish as an alternative to the NHS pension scheme and on any other potential alternative remuneration and conditions of service for CCG employees outside of, or in place of, national Agenda for Change arrangements..

Key Performance Highlights

During 2017/18 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
- Review and approval of remuneration for two newly appointed senior managers
- Review of the performance of the Accountable Officer and other senior CCG employees and determination of appropriate financial awards
- Consideration of a report benchmarking of GP Governing Body members remuneration

3.3.5 Primary Care Commissioning Committee

Responsibility

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

Key Performance Highlights

During 2017/18 key areas considered by the Committee included:

- Approved of a number of Locally Commissioned Services to support the CCG's wider Out of Hospital Strategy including virtual ward planning and winter resilience
- Approved a number of practice mergers
- Progressed issues relating to Thursday Afternoon Opening in General Practice
- Considered the Sheffield Primary Care Estates Strategy and recommended to Governing Body for approval
- Approved plans and related spend in regard to Sheffield CCG GP Forward View (GPFV) strategy
- Monitored and approved actions related to the formal consultation on Urgent Primary Care
- Approved the recommendations regarding the outcomes of the evaluation of the pilot of CASES

3.3.6 Strategic Patient Engagement, Evidence and Equality Committee (SPEEEC)

Responsibility

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

Key Performance Highlights

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

- Assurance of the consultation process on the proposed changes to urgent care services
- Assurance of engagement around children's short-break service and approval of plans for subsequent consultation
- Approval of an action plan to address issues raised in patient feedback on interpreting services
- Review of GP patient participation groups
- Assurance of elective care engagement and patient experience work

3.3.7 Governance Sub-committee

Responsibility

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 Governing Body Assurance Framework (GBAF)
- Operational risk register reviewed at each meeting and the scores of all new risks scrutinised
- 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.
- Assurance received with regard to Information Governance systems and processes, including IG toolkit and Freedom of Information requests, compliments and complaints
- Positive assurance received in support of health and safety initiatives, premises inspections and fire risk assessments
- On-going review of the policy management system for the review and updating of all corporate, human resources, clinical and financial policies

- Terms of Reference reviewed and updated to incorporate the Sub-committee's role with regard to overview of the Emergency Preparedness Resilience and Response (EPRR) Framework
- Annual review of Terms of Reference with recommendation to AIGC for approval by Governing Body

3.4 Committee Membership and Attendance

The table below sets out details of membership and attendance at each of the CCG's committees during 2017/18. Each committee meets quarterly (unless stated otherwise) - all meetings were quorate throughout the year

Committee Membership and Attendance 2017/18

Committee	Membership	Role	Attendance	
			Actual	Poss
Audit & Integrated Governance [1]	Phil Taylor	Lay Member and Chair	3	3
	John Boyington **(to 31.05.17)**	Lay Member	1	1
	Amanda Forrest	Lay Member and Vice Chair	2	3
	Ngozi Anumba	CCG GP Governing Body Member	3	3
	Leigh Sorsbie[2]	CCG GP Governing Body Member	3	3
	Tony Williams **(from 01.09.17 – 26.02.18)**	Lay Member	1	2
Quality Assurance	Amanda Forrest	Lay Member and Chair	5	5
	Penny Brooks[3] **(to 31.12.17)**	Chief Nurse and Vice Chair **(Vice Chair to 24.9.17)**	1	3
	Mark Gamsu	Lay Member	2	5
	Dr Terry Hudsen	CCG GP Lead for Quality	5	5
	Debbie Morton **(from 1.12.17, voting rights from 1.12.17)**	Deputy Chief Nurse	1	3
	Zak McMurray	Medical Director	2	5
	Mandy Philbin[5] (**from 25.9.17)**	Acting Chief Nurse and Vice Chair (**previously Deputy Chief Nurse, Vice Chair from 25.9.17)**	3	5
	Marion Sloan	CCG GP	4	5
	Dr Chris Whale **(from 1.7.17)**	Secondary Care Doctor	1	5
Primary Care Commissioning (*meets at least six times per year)*	Tony Williams **(from 1.9.17 – 26.02.18)**	Lay Member and Chair **(Chair from 1.9.17)**	3	4
	John Boyington **(to 31.5.17)**	Lay Member and Chair (**Chair up to 31.5.17)**	0	2
	Penny Brooks[3] **(to 31.12.17)**	Chief Nurse	1	6
	Nicki Doherty	Director of Delivery – Care Outside Hospital	6	8
	Amanda Forrest	Lay Member	7	8
	Mark Gamsu	Lay Member and Deputy Chair **(Chair from 1.7.17- 31.8.17)**	7	8

Committee	Membership	Role	Attendance	
			Actual	Poss
	Julia Newton	Director of Finance	7	8
	Mandy Philbin **(from 25.9.17)**	Acting Chief Nurse	4	5
	Maddy Ruff	Accountable Officer	8	8
Remuneration Committee	Phil Taylor[4] **(from 3.7.17)**	Lay Member **(Acting Chair from 3.7.17)**	3	3
	Amir Afzal **(to 30.9.17)**	CCG GP Governing Body Member	2	2
	Nikki Bates	CCG GP Governing Body Member	4	4
	John Boyington **(to 31.05.17)**	Lay Member and Chair **(Chair to 30.6.17)**	1	1
	Dr Gasan Chetty **(from 1.10.17)**	CCG GP Governing Body Member	2	2
	Amanda Forrest	Lay Member and Vice Chair	4	4
	Mark Gamsu	Lay Member	3	4
	Annie Majoka	CCG GP Governing Body Member	3	4
Strategic Patient Engagement, Experience and Equality Committee (SPEEEC) (formal committee of Governing Body from 10.11.17)	Mark Gamsu	Lay Member and Chair	2	3
	Eleni Chambers	Public Representative	1	3
	Nicki Doherty	Director of Delivery – Care Outside of Hospital	3	3
	Amanda Forrest	Lay Member and Deputy Chair	3	3
	David Foster	Public Representative	2	3
	Susan Hird	Consultant in Public Health	0	3
	Phil Holmes	Director of Adult Social Services, Sheffield City Council	0	3
	Dr Terry Hudsen	CCG GP Governing Body Member with responsibility for engagement, equality and diversity	3	3
	Richard Kennedy /Helen Mulholland	Engagement and Equality and Diversity Managers	3	3
	Margaret Kilner / Guy Weston	Healthwatch Sheffield Representative	2	3
	Eleanor Nossiter	Engagement, Communications and Equality Lead	2	3
	Mandy Philbin	Acting Chief Nurse	2	3
	Sarah Neil	Patient Experience Manager	1	3
	Sarah Salway	Health Equity and Inclusion Research Group, University of Sheffield	1	3
	Ed Sexton	Engagement Development Manager, Sheffield City Council	0	3

[1] The Audit and Integrated Governance Committee was due to meet 4 times during the financial year. However, the final meeting scheduled for March 2018 had to be deferred to the 5th April 2018 due to late changes to membership meaning that the original meeting would not have been quorate.

[2] Dr Leigh Sorsbie up to 5 March 2018

[3] Penny Brooks Governing Body voting rights to 24 September 2017

[4] Phil Taylor Acting Chair wef 3 July 2017, substantive wef 9 November 2017

[5] Mandy Philbin Governing Body voting rights from 25 September 2017

3.5 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 are provided across South and mid Yorkshire, Bassetlaw and North Derbyshire. The Committee currently has delegated authority to only make decisions on these two service areas. It held its first formal meeting in public on 18 April 2017 and made the decision to jointly commission out of hours Children's Surgery & Anaesthesia in June 2017, and Hyper Acute Stroke Services in November 2017.

South Yorkshire and Bassetlaw Accountable Care System/Integrated Care System/ Sustainability and Transformation Plan. The CCG is a partner in the South Yorkshire & Bassetlaw Sustainability and Transformation Plan (STP), which in June 2017 was named as one of the first Accountable Care Systems, now referred to as Integrated Care Systems (ICS), in the country. The ICS is a group of partners involved in health and social care, who have agreed to work in closer partnership to improve health and care. It does not replace any legal, or statutory, responsibilities of any of the partner organisations.

In the Integrated Care System, there are a number of groups that discuss issues and agree how best to take things forward. The ICS oversight and assurance group includes chairs from clinical commissioning groups, 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 organisations, NHS England and other arm's length bodies. Clinical chairs from commissioning groups 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 work streams. These are led by a Chief Executive and senior responsible officer (an Accountable Officer from a clinical commissioning group) and supported by a director of finance and a project manager/work stream lead.

The Accountable Care System has made a commitment to involving the patients and the public in health service developments. During 2017-2018 the ACS engaged patients and the public in a conversation about the South Yorkshire & Bassetlaw plan. The results of these conversations can be read here and here.

In August 2017 the ACS commenced a piece of work looking at hospital services in the area. Patient, public and clinical involvement has been key to the ongoing review, with engagement including conversations with seldom heard communities, a demographically representative tele-survey with 1000 people, an online survey and

regional and local meetings, stalls and events. The findings from the engagement to date can be found here.

In 2017-18 the ACS developed a Citizens' Panel in recognition that as their work develops, it's vital that the voice of local people is at the heart of the work. The panel brings together people from across South Yorkshire & Bassetlaw who can offer an independent view and critical friendship on matters relating to the work of Health and Care Working Together. Initial recruitment of eight volunteers has taken place, with further recruitment to the panel ongoing.

Sheffield Accountable Care Partnership (ACP). The CCG is a partner in the Sheffield Accountable Care Partnership (ACP). An outline of the ACP is set out on page 28 of this annual report, including the aims and ambitions. To support this partnership, the arrangements were formalised in 2017 through the establishment of a Memorandum of Understanding between the partner organisations (NHS Sheffield CCG, Sheffield City Council, Sheffield Children's NHS Foundation Trust, Sheffield Health & Social Care NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, and Primary Care Sheffield) setting out the values, behaviours and expectations of how the system partnership would work. However, no functions have been delegated to the ACP. Arrangements were further enhanced through the establishment of the Accountable Care Partnership (ACP) Programme Board and the appointment of the Accountable Care Partnership Programme Director.

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 2018, 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.

4.1 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.

5 DISCHARGE OF STATUTORY FUNCTIONS

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative

requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

We have ensured that the CCG has been able to properly discharge its statutory functions, duties and responsibilities, with robust performance management processes and clear lines of accountability through established formal arrangements. We have also had a clear focus on the future needs and requirements of our population. The CCG's Constitution outlines the principles of good governance, which include observing the highest standards of propriety, impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business. It also sets out the roles and responsibilities of the Governing Body. The Terms of Reference of each of our high level committees are available on the CCG's website. The CCG has a clear focus on its responsibilities in the use of the public funds made available to it and of the necessity to always achieve the very best value for money outcomes possible.

Last, but not least, we take due account of the NHS Constitution and strive to uphold its values.

6 RISK MANAGEMENT ARRRANGEMENTS AND EFFECTIVENESS

6.1 Risk Management Strategy

The CCG has a comprehensive Risk Management Strategy and Action Plan in place which is updated annually; the Strategy was updated in March 2017 and approved by the AIGC at its meeting in April 2017. The key elements of our strategy includes the ways in which risks are identified, assessed, evaluated and action plans implemented so that risks are controlled to the most appropriate level possible. Our strategy sets out the aims of the CCG to ensure that staff, patients, visitors, reputation, and finances associated with the CCG are protected through the process of risk identification, assessment, control and elimination/reduction. The strategy also sets out accountability arrangements in terms of risk management, including roles and responsibilities.

The 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 assurance 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, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

The objective of our Risk Management Strategy is to create a framework to achieve a culture that encourages staff to:

- identify and control risks which may adversely affect the operational ability of the CCG
- compare risks using the 5 x 5 grading system (see table 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

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:

- Risk prevention - Scheme of Delegation and Reservation and financial authorisation and authorisation levels
- Detection controls - performance monitoring and quality reports to Governing Body
- Internal control – eg statutory and mandatory training regime
- Directive controls – suite of policies and standard operating procedures monitored by Governance sub-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 report supports involving patients, carers and the public in the preparation of the report

6.2 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 and we have reviewed the approach used to ensure it is as effective as possible. We have also strengthened our approach to assuring we meet our equality duties by establishing a new committee of the governing body, the Strategic Patient Engagement, Experience and Equality Committee, which is responsible for overseeing this important area of work.

6.3 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 the importance of incident reporting.

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

Two Lay Members are identified with responsibility for public engagement and who attend Governing Body meetings, the Quality Assurance Committee, Remuneration Committee, Primary Care Commissioning Committee and the Strategic Patient Engagement, Experience and Equality Committee, to ensure there is a voice for patients and the public.

In addition to direct regular contact with our citizens through the Involve Me network and city-wide patient participation group meetings, we hear directly from harder to reach communities through tailored approaches and partnership working. We consult with relevant Overview and Scrutiny Committees and NHS England and work alongside our local Healthwatch, as well as the voluntary, community and faith sector in the City.

6.5 Capacity to Handle Risk

We take the management of risk seriously and the Governing Body, executive directors, managers and staff work together to provide an integrated approach to the management of risk and in developing a culture of reporting risk, understanding and challenging risk and providing opportunities for the analysis and discussions on risk across the organisation.

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

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 both the GBAF and Corporate Risk Register. 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 2 or more review cycles are also noted.
Deputy Directors meet monthly where risk management is a standing item for the agenda. Deputies offer leadership and guidance on mitigating the level of risk and ensuring that risks are appropriately managed. Deputy Directors will also consider potential escalation from team risk logs to the Corporate Risk Register where this is appropriate.

6.6 Risk Management Training

All members of staff are aware of their responsibilities in relation to the risk management strategy and policy. They have received training in relation to identifying, reporting, recording and managing risks. This ensures that risk is seen as the responsibility of all members of staff and not just senior managers.

6.7 Risk Assessment

Risk is assessed in accordance with the processes and procedures set out in our Risk Management Strategy and Action Plan. All of the CCG's risk registers use the same risk scoring matrix to ensure consistency in describing risks *(Fig 2).*

Risk is identified and embedded in the organisation via a number of mechanisms including the Corporate Risk Register which identifies current and prospective risks to the CCG. Risks were identified in relation to all of the corporate objectives set for 2016/17 and are included in our Governing Body Assurance Framework (GBAF). There have been no risks identified in relation to compliance with our licence.

When carrying out risk assessments, staff are required to indicate the initial risk score, (prior to identification of controls), the current risk score and the risk appetite. Actions identified to treat risks are designed to reduce the risk score to the risk appetite. The process of risk management includes the following 5 steps to risk assessment:

- Identify
- Assess
- Evaluate
- Record
- Review

Fig 2 NHS Sheffield CCG Risk Management Matrix

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

Identified risks are assigned a score based on a combination of the **likelihood** of a risk being realised and the **consequences** if the risk is realised.

An Annual Risk Management Report was presented to the Governance Sub-committee in August 2017 and AIGC in September 2017 providing assurance of the continued progress throughout the year with regard to risk management.

6.8 Governing Body 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

organisations 5 strategic objectives, eight strategic goals and principle risks and aligned to the Risk Register. It is a dynamic tool that maps out key controls and highlights any gaps in controls and assurances to mitigate the risks identified, providing a mechanism to assure the Governing Body of the 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 in place are operating in a way that is safe and effective.

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

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

A meeting of Executive Directors was held on 7 March 2017 to discuss the content of the GBAF and to ensure that those risks identified remained relevant for the financial year ahead, the session was attended by internal audit colleagues. This was followed by a 'Confirm and Challenge' session attended by Directors who reviewed and challenged the scores of all principle risks highlighted on the refreshed Framework. The Governing Body was provided with details of the refreshed GBAF at its meeting in March 2017 which included details of the changes to be taken forward for 2017/18. 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. This is to ensure the controls and assurances remain valid and any identified gaps are mitigated by timely implementation and are clearly defined.

At the end of the monitoring period there remained 17 risks identified on the GBAF – the level of risk is set out below. No new risks were added during the year and no risks closed. This is compared, in the table below, to the position reviewed in previous quarters.

Review period	Critical	Very High	High	Medium	Low
Initial Risk score at 2017/18	0	5	7	5	0
Up to and including 15 May 2017	0	5	4	8	0
Up to and including 29 November 2017	0	3	5	9	0
Up to and including 31 March 2018	0	1	6	10	0

At 31 March 2018, the Governing Body Assurance Framework identified the following outstanding gaps in control. Each have robust action plans and have been built into the 2018/19 Framework.

Risk Ref	Principal Risk	Identified Gap in Control
2.3	That the CCG fails to achieve Parity of Esteem for its citizens who experience mental health conditions, so reinforcing their health inequality and life expectancy.	Need to continue to develop a coherent response to Parity of Esteem
5.2	Unable to secure timely and effective commissioning support to enable us to adequately respond and secure delivery to existing and new emerging requirements. Quality of externally purchased commissioning support (IT and data management) falls below required levels.	Limited contractual mechanisms available via the LPF contract to drive performance improvement.

6.9 Corporate Risk Register

In accordance with the CCG's Risk Management Strategy, senior managers have initial responsibility for identifying and managing operational risks within their areas of responsibility; all staff are required to report potential risks to their line manager. When a risk has been confirmed it is added to the web based Corporate Risk Register and rated using the standard NHS 5 x 5 scoring system and are assigned a score based on a combination of the **likelihood** of a risk being realised and the **consequences** if the risk is realised.

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 regularly updated and circulated to risk owners.

Each risk is reviewed by the risk owner, senior manager and director during the 13 week review cycle. Teams are encouraged to review their risks at monthly team meetings.

The CCG uses three risk scores:

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

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

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

Current Risks

The number and severity of the risks on the Corporate Risk Register during the year is summarised in the table below:

Date	Critical (Black)	Very High (Red)	High (Amber)	Medium (Green)	Low (Light Green)	Total
Quarter 1	0	0	15	5	2	22
Quarter 2	0	0	21	8	3	32
Quarter 3	0	4	14	10	5	33
Quarter 4	0	3	12	8	4	27

Current Risks

At 31 March 2018 there were 27 risks identified and included on the Corporate Risk Register. The following three risks were classified as Very High (Serious):

- There is a risk of the Urgent Primary Care review failing to deliver the objectives agreed prior to the consultation due to the findings of the public consultation not supporting the preferred proposed option, resulting in the possibility of delivering an alternate option or maintenance of the status quo and in turn failing to deliver some or all the objectives of the programme.
- Inability to meet NHS Constitution pledge on A&E waits, flow through Sheffield Teaching Hospitals NHS FT and impact on elective waiting times & also the revised STF trajectory which requires 90% in Q1, 91% Q2, 90% in Q3 and 90% in Q4 with the exception of March where 95% is required for the subject month.
- Long waiting times in the adult Sheffield Autism and Neurodevelopmental Support Service creates a risk of patient harm due to lack of access to autism and ADHD diagnosis and treatment, resulting in the potential loss of employment/ education/ accommodation and relationship breakdown, and in the extreme, self harm/ suicide. There is also a risk of challenge through the Autism Act and national strategy in relation to our responsibility to provide an accessible autism diagnostic pathway.

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

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

The report to Governance Sub-committee also reviews details of those risks which have remained static in score for two or more cycles.

7 Other sources of assurance

7.1 Internal Control Framework

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

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

A system of internal control has been in place continuously for the year ended 31 March 2018, which continues to be developed as the organisation matures.

Our control framework is articulated through our Constitution, Standing Orders, Scheme of Reservation and Delegation and detailed Prime Financial Policies.

7.2 Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) 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.

Management of conflicts of interest is taken very seriously by the CCG and we work within a robust Standards of Business Conduct and Conflict of Interest Policy and Procedure ("the Standards") in undertaking our business. In order to demonstrate compliance with the requirements of the revised statutory guidance on managing conflicts of interest, assurance is provided to NHS England in the form of an annual and quarterly self-certification returns.

Training and development with staff has been undertaken throughout the year and has been a key focus for the CCG during 2017/18 which included induction for new staff and specific training for business managers and administrators. The CCG has a Conflicts of Interest Guardian and a robust support structure in place underpinning this role. There were no breaches of conflict of interest to report in 2017/18.

Our “Standards” were reviewed and updated following the issue of revised statutory guidance for CCGs in June 2017 and given the changes to the guidance, NHS England included an audit within the financial year internal audit plan to understand how these arrangements were working in practice at a sample of ten CCGs. NHS Sheffield CCG was selected to take part in this audit, including consideration of how conflicts of interest have been managed for commissioning decisions and remuneration decisions for members of the Governing Body. In addition, the scope of the audit considered the processes for the management of gifts and hospitality.

Below is a summary of the number of exceptions identified within each area of the statutory guidance. An action plan is in place to take forward recommendations from the audit, with the majority of actions now complete.

Statutory Guidance	No of observations		
	Priority 1	**Priority 2**	**Priority 3**
Governance	-	-	1
Identifying and declaring conflicts and gifts and hospitality	-	1	-
Recording, maintaining and publishing conflicts and gifts and hospitality	1	3	2
Procurement decisions and contract monitoring	1	3	-
Identifying and managing non-compliance	-	-	-
Remuneration	-	-	-
Total	**2**	**7**	**3**

Definition of Priorities

Category	Description
1	The observation is a critical priority and should be addressed immediately
2	The observation is important and should be addressed in a timely manner
3	The observation is an opportunity for improvement and should be addressed when resources and time are available

7.3 Data Quality

All reports received by Governing Body provide information on how they link to the Governing Body Assurance Framework. The Governing Body receives a monthly Performance, 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.

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

7.4 Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing / have developed information governance processes and procedures in line with the Information Governance 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. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

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.

This is managed via the robust information governance systems and processes we have in place to help protect patient and corporate information. We have established an information governance management framework and are always evolving or developing / have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training (current compliance is over 95%) 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 SIRO for the organisation and feeds into the Governance Sub-committee.

The level of compliance demonstrated by completion of the 2017/18 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.

A level two Information Governance incident has been reported to the Information Commissioner. Whilst the breach occurred during 2016/17, it became apparent in 2017/18 and related to data security.

7.5 Business Critical Models

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

7.6 Third party assurances

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

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

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

- From NHS Shared Business Services for the provision of Financial Accounting Services
- From NHS Business Service Authority regarding Prescription Payment Processes
- 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. Assurance is received through the contract and regular 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.

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

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

8 CONTROL ISSUES

The CCG has reviewed its control arrangements and concluded that there were no significant control issues facing the organisation.

An IG incident has been identified and reported to Information Commissioners Office (ICO) and is currently being investigated. Initial legal advice indicates that the CCG is not in breach of its legal responsibilities.

9 REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive directors 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 external auditors in their management letter and other reports.

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit and Integrated Governance Committee and Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. There are procurement processes in place to which the CCG adheres. There is a Scheme of Reservation and Delegation which ensures that financial controls are in place across the organisation.

The roles of accountable and delegated committees and groups are clearly articulated in Section 3 (Governance Arrangements and Effectiveness) of this Statement. The Scheme of Reservation and Delegation has been reviewed, and approved in year.

As detailed in Section 11 below, the CCG actively deters risk through the adoption of robust counter-fraud methodology.

NHS England assesses the CCG's Quality of Leadership within the CCG Improvement and Assessment Framework. NHS England has advised that the year-end results for the Quality of leadership Indicator will be available from July 2018 at www.nhs.uk/service-search/scorecard/results/1175. The assessment of the CCG's quality of leadership for 2016/17 was 'Good'.

The Director of Finance, who is a member of the Governing Body, is responsible for providing financial advice and for supervising financial control and accounting systems. She presents a monthly finance report to Governing Body, encouraging open debate and understanding from its members. This report provides members with information on cumulative expenditure against the approved budgets, together with a forecast of the likely year end position, and any risks or actions required to manage the overall financial position. The CCG contained expenditure within allocated resources, both for Programme (including primary care Co-commissioning) and Running Costs and has ended the year with a surplus of £18 million, made up of:

- £1.6m in year surplus (in line with our approved financial plan)
- brought forward surplus of £11.6m
- NHS England top-sliced the financial benefit of agreed pricing changes in relation to certain drugs (referred to as category M drugs). NHS England returned this financial benefit to CCGs in March 2018 and required that this funding be used to increase reported surpluses (£1.1m)
- Finally the CCG has released the 0.5% risk reserve which all CCGs were required to hold throughout 2017/18 as uncommitted. For Sheffield, this increased the reported surplus by a further £3.7m.

The Director of Commissioning and Performance, who is a member of Governing Body, is responsible for providing advice to the Governing Body on the progress of the CCG's Quality, Innovation, Productivity and Prevention (QIPP) programme. He

presents a monthly QIPP report to Governing Body outlining the progress of the key programmes and projects, and the impact that these initiatives are having on the delivery of improved quality, efficiency and effectiveness.

Third party assurance is provided by Internal Audit in relation to the effectiveness of the CCG's key financial systems and External Audit provide an opinion in relation to the CCG's use of resources in their Value for Money (VFM) conclusion.

10 DELEGATION OF FUNCTIONS

We 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 Y&H Joint Strategic Commissioning Board. Limited delegation in respect of quality and performance matters is in place to the Coordinating commissioners for YAS 999 (Wakefield CCG) and NHS 111 (Greater Huddersfield CCG) through the Memorandum of Understanding.

11 COUNTER FRAUD ARRANGEMENTS

The Director of Finance is responsible for ensuring adherence to 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. We have in place a Fraud, Bribery and Corruption Policy which is agreed and monitored by AIGC. Our Counter Fraud Service is provided by 360 Assurance and provides regular comprehensive update reports to AIGC to ensure members are made aware of work undertaken by the Local Counter Fraud Specialist (LCFS). The content is formatted to report upon compliance with NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption, covering the following areas:

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

The LCFS attends meetings of the Audit and Integrated Governance Committee and provides comprehensive updates on progress towards completion of the Annual Work Plan and compliance with the Standards for Commissioners.

12 HEAD OF INTERNAL AUDIT OPINION

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

Significant Assurance

I am providing an opinion of Significant Assurance, that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently. This opinion is based on my review of your systems of internal control, primarily through the operation of your Board Assurance Framework in the year to date, the outcome of individual assignments completed and your response to recommendations made.

I have reflected on the context in which the CCG operates, as well as the significant challenges currently facing many organisations operating in the NHS, and my opinion recognises that the system of internal control is designed to manage risk to a reasonable level, rather than eliminate all risk of failure to the achievement of strategic objectives.

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

Area of Audit	**Level of Assurance Given**
Integrity of the General Ledger and Key Financial Systems	Significant
Shared Systems Review - IFR	Significant
Commissioning Strategy Development	Significant
Information Governance Toolkit	Significant
Risk Management	Significant
Data Quality Framework	Significant
Quality Governance	Significant
Review of Agreement with Primary Care Sheffield	N/A*

** Public Sector Internal Audit Standards require that all work undertaken for an organisation will be considered for the Head of Internal Audit Opinion, even where we have not specifically provided an opinion level.*

13 REVIEW OF THE EFFECTIVENESS OF GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

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

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

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

- **The Governing Body:** responsible for providing clear commitment and direction for risk management within the organisation and approving the CCG's risk management arrangements. It is responsible for determining the nature and extent of significant risks it is willing to take in achieving its strategic objectives. During 2017/18 it has maintained sound risk management and internal control systems as described in the risk management section of this statement.

- **The Audit and Integrated Governance Committee:** responsible for providing an independent overview of the arrangements for risk management within the CCG, with specific responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews all internal and external audits.

- **The Quality Assurance Committee:** has a responsibility for ensuring clinical risks are identified and reported on the risk register, escalating to the Assurance Framework where necessary. The Committee provides assurance to the Governing Body that appropriate clinical risk management arrangements are in place across the organisation. Its work programme addresses safeguarding, infection control, quality in contracts, incidents and medicines management.

- **Primary Care Commissioning Committee:** is a committee of the Governing Body. The Committee has been established to enable Members to make collective decisions on the review, planning and procurement of primary care services in Sheffield under delegated authority from NHS England. In performing its role, the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG. Minutes of each meeting of the PCCC are forwarded to NHS England for information, including the minutes of any sub-committees to which responsibilities are delegated.

- **Internal Audit:** reviews of systems of internal control and progress reports to Audit and Integrated Governance Committee have supported my review, especially with regard to the Assurance Framework and Risk Management – Risk Identification reviews.

- **Executive Directors:** Each director is responsible for ensuring that risks have been properly identified and assessed across all their work areas. They are responsible for reviewing risks entered onto the corporate risk register and that each risk owner is actively managing their risks and escalating as appropriate. Directors are responsible for the management of all high level risks facing delivery of the organisations objectives. Directors also play a crucial role in ensuring that risk related issues are adequately dealt with when policies are developed within their area of work.

- **Director of Finance:** is responsible for ensuring that the organisation complies with the Standing Orders to achieve financial balance and reporting of financial risk to the Governing Body.

- **Senior Managers and Clinical Leads within the CCG** who have responsibility for the development and maintenance of the internal control framework
- **Performance information** – Quarterly Quality and Performance reports to Governing Body
- **External Auditors** - Comments in their Annual Audit Letter and other reports

My review was also informed by:

- Delivery and audit plans by External and Internal Auditors
- Results from the Staff Survey
- Results from the NHS England Conflicts of Interest Audit
- Annual Operational Plan
- Information Governance Toolkit Assessment
- Monthly delivery and performance reports
- Regular reviews of risk registers
- Regular reports to the Governing Body from each of the formal committees
- Quarterly Assurance reports to NHS England
- Results of the 360 Stakeholder Review
- NHS England Assurance review
- Governance Sub-committee

14 CONCLUSION

My review confirms that NHS Sheffield Clinical Commissioning Group 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:

Maddy Ruff
Accountable Officer

24 May 2018

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 3.3.4, page 64). The Committee is responsible for advising about the appropriate remuneration and terms of service for the Accountable Officer, Executive Directors and other Senior Managers, as well as monitoring and evaluating their performance.

2. Senior Managers' Remuneration and Terms of Service

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

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

The Accountable Officer of the CCG has determined that this definition applies to all voting members of the Governing Body as set out in the CCG's Constitution. NHS England approved changes to the CCG's Constitution which included changes to job titles for certain directors and also the number of voting members with effect from November 2017. While some directors may have used a locally agreed title before the approved changes to the Constitution, for the purposes of this Annual Report we have only used the titles set out in the Constitution. For the relevant directors remuneration information is provided from the date they became a voting member. Profiles of each Governing Body member can be found in the Members' Report section of this Annual Report.

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

Senior Managers' remuneration for 2017/18 was determined by the Remuneration Committee and took account of national guidance, the prevailing economic climate, local market conditions and the requirement to obtain best possible value for money. The costs of posts are met from the notified Clinical Commissioning Group running cost allowance.

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

- The Agenda for Change guidance from NHS Employers including the staffing body pay and employment conditions in relation to senior managers' remuneration to ensure parity as far as reasonably practicable. Staff engaged on Agenda for Change payscales received a 1% pay increase.
- 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.

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

The Remuneration Committee agreed a 1% increase for all Governing Body voting members from 1 April 2017 in line with that awarded to staff engaged on Agenda for Change payscales.

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

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

The Remuneration Committee sets the framework within which the terms and conditions of the Very Senior Managers are developed and agreed. It also receives reports on performance against standards set in relation to local and national targets from the CCG's strategic and operational plans. The remuneration is set through a process that is based on a consistent framework and independent decision of performance measures against an individual's performance with due consideration to comparative salary data, the labour market, the financial circumstances of the organisation plus any national guidance. Non-consolidated Performance Related Pay was paid to the Accountable Officer and Director of Finance at 3% of basic salary following assessment of individual performance in 2016/17 and a subsequent recommendation by the Remuneration Committee. The Director of Commissioning and Performance was not eligible for performance related pay relating to 2016/17 as he was not in post until 2017/18.

Very Senior Managers are on permanent contracts. Six months' notice is required by

the organisation to terminate the contract and three months' notice by the individual. Directors engaged under Agenda for Change and the Medical Director have a three month notice period on either side to terminate the contract. All other Governing Body voting members are appointed for a period of up to three years, with a notice period of three months. Further information can be found in the CCG's Standing Orders which are available on the CCG's website as part of the CCG's Constitution: http://www.sheffieldccg.nhs.uk/about-us/our-constitution.htm

There are four Senior Managers on the Governing Body whose salary exceeds £150,000 per annum when adjusted to reflect a full time annualised equivalent post. Two 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. One post was a Director post which was paid for on an off-payroll basis due to the CCG at the time being unable to recruit substantively because of the specialist skills and knowledge required. The CCG followed NHS England's national approvals process for this temporary off payroll appointment. This arrangement ceased in May 2017 following a substantive appointment to the Director of Commissioning and Performance. The fourth post is that of the Accountable Officer and the level of remuneration was agreed by the Remuneration Committee to reflect the responsibility of the post in a large and complex health system.

Name	Title	*Contract Commencement	Contract Expiration
Dr Tim Moorhead	Chair	01-Apr-13	31-Oct-18
	Locality Appointed GP	01-Nov-14	30-Sep-20
Mrs Madeline Ruff	Accountable Officer	01-Sep-15	Substantive Post
Mrs Penny Brooks	Chief Nurse	01-Sep-16	24-Sep-17
Mrs Mandy Philbin	Acting Chief Nurse	25-Sep-17	30-Apr-18
Miss Julia Newton	Director of Finance	01-Apr-13	Substantive Post
Ms Nicola Doherty	Director of Delivery - Care Outside of Hospital (Interim up to 02-Nov-17, substantive from 03-Nov-17)	03-Nov-17	Substantive Post
Mr Matthew Powls (interim)	Interim Director of Commissioning and Performance	01-Nov-16	19-May-17
Mr Brian Hughes	Director of Commissioning and Performance	29-May-17	Substantive Post
Mr Peter Moore (external secondment)	Director of Strategy and Integration	01-Nov-16	30-Sept-17
Dr Zak McMurray	Medical Director	01-Apr-13	Substantive Post
Dr Nikki Bates	GP Elected Member	01-Jan-17	31-Dec-19
Dr Marion Sloan	GP Elected Member	01-Oct-13	31-Dec-19
Dr Jennie Joyce	Locality Appointed GP (cover for sabbatical)	06-Mar-18	06-Sep-18
Dr Gasan Chetty	Locality Appointed GP	01-Oct-17	30-Sep-20
Dr Amir Afzal	Locality Appointed GP	01-Nov-14	30-Sep-17
Dr Ngozi Anumba	Locality Appointed GP	14-May-15	17-May-18
Dr Leigh Sorsbie	Locality Appointed GP (to 05-Mar-18 - on sabbatical)	01-Nov-14	05-Mar-18
Dr Annie Majoka	GP Elected Member	01-Jan-17	31-Dec-19
Dr Terry Hudsen	GP Elected Member	01-Jan-17	31-Dec-19
Mr John Boyington	Vice Chair and Lay Member	01-Jul-13	31-May-17
Ms Amanda Forrest	Lay Member	01-Jul-13	31-Mar-20
Prof Mark Gamsu	Lay Member	01-Jul-13	30-Jun-19
Mr Tony Williams	Lay Member	01-Sep-17	26-Feb-18
Mr Phillip Taylor	Lay Member (Deputy Chair from 09-Nov-17)	01-Mar-16	28-Feb-19
Dr Christopher Whale	Secondary Care Doctor	01-Jul-17	30-Jun-20

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

3. Salaries and Allowances (subject to audit)

The table at Appendix Bi details the salaries and allowance for all the senior managers of the CCG, as defined above. Prior year comparators are shown for 2016/17 within Appendix Bii.

4. 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.

5. Payments to Past Senior Managers (subject to audit)

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

6. Pension Benefits (subject to audit)

The table at Appendix 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 2016/17.

7. 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 2017/18 was £155,039 (£165,439 in 2016/17). This was 4.36 (4.75 times in 2016/17) times the median remuneration of the workforce which was £35,577 (£34,818 in 2016/17). The year-on year change to the remuneration of the highest paid member is as a result of the exclusion of the chair of the CCG (previously noted as the highest paid member) reflecting national guidance on the treatment of shared posts. There has been no material change to the median remuneration of all CCG staff.

There has been a small 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 2017/18 rose from 369 employees in 2016/17 to 410 employees.

There was a 1% pay increase for all staff on Agenda for Change terms and conditions in 2017/18.

In 2017/18 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 2016/17) reflecting national guidance on the treatment of shared posts. Remuneration for CCG employees ranged from £6,839 to £155,039 where the salary is calculated on an annualised, full-time equivalent basis.

The South Yorkshire and Bassetlaw Accountable Care System (SY&BL ACS) 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 core SY&BL ACS team and accounts for national funding received from NHS England to fund the team. In 2017/18 there was one full time director within the ACS team who received remuneration in excess of the highest paid member of the CCG's Governing Body. The remuneration was £190,276.

Staff Report

1. Senior Managers

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

Pay Band	No. of Employees
Senior Managers	8
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

The table below summarises the average number of people employed by Sheffield CCG in 2016/17, 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	311	268	42
Net employee benefit costs In £'000s	14,734	12,773	1,961

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 2018.

	Female	Male
All Employees	267	63
Of which; Very Senior Managers (VSM)	2	1
Of which; Voting Members of the Governing Body	11	7

4. Sickness absence data

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

	2017 Number	2016 Number
Total Days Lost	2,211	2,228
Total Staff Years	256	240
Average working Days Lost	8.6	9.3

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 2017 to 31 March 2018 was as follows:

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent number*
2	**0.226**

Percentage of time spent on facility time: The percentage of the employees' time spent on facility time was as follows:

Percentage of time	*Number of employees*
0%	0
1%-50%	**2**
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 2017/18 was as follows:

Total cost of facility time	**£7,436**
Total pay bill	**£10,623,000**
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*	**6.18%**

6. Staff policies applied during the financial year:

6.1. Equality Impact Assessment

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

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

6.2 Training

CCG staff members completed mandatory Data Security Awareness e-learning training and Bullying and Harassment Prevention training. Our first in-house Management and Leadership Training Cohort successfully completed their course. We now have a trained team of 17 Mental Health First Aiders in the CCG. Senior management team members as well as Deputy Directors have attended bespoke development sessions to improve leadership skills. Staff have trained to become ILM accredited Coaches and we participated in organisational development forums developing system-wide work streams across the Integrated Care System.

6.3 Equality of Opportunity

The organisation is committed to equality of opportunity for all employees and potential employees. It views diversity positively and, in recognising that everyone is different, the unique contribution that each individual's experience, knowledge and

skills can make is valued equally. The promotion of equality and diversity will be actively pursued through policies and procedures which will ensure that employees and potential employees are not subject to direct or indirect discrimination. NHS Sheffield 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. Expenditure on consultancy

NHS Sheffield Clinical Commissioning Group spent £1,633k in total on consultancy services in 2017/18. Of this, £1,506k related to consultancy services commissioned by the Accountable Care System (ACS), mainly in relation to the Hospital Services Review and developmental support to the ACS plan. NHS Sheffield Clinical Commissioning Group also hosts the Accountable Care Partnership (ACP) which in addition to the CCG includes the three Sheffield NHS Foundation Trusts, Sheffield City Council and Primary Care Sheffield. £32k was spent on consultancy for the ACP with £25k being recharged to the partner organisations, leaving £7k net spend for the CCG. The remaining £99k expenditure on consultancy services related to the CCGs own functions.

8. Off-payroll engagements

Following the Review of *Tax Arrangements of Public Sector Appointees* published by the Chief Secretary to the Treasury on 23 May 2012, CCGs must publish information on their highly paid and/or senior off-payroll engagements. Highly paid is defined as off-payroll engagements for more than £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 2018 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 2018	20
Of which, the number that have existed:	
for less than one year at the time of reporting	10
for between one and two years at the time of reporting	3
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	3
for 4 or more years at the time of reporting	3

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 2017 and 31 March 2018, 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 2017 and 31 March 2018	14
Of which:	
Number assessed as falling within the scope of IR35	3
Number assessed as falling within the scope of IR35	11
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	7
Number of engagements reassessed for consistency / assurance purposes during the year	14
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 01 April 2017 and 31 March 2018.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	2
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).	25

There were two off-payroll engagements for Governing Body members during the financial year in Table 3 above. One was for a temporary role to cover the post of the Director of Commissioning and Performance, for the period 1 July 2016 to 19 May 2017. Due to recruitment difficulties to such a key role within the Governing Body it was necessary to use a recruitment agency to provide interim cover for the vacancy. The CCG followed NHS England's national approvals process for this temporary appointment. The other was for a GP member who carried out commissioning work for one of the City's localities up to September 2017. The CCG has 4 localities made up of GP practices to support it's commissioning function. One of the localities asked their Governing Body locality appointed GP to undertake a number of commissioning projects. This work was carried out on an ad-hoc basis and hence the role did not fit with a pattern of regular extra hours that could convert to payroll arrangements.

9. Exit Packages (subject to audit)

The table below details the number and value of the exit packages agreed in 2017/18 (2016/17 £247k).

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	1	2,426			1	2,426		
£10,000 - £25,000								
£25,001 - £50,000	1	26,683			1	26,683		
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 – £200,000								
>£200,000								
TOTALS	**2**	**29,109**	**0**	**0**	**2**	**29,109**	**0**	**0**

Redundancy costs have been paid in accordance with the provisions of the NHS Pension Scheme with the full cost being met by Sheffield CCG. Other Departure costs are shown in Table 2 below.

The exit packages detailed in Table 1 above relate to two compulsory redundancies for a senior manager of the CCG who is not a Governing Body member and for an admin/clerical worker.

Analysis of Other Departures

There were no other departures in 2017/18.

Signed:

Maddy Ruff
Accountable Officer

24 May 2018

REGISTER OF INTERESTS
GOVERNING BODY 17/18/19

Appendix A

(Historic interests will be retained by the CCG for a minimum of 6 years after the date on which the interest expired. To submit a request for this information, please contact Carol Henderson, Committee Secretary, on 0114 305 1102 or carol.henderson2@nhs.net)

Name	Current position(s) held i.e. Governing Body, Member practice, Employee or Other (specify)	Declared Interest (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Dr Amir Afzal **(GB Member to 30.9.17)**	CCG GP Locality representative	• Senior Partner, Duke Medical Centre	✓					1/8/94		Always declared
		• GP Appraiser		✓				1/1/00		Not really relevant Declaration if it becomes relevant
		• Director, Central Care Sheffield Ltd (not trading)						1/2/10	1/2/14	No longer exists
		• Director, Saihara Care Ltd (Care agency based in London)								Ad hoc meeting personal capacity.
		• B-TAK Enterprise Ltd (Rental of furnished offices company run by brother)	✓					1/1/06		Personal/
		• Chair of Medical Education meeting, Astra-Zeneca		✓				1/1/10		Practice capacity only
		• Various pharmaceutical companies provide lunch to weekly practice nurses / GP meetings at practice		✓				1/7/94		
		• GP out of hours ad hoc shifts, Care UK								Declared and appropriate action taken at relevant
		• Practice is a shareholder in Primary Care Sheffield (PCS)	✓					1/1/11		

		Ltd	✓					2015		discussions
Dr Ngozi Anumba	CCG GP Locality representative	• GP Partner, Woodhouse Health Centre • Director, Woodhouse Healthcare Services Ltd (community pharmacy) • Trustee, City Hearts (unpaid) • Partner in a practice which is a shareholder in Primary Care Sheffield (PCS) Ltd	✓ ✓ ✓		✓			2015		Declared as an interest in meetings
Dr Nikki Bates	CCG GP Elected City-wide Representative	• GP Partner, Porter Brook Medical Centre • Practice is provider of Occupational Health Services for students at Sheffield Hallam University • GP Appraiser • Minority stakeholder in Rivelin Healthcare Ltd • Partner Governor, Sheffield Children's NHS Foundation Trust • Spouse is a Director of Chesterfield Orthodontics (Smile by Design Ltd) • Practice is a shareholder in Primary Care Sheffield (PCS) Ltd	✓ ✓ ✓ ✓			Indirect		1990 1990 2010 2007 2013 2013	Ongoing	Declare as appropriate Declare as appropriate
John Boyington CBE **(GB member up to 31.05.17)**	Deputy Chair and Lay Member	• Chairman (2 days per week paid), Bury GP Practices Ltd, a Company Limited by shares which is a provider of health services in Bury, Greater Manchester • Chairman (unpaid) of Masonic Care Ltd, a charitable Company providing residential care to 12 people with a learning disability in Thorne, South Yorkshire • Trustee (unpaid), Croft House Settlement a registered	✓	✓ ✓				2015 2014 2000		Company situated 40 miles away and no established or planned links with CCG. Member would be excluded from any decisions where a conflict might occur Home situated in Thorne, Doncaster. Not personally involved in or able to influence any decisions about client placement.

		charity providing premises and facilities for voluntary groups to meet in Sheffield city centre • Trustee of the Masonic Charitable Foundation, a charity providing local, national and international support to Freemasons and to the community at large o Member of the Charitable Support Executive Committee o Member of the Community Support sub-committee o Member of the Medical Research sub-committee • Director of the Royal Masonic Benevolent Institution Care Company, a subsidiary charity of The MCF providing care to 1,000 people in 17 homes across England and Wales. The position is non-remunerated. The nearest care home is situated in York	 ✓	 ✓				 2016 2014		This role predates appointment to CCG by many years and there are no evident links in related business. MCF is a grant-making charity which neither commissions nor takes commissions from CCGs or other commissioners Nearest care home situated in York does take residents from Sheffield but I have no involvement or influence on admissions policy or practice
Penny Brooks (**GB Member up to 31.12.17. Governing Body voting rights to 24.9.17)**	Chief Nurse	• Trustee (unpaid), Ashgate Hospice Care • Director, PJ Brooks Consulting Ltd			✓					Out of area provider
Dr Gasan Chetty **(GP Member from 1.10.17)**	CCG GP Locality representative	• GP Partner Mathews Practice • Minor Surgery – practice provides this service for Sheffield surgeries, interpractice referrals • Doncaster surgical skills Course Trainer • Occupational health work for 2 South Yorkshire bus companies	✓ ✓					Ongoing Ongoing Ongoing Ongoing		Declare where relevant “ “

Nicki Doherty **(GB Member from 1.1.17)**	Director of Delivery – Care Outside of Hospital **(Interim up to 02-Nov-17, substantive from 03-Nov-17)**	• Parent works one day a week for Yorkshire Ambulance Service NHS Trust (YAS) around community relationships and social prescribing at scale • Parent works on a zero hours contract for Yorkshire Ambulance Service NHS Trust (YAS) around community relationships and social prescribing at scale				Indirect Indirect		1/1/18 1/11/17	 1/1/18	This will largely link in at Accountable Care System level. Although involved in social prescribing I do not hold the budget for it For any bidding process for local commission of social prescribing funds I will not be involved directly in any detail. YAS will be advised of this and a link established with the Local Authority Lead Commissioner for Social Prescribing. For any decisions around social prescribing locally if YAS is involved I will declare an interest and absent myself from the decision making process It is possible that new areas of conflict arise as the YAS role develops. When this happens any conflicts will be

										considered and declared along with appropriate mitigations
Amanda Forrest	Lay Member	• Partner Governor, STHFT • Team Associate, University of Durham (2 year contract freelance) • Team Associate, University of Sheffield (2 year contract freelance) • Stage 2 Complaints Independent Investigator (Children Act) Sheffield City Council (freelance) • Co-opted Trustee Sheffield Carers Centre • Elected Trustee Sheffield Carers Centre	✓ ✓ ✓ ✓		 ✓ ✓			21/4/15 Sept 15 Jan 16 Oct 14 14/2/17 21/9/17	 July 17 Dec 17 2018 20/9/17	
Mark Gamsu	Lay Member	• Director, Local Democracy and Health Ltd (public health consultancy) • Trustee - Chair, Sheffield Citizens Advice (organisation does receive contract funding from the CCG) • Committee Member, Darnall Wellbeing (health project) (organisation does receive contract funding from the CCG) • Trustee, Citizens Advice (national voluntary organisation) • Professor Institute for Health Development, Leeds Beckett University (academic institution) (part time paid role) • Chair, Chance to Dance (voluntary organisation) • Co-ordinator of European Health Equity Programme, UK Health Forum (national voluntary organisation) (to 4.1.17) • Trustee, Voluntary Action Sheffield • Trustee, Sheffield Mental Health CAB (organisation does not receive contract funding from the CCG) • Trustee, Community Legal Advice Service South Yorkshire (organisation does not receive contract funding from the CCG) • Trustee, INVOLVE Yorkshire and Humber	✓ ✓ 		 ✓ ✓ ✓ ✓ 			2013 2013 2013 2013 2016 2012 	 31.3.17 4.1.17 4.1.17 4.1.17 4.1.17 4.1.17	Declared Declared Declared Declared Declared Declared

Dr Terry Hudsen	CCG GP Elected City-wide Representative	• GP Principal, University of Sheffield Health Service • Employer holds shares in Primary Care Sheffield Ltd	✓ ✓					May 14 26.3.18	Ongoing Ongoing	Declare at meetings as appropriate
Brian Hughes **(GB Member from 30.5.17)**	Director of Commissioning and Performance	• No interests to declare								
Dr Jennie Joyce **(GB Member from 6.3.18 to cover 6 month sabbatical)**	CCG GP Locality representative - North	• GP Partner, Pitsmoor Surgery • Board and Executive Member, Foundry Medical Group • Shareholder, Primary Care Sheffield Ltd	✓ ✓ ✓					07/12 1.11.15 14.3.15	Ongoing Ongoing Ongoing	Declare at meetings as appropriate Declare at meetings as appropriate
Dr Annie Majoka	CCG GP Elected City-wide Representative	• GP Principal, Abbey Lane Surgery • Practice is a shareholder in Primary Care Sheffield (PCS) Ltd • CASES GP for cardiology and gynaecology peer reviewing	✓ ✓	 ✓				2015		Declare at meetings as appropriate Declare at meetings as appropriate
Dr Zak McMurray	Medical Director	• Shareholder, Woodhouse Health Care Services Ltd – 10% holding (Woodhouse Pharmacy) • Trustee, Talbot Trusts • Spouse is Director of North East Derbyshire Healthcare	✓	 ✓		 Indirect		06/14 10/12/12 02/16		Declare and abstain from discussion if needed. Declare and abstain from discussion if needed. Declare and abstain from discussion if needed.
Peter Moore **(GB Member (from 1.1.16 to 30.9.17)**	Director of Strategy and Integration	• Director of Strategy and Integration, Sheffield City Council (SCC) (50% SCC funded post)		✓				Oct 15	Sept 17	
Dr Tim Moorhead	CCG GP Locality representative CCG Chair	• Senior Partner, Oughtibridge Surgery • Minority shareholder, Rivelin Healthcare Ltd • Executive Member of Local Medical Committee • Practice is a shareholder in Primary Care Sheffield (PCS) Ltd	✓ ✓ ✓	 ✓				 12/16 2015	 Ongoing	Declaration of Interest Declaration of Interest Declaration of Interest Declare an interest in any relevant

		• Board Member – NHS Clinical Commissioners • Sibling is a GP Partner at Baslow Road Surgery		✓		Indirect		07/17		discussion Declare an interest in any relevant discussion
Julia Newton	Director of Finance	• No Interests to declare								
Matt Powls **(GB member to 19.5.17)**	Interim Director of Commissioning and Performance	• Director, Pentland Healthcare Consulting						27/11/13	14/7/15	Dissolved
Mandy Philbin **(GB Member from 25.9.17)**	Acting Chief Nurse	• Distant relative works in Continuing Health Care (CHC) team				Indirect		1/17		Declare at meetings as appropriate
Maddy Ruff	Accountable Officer	• Spouse works for Royal Mail • Occasionally see a Director of the Worklife Company outside of work. This happens infrequently now that they have moved from York to Hampshire • Sibling is a Director at Legal and General HQ in London				Indirect Indirect		2017	Ongoing Ongoing	Contract managed through Director of Finance and Chief Nurse None at present. Will monitor the situation as it develops
Dr Marion Sloan	CCG GP Elected City-wide Representative	• GP Principal, Sloan Medical Centre • Sessional GP, GP Collaborative • Clinical Assessor, STHFT • Lead GP, Gastroenterology Community Service • Practice is a shareholder in Primary Care Sheffield (PCS) Ltd	✓ ✓ ✓					1978 1995 2015	 30.11.16 30.11.16 Ongoing	 Declare at meetings as appropriate
Dr Leigh Sorsbie **(on 6 month sabbatical from 6.3.18)**	CCG GP Locality representative - North	• GP Partner, Firth Park Surgery (salaried) • GP Partner, Firth Park Surgery • GP Appraiser • Sessional GP Sheffield OOH Collaborative	✓					1/3/17 1/4/97 2005 2001	 28/2/17 2016 2016	
Phil Taylor	Lay Member (and acting Deputy Chair from 3.7.17 and substantive Deputy Chair from 9.11.17)	• Managing Director, Phil Taylor Associates Ltd (Management Consultancy) • Treasurer. Dore Club	✓		 ✓			1/3/16 1.3.16	Ongoing Ongoing	Company in process of closure Interest declared but unlikely to have any conflicts Charity now closed

		• Chair and Trustee, Sheffield Hospitals Charity (NHS Charity) • Chair and Trustee, Sheffield Hospitals Charity (independent charity) • Chair and Director of Sheffield Hospitals Charity Trading Ltd (dormant organisation not in operation) • Honorary Fellow of the Healthcare Financial Management Association (HFMA) • Chair of the HFMA Non Executive Director and Lay Member Faculty (unpaid)			✓ ✓ ✓ ✓ ✓			1/3/16 30/9/16 30/9/16 1/3/17 1/3/17	31.3.17 1.3.17 Ongoing Ongoing Ongoing	down Interest to be declared if any discussion of charity Interest to be declared and expect to be absent from any contracting decisions Interest declared and expect to be absent from any contracting decisions Interest declared and expect to be absent from any contracting decisions
Dr Chris Whale **(GB member from 1.7.17)**	Secondary Care Doctor	• Consultant Physician at Derby Teaching Hospitals NHS Foundation Trust		✓				10/2009	Ongoing	Declare at meetings if the situation arises
Tony Williams **(GB member from 1.9.17 to 26.2.18)**	Lay Member	• No interests to declare								

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

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 in 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.

Remuneration Report: Senior Managers: Salaries and Allowances 2016/17

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

	2016-17					
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	95 - 100	0	0	0	17.5 - 20.0	115 - 120
M Ruff Accountable Officer	140 - 145	51	0-5	0	55.0 - 57.5	200 - 205
I Griffiths Chief Operating Officer (to 30 September 2016)	45 - 50	0	0	0	0	45 - 50
N Doherty Director of Delivery - Care Outside of Hospital (Interim) (from 1 January 2017)	15 - 20	0	0	0	25.0 - 27.5	40 - 45
K Clifford Chief Nurse (to 31 August 2016)	40 - 45	1	0	0	0	40 - 45
P Brooks Chief Nurse (0.6 wte from 1 September 2016)	30 - 35	0	0	0	0	30 - 35
*T Furness Chief of Business Planning & Partnerships (to 1 September 2016)	40 - 45	0	0	0	7.5 - 10.0	50 - 55
J Newton Director of Finance	110 - 115	1	0	0	15.0 - 17.5	125 - 130
Z McMurray Medical Director	110 - 115	0	0	0	0	110 - 115
*P Moore Director of Strategy & Integration (voting rights from November 2016)	40 - 45	1	0	0	75 - 77.5	115 - 120
*M Powls Director of Commissioning & Performance (Interim) - (voting rights from November 2016)	70 - 75	0	0	0	0	70 - 75
N Bates GP Elected Member	10 - 15	0	0	0	2.5 - 5.0	15 - 20
A Gill GP Elected Member (to 23 September 2016)	5 - 10	0	0	0	0 - 2.5	5 - 10
T Hudsen GP Elected Member (from 1 January 2017)	0 - 5	0	0	0	0 - 2.5	0 - 5
A Majoka GP Elected Member (from 1 January 2017)	0 - 5	0	0	0	0 - 2.5	0 - 5
M Sloan GP Elected Member	10 - 15	0	0	0	0	10 - 15
T Turner GP Elected Member (to 30 September 2016)	5 - 10	0	0	0	0 - 2.5	5 - 10
A Afzal Locality appointed GP	10 - 15	0	0	0	0	10 - 15
N Anumba Locality appointed GP	10 - 15	0	0	0	2.5 - 5.0	15 - 20
L Sorsbie Locality appointed GP	10 - 15	0	0	0	17.5 - 20.0	30 - 35
D Fernando Secondary Care Doctor (to 31 January 2017)	10 - 15	0	0	0	0	10 - 15
J Boyington CBE Vice Chair and Lay Member	10 - 15	0	0	0	0	10 - 15
A Forrest Lay Member	10 - 15	0	0	0	0	10 - 15
M Gamsu Lay Member	10 - 15	0	0	0	0	10 - 15
P Taylor Lay Member	10 - 15	0	0	0	0	10 - 15

Notes

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

Pension related benefits is the increase in the annual pension entitlement determined in accordance with the HMRC method. This compares the accrued pension and the lump sum at age 60 at the end of the financial year against the same figures at the beginning of the financial year. 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 is on such a contract and the perfomanance bonus paid in 2016/17 relates to the 2015/16 financial year.

*The salary relating to M Powls is paid on an off-payroll basis via an Agency. To ensure the salary 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.

*There was a compulsory redundancy and a contractual payment in lieu of notice in year for T Furness. The details are shown in Section 8 of the Remuneration Report under Exit Packages.

Three of the Governing Body members were paid on an off-payroll basis during the year. Two of the payments were for clinicians who carried out ad-hoc clinical engagement work outside of their Governing Body role.

Pension Benefits - 2017-18 **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 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
T Moorhead Chair of the Governing Body	0 - 2.5	0- 2.5	20 - 25	65 - 70	404	34	441	0
M Ruff Accountable Officer	0 - 2.5	5.0 - 7.5	45 - 50	140 - 145	880	87	976	0
*P Brooks Chief Nurse (voting rights ceased 24 September 2017)	0	0	0	0	0	0	0	0
M Philbin Acting Chief Nurse (from 25 September 2017)	2.5 - 5.0	5.0 - 7.5	25 - 30	75 - 80	385	48	482	0
N Doherty Director of Delivery - Care Outside of Hospital	0 - 2.5	0 - 2.5	10 - 15	25 - 30	130	32	164	0
B Hughes Director of Commissioning and Performance (from 29 May 2017)	5.0 - 7.5	40.0 - 42.5	25 - 30	70 - 75	335	92	447	0
*Z McMurray Medical Director	0	0	0	0	0	0	0	0
P Moore Director of Strategy & Integration (to 30 September 2017)	0 - 2.5	0	10 - 15	0	126	12	151	0
J Newton Director of Finance	2.5 - 5.0	7.5 - 10.0	35 - 40	105 - 110	634	100	740	0
*M Powls Director of Commissioning and Performance (interim) (to 19 May 2017)	0	0	0	0	0	0	0	0
N Bates GP Elected Member	0 - 2.5	0 - 2.5	5 - 10	20 - 25	153	3	158	0
T Hudsen GP Elected Member	0 - 2.5	(0 - 2.5)	0 - 5	5 - 10	41	3	44	0
A Majoka GP Elected Member	5.0 - 7.5	20.0 - 22.5	5 - 10	25 - 30	34	111	145	0
*M Sloan GP Elected Member	0	0	0	0	0	0	0	0
*A Afzal Locality Appointed GP (to 30 September 2017)	0	0	0	0	0	0	0	0
N Anumba Locality appointed GP	5.0 - 7.5	20.0 - 22.5	5 - 10	25 - 30	54	117	171	0
*G Chetty Locality Appointed GP (from 1 October 2017)	0	0	0	0	0	0	0	0
L Sorsbie (voting rights ceased 5 March 2018) Locality appointed GP	0 - 2.5	0 - 2.5	10 - 15	30 - 35	203	10	215	0
J Joyce Locality Appointed GP (from 6 March 2018)	0 - 2.5	0 - 2.5	0 - 5	10 - 15	41	1	51	0
**C Whale Secondary Care Doctor (from 01 July 2017)	0	0	0	0	0	0	0	0

*P Brooks, Dr McMurray, M Powls, 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.

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 18 against the accrued pension/lump sum at 31 March 17 which is then adjusted by a factor of 1% to account for inflation (1% 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 2018 and/or that the remuneration of the individual has decreased in the current financial year compared to the previous financial year.

Parliamentary Accountability and Audit Report

Sheffield CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report, see Annual Accounts pages 1-24. An audit certificate and report is also included in this Annual Report at pages 114-116.

ANNUAL ACCOUNTS

Maddy Ruff

Accountable Officer

24 May 2018

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www.sheffieldccg.nhs.uk

KPMG

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 2018 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 2018 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 2017/18.

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

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 twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

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 2017/18.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 53, 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 53, 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
24 May 2018

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Annual Accounts for the Period

1st April 2017

to 31st March 2018

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 2018 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 2017-18

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(2,430)	(2,421)
Other operating income	2	(2,833)	(3,499)
Total operating income		**(5,263)**	**(5,920)**
Staff costs	4	15,184	13,593
Purchase of goods and services	5	837,503	816,068
Depreciation and impairment charges	5	35	0
Provision expense	5	5	0
Other Operating Expenditure	5	488	408
Total operating expenditure		**853,215**	**830,069**
Net Operating Expenditure		**847,952**	**824,149**
Finance income			
Finance expense		0	0
Net expenditure for the year		**847,952**	**824,149**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**847,952**	**824,149**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2018		**847,952**	**824,149**

The notes on pages 5 to 24 form part of this statement

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	8	260	175
Trade and other receivables	9	0	0
Total non-current assets		**260**	**175**
Current assets:			
Trade and other receivables	9	5,655	7,632
Cash and cash equivalents	10	180	141
Total current assets		**5,835**	**7,773**
Total assets		**6,095**	**7,948**
Current liabilities			
Trade and other payables	11	(42,501)	(45,015)
Provisions	12	(5)	0
Total current liabilities		**(42,506)**	**(45,015)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(36,411)**	**(37,067)**
Assets less Liabilities		**(36,411)**	**(37,067)**
Financed by Taxpayers' Equity			
General fund		(36,411)	(37,067)
Total taxpayers' equity:		**(36,411)**	**(37,067)**

The notes on pages 5 to 24 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 24th May 2018 and signed on its behalf by:

Accountable Officer
Maddy Ruff

Statement of Changes In Taxpayers Equity for the year ended 31 March 2018

	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)	0	0	**(37,067)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(37,067)**	**0**	**0**	**(37,067)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(847,952)			(847,952)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Yea	**(847,952)**	**0**	**0**	**(847,952)**
Net funding	848,608	0	0	848,608
Balance at 31 March 2018	**(36,411)**	**0**	**0**	**(36,411)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	(27,230)	0	0	(27,230)
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(27,230)**	**0**	**0**	**(27,230)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(824,149)			(824,149)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Yea	**(824,149)**	**0**	**0**	**(824,149)**
Net funding	814,312	0	0	814,312
Balance at 31 March 2017	**(37,067)**	**0**	**0**	**(37,067)**

The notes on pages 5 to 24 form part of this statement

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(847,952)	(824,149)
Depreciation and amortisation	5	35	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	9	1,977	2,622
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	(2,518)	7,444
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	12	0	0
Increase/(decrease) in provisions	12	5	0
Net Cash Inflow (Outflow) from Operating Activities		**(848,453)**	**(814,083)**
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(116)	(148)
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**(116)**	**(148)**
Net Cash Inflow (Outflow) before Financing		**(848,569)**	**(814,231)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		848,608	814,312
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**848,608**	**814,312**
Net Increase (Decrease) in Cash & Cash Equivalents	10	**39**	**81**
Cash & Cash Equivalents at the Beginning of the Financial Year		**141**	60
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**180**	**141**

The notes on pages 5 to 24 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health. 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 the going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

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

1.3 Pooled Budgets

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

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

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

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

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.4.1 Critical Judgements in Applying Accounting Policies

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

• Operating lease commitments - 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.

1.4.2 Key Sources of Estimation Uncertainty

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

• Basis of estimation of key accruals - 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.

1.5 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 Retirement Benefit Costs

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

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

1.7 Other Expenses

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

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

1.8 Property, Plant & Equipment

1.8.1 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.

1.8.2 Valuation

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

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

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

1.8.3 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.

1.9 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 tangible 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.

1.10 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.

1.10.1 The Clinical Commissioning Group as Lessee

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.

1.10.2 The Clinical Commissioning Group as Lessor

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.

1.11 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.

1.12 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.420% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

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.

1.13 Clinical Negligence Costs

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

1.14 Non-clinical Risk Pooling

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

1.15 Continuing healthcare risk pooling

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

1.16 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.16.1 Financial Assets at Fair Value Through Profit and Loss

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

1.16.2 Held to Maturity Assets

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

1.16.3 Available For Sale Financial Assets

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

1.16.4 Loans & Receivables

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

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

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

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

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

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

1.17 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.

1.17.1 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.

1.17.2 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.

1.17.3 Other Financial Liabilities

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

1.18 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.

1.19 Foreign Currencies

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

1.20 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).

1.21 Joint Operations

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

1.22 Research & Development

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

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

The DH Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year.

2 Other Operating Revenue

	2017-18 Total £'000	2016-17 Total £'000
Recoveries in respect of employee benefits	450	344
Education, training and research	29	46
Charitable and other contributions to revenue expenditure: non-NHS	268	327
Non-patient care services to other bodies	2,401	2,375
Non cash apprenticeship training grants revenue	5	0
Other revenue	2,110	2,828
Total other operating revenue	**5,263**	**5,920**

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 2017/18, revenue shown under 'Other revenue' includes includes £1m income received from Sheffield City Council (SCC) for the recharge of prescribing costs for the services that SCC commission, £0.6m relates to pharmaceutical rebate schemes, £0.2m income for Resettlement programmes, £0.2m was income for staffing and associated costs for hosted services.

For 2016/17, revenue shown under 'Other revenue' includes £1m income received from Sheffield City Council (SCC) for the recharge of prescribing costs for the services that SCC commission, £0.8m was income for staffing and associated costs for hosted services, £0.4m relates to pharmaceutical rebate schemes, £0.4m income for Resettlement programmes and £0.1m recharge of care costs for care where SCC have funding responsibility.

3 Revenue

	2017-18 Total £'000	2016-17 Total £'000
From rendering of services	5,263	5,920
From sale of goods	0	0
Total	**5,263**	**5,920**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2017-18	Total		
	Total £'000	**Permanent Employees £'000**	**Other £'000**
Employee Benefits			
Salaries and wages	12,428	10,623	1,805
Social security costs	1,199	1,121	78
Employer Contributions to NHS Pension scheme	1,487	1,409	78
Other pension costs	2	2	0
Apprenticeship Levy	39	39	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	29	29	0
Gross employee benefits expenditure	**15,184**	**13,223**	**1,961**
Less recoveries in respect of employee benefits (note 4.1.2)	(450)	(450)	0
Total - Net admin employee benefits including capitalised costs	**14,734**	**12,773**	**1,961**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**14,734**	**12,773**	**1,961**

4.1.1 Employee benefits

2016-17	Total		
	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	11,009	9,696	1,313
Social security costs	1,055	1,031	24
Employer Contributions to NHS Pension scheme	1,306	1,280	26
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	223	223	0
Gross employee benefits expenditure	**13,593**	**12,230**	**1,363**
Less recoveries in respect of employee benefits (note 4.1.2)	(344)	(344)	0
Total - Net admin employee benefits including capitalised costs	**13,249**	**11,886**	**1,363**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**13,249**	**11,886**	**1,363**

4.1.2 Recoveries in respect of employee benefits

	2017-18			2016-17
	Total £'000	**Permanent Employees £'000**	**Other £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(329)	(329)	0	(275)
Social security costs	(54)	(54)	0	(31)
Employer contributions to the NHS Pension Scheme	(67)	(67)	0	(38)
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	**(450)**	**(450)**	**0**	**(344)**

4.2 Average number of people employed

	2017-18 Total Number	2017-18 Permanently employed Number	2017-18 Other Number	2016-17 Total Number
Total	**269**	**254**	**15**	**246**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

4.3 Exit packages agreed in the financial year

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	2,525	0	0	1	2,525
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	1	26,683	0	0	1	26,683
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**2**	**29,208**	**0**	**0**	**2**	**29,208**

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	1	24,859	1	24,859
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	2	222,908	0	0	2	222,908
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**2**	**222,908**	**1**	**24,859**	**3**	**247,767**

	2017-18 Departures where special payments have been made		2016-17 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	2017-18 Other agreed departures		2016-17 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	1	24,859
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	**0**	**0**	**1**	**24,859**

As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

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

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

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

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

4.5 Pension costs

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

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

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2017-18, employers' contributions of £1,410,507 were payable to the NHS Pensions Scheme (2016-17: £1,300,444) at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012.

5. Operating expenses

	2017-18 Total £'000	2016-17 Total £'000
Gross employee benefits		
Employee benefits excluding governing body members	14,399	12,915
Executive governing body members	785	678
Total gross employee benefits	**15,184**	**13,593**
Other costs		
Services from other CCGs and NHS England	760	689
Services from foundation trusts	533,854	522,807
Services from other NHS trusts	25,972	24,389
Services from other WGA bodies	0	2
Purchase of healthcare from non-NHS bodies*	63,893	64,358
Purchase of social care*	22,225	16,990
Chair and Non Executive Members	294	296
Supplies and services – clinical	0	0
Supplies and services – general	2,370	1,990
Consultancy services	1,633	1,126
Establishment	1,281	1,032
Transport	46	27
Premises	3,327	2,460
Depreciation	35	0
Audit fees	49	86
Other non statutory audit expenditure		
· Internal audit services	0	0
· Other services	0	0
Prescribing costs	94,589	96,568
Pharmaceutical services	376	429
General ophthalmic services	320	291
GPMS/APMS and PCTMS	86,118	81,254
Other professional fees excl. audit*	54	0
Legal fees*	450	365
Research and development (excluding staff costs)	139	49
Education and training	181	177
Provisions	5	0
CHC Risk Pool contributions	0	1,028
Non cash apprenticeship training grants	5	0
Other expenditure	55	63
Total other costs	**838,031**	**816,476**
Total operating expenses	**853,215**	**830,069**

NHS Sheffield Clinical Commissioning Group spent £1,633k in total on consultancy services in 2017/18. Of this, £1,506k related to consultancy services commissioned by the Accountable Care System (ACS), mainly in relation to the Hospital Services Review and developmental support to the ACS plan. NHS Sheffield Clinical Commissioning Group also hosts the Accountable Care Partnership (ACP) which in addition to the CCG includes the three Sheffield NHS Foundation Trusts, Sheffield City Council and Primary Care Sheffield. £32k was spent on consultancy for the ACP with £25k being recharged to the partner organisations, leaving £7k net spend for the CCG. The remaining £99k expenditure on consultancy services related to the CCGs own functions.

* The standard format for accounts that clinical commissioning groups are recommended to use has been amended to include Purchase of social care and Legal fees as separate headings. Expenditure in these areas was previously included within Purchase of healthcare from non-NHS bodies and Other professional fees excl. audit. The 2016/17 figures for these headings have been restated accordingly to aid comparison.

6.1 Better Payment Practice Code

Measure of compliance	2017-18 Number	2017-18 £'000	2016-17 Number	2016-17 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	16,011	190,223	14,714	206,139
Total Non-NHS Trade Invoices paid within target	15,778	189,536	14,511	205,339
Percentage of Non-NHS Trade invoices paid within target	**98.54%**	**99.64%**	**98.62%**	**99.61%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,227	581,696	4,179	563,685
Total NHS Trade Invoices Paid within target	4,200	580,841	4,171	563,636
Percentage of NHS Trade Invoices paid within target	**99.36%**	**99.85%**	**99.81%**	**99.99%**

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense

	2017-18			2016-17		
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	2,937	13	**2,950**	2,235	18	**2,253**
Contingent rents	0	0	**0**	0	0	**0**
Sub-lease payments	0	0	**0**	0	0	**0**
Total	**2,937**	**13**	**2,950**	**2,235**	**18**	**2,253**

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 2017-18 is £1,127k (2016-17 £890k).

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 2017-18 is £1,710k (2016-17 £1,231k).

NHS Sheffield Clinical Commissioning Group had entered into a financial arrangement involving the use of Walk In Centre premises with One Medicare Limited. This arrangement ceased in 2016-17. Whilst this arrangement fell within the definition of an operating lease, there was no formal contract in place. The financial value included in the Statement of Comprehensive Net Expenditure for 2016-17 was £114k.

7.1.2 Future minimum lease payments

	2017-18			2016-17		
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	0	11	**11**	0	62	**62**
Between one and five years	0	109	**109**	0	39	**39**
After five years	0	0	**0**	0	0	**0**
Total	**0**	**120**	**120**	**0**	**101**	**101**

8 Property, plant and equipment

2017-18	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2017	175	205	380
Addition of assets under construction and payments on account			0
Additions purchased	120	0	120
Additions donated	0	0	0
Additions government granted	0	0	0
Additions leased	0	0	0
Reclassifications	0	0	0
Reclassified as held for sale and reversals	0	0	0
Disposals other than by sale	0	0	0
Upward revaluation gains	0	0	0
Impairments charged	0	0	0
Reversal of impairments	0	0	0
Transfer (to)/from other public sector body	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0
Cost/Valuation at 31 March 2018	**295**	**205**	**500**
Depreciation 01 April 2017	0	205	205
Reclassifications	0	0	0
Reclassified as held for sale and reversals	0	0	0
Disposals other than by sale	0	0	0
Upward revaluation gains	0	0	0
Impairments charged	0	0	0
Reversal of impairments	0	0	0
Charged during the year	35	0	35
Transfer (to)/from other public sector body	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0
Depreciation at 31 March 2018	**35**	**205**	**240**
Net Book Value at 31 March 2018	**260**	**0**	**260**
Purchased	260	0	260
Donated	0	0	0
Government Granted	0	0	0
Total at 31 March 2018	**260**	**0**	**260**
Asset financing:			
Owned	260	0	260
Held on finance lease	0	0	0
On-SOFP Lift contracts	0	0	0
PFI residual: interests	0	0	0
Total at 31 March 2018	**260**	**0**	**260**

Revaluation Reserve Balance for Property, Plant & Equipment

	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2017	0	0	0
Revaluation gains	0	0	0
Impairments	0	0	0
Release to general fund	0	0	0
Other movements	0	0	0
Balance at 31 March 2018	**0**	**0**	**0**

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:

	2017-18 £'000	2016-17 £'000
Information technology	0	0
Furniture & fittings	205	205
Total	**205**	**205**

8.2 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Information technology	5	5
Furniture & fittings	0	0

9 Trade and other receivables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS receivables: Revenue	576	0	966	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	3,249	0	3,405	0
NHS accrued income	288	0	386	0
Non-NHS and Other WGA receivables: Revenue	265	0	1,355	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	154	0	121	0
Non-NHS and Other WGA accrued income	844	0	1,256	0
Provision for the impairment of receivables	0	0	0	0
VAT	98	0	90	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables and accruals	181	0	53	0
Total Trade & other receivables	**5,655**	**0**	**7,632**	**0**
Total current and non current	**5,655**		**7,632**	
Included above:				
Prepaid pensions contributions	0		0	

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

9.1 Receivables past their due date but not impaired	2017-18 £'000 DH Group Bodies	2017-18 £'000 Non DH Group Bodies	2016-17 £'000 All receivables prior years
By up to three months	17	14	586
By three to six months	103	8	31
By more than six months	20	6	1
Total	**140**	**28**	**618**

£7k 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 2018.

9.2 Provision for impairment of receivables	2017-18 £'000 DH Group Bodies	2017-18 £'000 Group Bodies	2016-17 £'000 All receivables prior years
Balance at 01 April 2017	0	0	(123)
Amounts written off during the year	0	0	0
Amounts recovered during the year	0	0	123
(Increase) decrease in receivables impaired	0	0	0
Transfer (to) from other public sector body	0	0	0
Balance at 31 March 2018	**0**	**0**	**0**

	2017-18 %	2016-17 %
Receivables are provided against at the following rates:		
NHS debt	0	0
Debt with a payment plan in place that is being adhered to	0	0
All other non-NHS debt between 1-90 days overdue	0	0
All other non-NHS debt between 91-120 days overdue	0	0
All other non-NHS debt over 121 days overdue	0	0

10 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	141	60
Net change in year	39	81
Balance at 31 March 2018	**180**	**141**
Made up of:		
Cash with the Government Banking Service	180	141
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financia	**180**	**141**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2018	**180**	**141**
Patients' money held by the clinical commissioning group, not included above	0	0

11 Trade and other payables

	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Interest payable	0	0	0	0
NHS payables: revenue	2,376	0	2,571	0
NHS payables: capital	0	0	0	0
NHS accruals	4,920	0	8,550	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	5,747	0	4,107	0
Non-NHS and Other WGA payables: Capital	31	0	27	0
Non-NHS and Other WGA accruals	27,948	0	28,512	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	171	0	149	0
VAT	0	0	0	0
Tax	139	0	118	0
Payments received on account	10	0	0	0
Other payables and accruals	1,159	0	981	0
Total Trade & Other Payables	**42,501**	**0**	**45,015**	**0**
Total current and non-current	**42,501**		**45,015**	

Non-NHS and Other WGA accruals includes £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 (31 March 2017: £16.3m Prescribing accrual, £5.6m in relation to Primary Care, £4.9m Continuing Healthcare accruals and £1m in relation to Non-NHS contracts).

Other payables include £221k outstanding pension contributions at 31 March 2018 (31 March 2017: £194k).

12 Provisions

	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Legal claims	5	0	0	0
Total	**5**	**0**	**0**	**0**
Total current and non-current	**5**		**0**	

	Legal Claims £'000	Total £'000
Balance at 01 April 2017	**0**	**0**
Arising during the year	5	**5**
Utilised during the year	0	**0**
Reversed unused	0	**0**
Unwinding of discount	0	**0**
Change in discount rate	0	**0**
Transfer (to) from other public sector body	0	**0**
Transfer (to) from other public sector body under absorption	0	**0**
Balance at 31 March 2018	**5**	**5**
Expected timing of cash flows:		
Within one year	5	**5**
Between one and five years	0	**0**
After five years	0	**0**
Balance at 31 March 2018	**5**	**5**

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 2018 is £505k (31 March 2017: £668k).

13 Contingencies

	2017-18 £'000	2016-17 £'000
Contingent liabilities		
NHS Resolution employee liability claim	1	0
HMRC review	3	0
Net value of contingent liabilities	**4**	**0**

Legal Claims

NHS Sheffield Clinical Commissioning Group received notification of two potential claims currently under review by NHS Resolution where there may be a potential liability for the CCG. NHS resolution have indicated that the two claims have a 50% probability of being settled and as a result £5k is included as a provision (see Note 12) with £1k recognised above as a contingent liability.

HMRC periodic PAYE review

In March 2017 HMRC commenced one of their periodic reviews of compliance with PAYE regulations at the CCG. The majority of the work has concluded, however there is a level of uncertainty as to the outcome a small number of queries. It is not considered appropriate to recognise a provision within the accounts, but a small contingent liability of £3k is estimated in relation to the areas remaining under review.

14 Commitments

14.1 Other financial commitments

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

	2017-18	2016-17
	£'000	£'000
In not more than one year	1,339	1,253
In more than one year but not more than five years	1,266	2,414
In more than five years	0	0
Total	**2,605**	**3,667**

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 2018 is £2,413k (31 March 2017: £3,667k).

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 the 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 from 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.

15.1.3 Liquidity risk

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

15 Financial instruments cont'd

15.2 Financial assets

	At 'fair value through profit and loss' 2017-18 £'000	**Loans and Receivables 2017-18 £'000**	**Available for Sale 2017-18 £'000**	**Total 2017-18 £'000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	864	0	864
· Non-NHS	0	1,109	0	1,109
Cash at bank and in hand	0	180	0	180
Other financial assets	0	181	0	181
Total at 31 March 2018	**0**	**2,334**	**0**	**2,334**

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Available for Sale 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,352	0	1,352
· Non-NHS	0	2,611	0	2,611
Cash at bank and in hand	0	141	0	141
Other financial assets	0	53	0	53
Total at 31 March 2018	**0**	**4,157**	**0**	**4,157**

15.3 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £'000	**Other 2017-18 £'000**	**Total 2017-18 £'000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	7,296	7,296
· Non-NHS	0	34,885	34,885
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2018	**0**	**42,181**	**42,181**

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	11,122	11,122
· Non-NHS	0	33,626	33,626
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2018	**0**	**44,748**	**44,748**

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 Services	853,215	(5,263)	**847,952**	6,095	(42,506)	**(36,411)**

During the year NHS Sheffield Clinical Commissioning Group paid £401,900k, approx. 47% of total expenditure, (2016-17: £393,677k approx. 48%) to Sheffield Teaching Hospitals NHS Foundation Trust for the purchase of healthcare and other services provided.

During the year NHS Sheffield Clinical Commissioning Group paid £82,678k, approx. 10% of total expenditure (2016-17: £82,232k approx. 10%) to Sheffield Health and Social Care 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.

With effect from the 1st April 2017 a new theme for mental health was added to the Better Care Fund. NHS Sheffield Clinical Commissioning Group and Sheffield City Council agreed to pool their mental health resources through joint commissioning of Mental Health Activity.

The 2016/17 Sheffield City Council comparatives have been restated by grossing up £44.2m of income previously shown net within expenditure. This adjustment more accurately shows the gross resources of the pooled budget.

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:

	2017/18			2016/17 (Restated)		
	NHS Sheffield CCG	**Sheffield City Council**	**Total**	NHS Sheffield CCG	Sheffield City Council	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
The Better Care Fund	256,921	169,830	**426,751**	175,008	158,007	**333,015**

The CCG net contribution to the Better Care Fund for 2017/18 shown above is included within the expenditure recorded in note 5 to these accounts (Services from foundation trusts £182,530k; Purchase of healthcare from non-NHS bodies £51,174k; GPMS/APMS and PCTMS £912k; Services from other CCGs and NHS England £43k; Purchase of Social Care £22,225k; Employee Benefits £30k and Supplies and Services - General £6k).

The memorandum account for the pooled budget is:

The Better Care Fund	**2017/18**	2016/17 (Restated)
Income	**£'000**	£'000
NHS Sheffield Clinical Commissioning Group	256,921	175,008
Sheffield City Council	169,830	158,007
	426,751	**333,015**
Allocation of expenditure		
Theme 1 - People Keeping Well in their Local Community	(9,033)	(9,756)
Theme 2 - Active Support and Recovery	(51,458)	(52,399)
Theme 3 - Independent Living Solutions	(6,303)	(6,213)
Theme 4 - Ongoing Care	(186,410)	(202,825)
Theme 5 - Adult inpatient Medical Emergency Admissions	(65,177)	(59,230)
Theme 6 - Mental Health	(105,637)	0
Theme 7 - Capital Grants	(2,733)	(2,592)
	(426,751)	**(333,015)**

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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 Individual	Purpose of Payment/Receipt	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
A Afzal, Locality Appointed GP (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, Locality Appointed GP and 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

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.

Prior Year Comparator 2016-17*

Name & Role of Individual	Related Parties for which transactions made & Role of Individual	Purpose of Payment/Receipt	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
A Afzal, Locality Appointed GP	Duke Medical Centre - Senior Partner	Core Contract/Locality Reimbursement	866	0	63	0
N Anumba, Locality Appointed GP	Woodhouse Health Centre - GP Partner	Core Contract/LCS/Locality Allowance/VPN Receipts	1,704	(3)	155	0
	Woodhouse Healthcare Services Ltd - Director	Contract Payments	10	0	0	0
N Bates, GP Elected Member	Porterbrook Medical Centre - GP Partner	Core Contract/LCS/VPN Receipts	2,395	(1)	151	0
	Rivelin Healthcare Ltd - Minority Stakeholder	Contract Payments	68	0	7	0
J Boyington, Lay Member	Masonic Care Ltd - Chair	Continuing Healthcare Payments	12	0	0	0
T Furness, Chief of Business Planning and Partnership (to 1 September 2016)	Community First Sheffield LIFT Company - Local Public Sector Director	Estates Strategy Development Support	20	0	0	0
M Gamsu, Lay Member	Voluntary Action Sheffield - Trustee	Contract Payments	30	0	0	0
	Darnall Wellbeing - Committee Member	Contract Payments	73	0	0	0
	Citizens Advice - Trustee	Contract Payments	247	0	0	0
A Gill, GP Elected Member (to 23 September 2016)	Selborne Road Medical Centre - GP Principal	Core Contract/LCS/VPN Receipts	283	(0)	21	0
	NHS Sheffield CCG - GP Elected Member	Overpayment of salary	0	(2)	0	0
T Hudsen, GP Elected Member (from 1 January 2017)	University of Sheffield Health Service - GP Principal	Contract Payments	2,035	0	0	0
A Majoka, GP Elected Member (from 1 January 2017)	Abbey Lane Surgery - GP Principal	Core Contract/LCS/VPN Receipts	383	(0)	26	0
Z McMurray, Medical Director	Woodhouse Healthcare Services Ltd - Shareholder	Contract Payments	10	0	0	0
T Moorhead, Chair of the Governing Body	Rivelin Healthcare Ltd - Minority Stakeholder	Contract Payments	68	0	7	0
	Oughtibridge Surgery - Senior Partner	Core Contract/LCS/Locality Allowance	898	0	51	0
	Sheffield Local Medical Committee - Executive Member	Voluntary & Statutory Levy	249	0	0	0
J Newton, Director of Finance	NHS Sheffield CCG	Pension adjustment	0	0	0	(1)
M Sloan, GP Elected Member	Sloan Medical Centre - GP Principal	Core Contract/LCS/Locality Allowance/VPN Receipts	1,657	(0)	107	0
L Sorsbie, Locality Appointed GP	Firth Park Surgery - GP Partner	Core Contract/LCS/Locality Allowance	1,150	0	105	0
T Turner, GP Elected Member (to 30 September 2016)	Shiregreen Medical Centre - GP Partner & Principal	Core Contract/LCS/Locality Allowance	932	0	76	0
	Sheffield Local Medical Committee - Committee Member	Voluntary & Statutory Levy	249	0	0	0

19 Losses and special payments

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

19.1 Losses

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Administrative write-offs	0	0	0	0
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**0**	**0**	**0**	**0**

19.2 Special payments

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	1	2	2	21
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**1**	**2**	**2**	**21**

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:

	2017-18 Target £'000	**2017-18 Performance £'000**	2016-17 Target £'000	2016-17 Performance £'000
Expenditure not to exceed income	859,715	853,335	841,694	830,069
Capital resource use does not exceed the amount specified in Directions	120	120	175	175
Revenue resource use does not exceed the amount specified in Directions	854,332	847,952	835,774	824,149
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	12,722	10,372	12,682	11,645