NHS
Barnsley
Clinical Commissioning Group

Annual Report and Accounts 2017/18

Putting Barnsley People First

Contents

Message from the Chief Officer

Welcome to the annual report and accounts for NHS Barnsley Clinical Commissioning Group (CCG) for the financial year 2017/18.

This is our fifth annual report and it highlights the things we have been doing over the past year, working with local people and our partners across the borough and the wider region to ensure that everyone across Barnsley receives the high-quality healthcare they deserve.

Our work to join up local health and care services with local people and communities has been a huge focus for us this year. Everyone working on this in Barnsley has shown tremendous effort and willingness to go even further to improve health outcomes for local people.

Improving the health and care of people living in a care home has been a key focus for us this year too and teams from across the NHS who provide nursing care into these homes have worked incredibly well together across the borough. In just eight months their efforts have seen 34% fewer admissions to hospital from people living in a care home. This means individuals are getting the right type of care at the right time and are able to stay at home.

"In just eight months efforts have seen 34% fewer admissions to hospital from people living in a care home."

We have also launched a new respiratory service called Breathe, which takes services out into local communities rather than expecting people to visit hospital for routine appointments – something which people living with long term breathing difficulties have really welcomed.

The CCG's results from the NHS staff survey this year have been our best ever and matched some of the highest results in the country. Staff told us they were highly motivated and engaged and felt their jobs made a difference to the people of Barnsley. This has been reflected in the national recognition Barnsley has received this year, successfully bringing home nine national awards for the improvements in local healthcare.

We are particularly proud that we were highly commended as CCG of the Year 2017, as this recognises not only the hard work of the CCG but showcases the difference local services have been having by us all working together better and designing services which put Barnsley people at the centre.

Designing services, which produce the best clinical outcomes for people, are joined up and make the best use of our resources can sometimes create unease, as it often means something needs to change.

This year we have made a number of commissioning decisions, following conversations with patients, local communities, clinicians and partners, which have been led by these very things – getting the best clinical outcomes, designing services around people not organisations and making the best use of the resources we have. The newly designed and commissioned diabetes service will offer more support for people from their GP, freeing up specialist nurse and consultant time to support people with more complex needs. Similarly the new musculoskeletal service will provide timely, appropriate treatments for people with bone, muscle or joint issues.

We took the decision to de-commission the care navigation and telephone based health coaching and monitoring service this year. During the review, people told us they liked how personalised the care was and that they felt reassured, which is a credit to the staff working in the teams. However, there was limited evidence that it reduced the times people needed to go to hospital, or use other health services. We were able to identify that there are other services available to people, which can offer this reassurance and personalised approach.

Finally, I'd like to note the work that has taken place this year to continue to build strong and sustainable GP services across the borough. General practice is at the heart of healthcare in the NHS and locally, GP practices are rising to the challenges faced across the country when it comes to seeing more people, ensuring they have the right workforce and having sufficient investment to develop services which really meet the needs of their local communities.

On behalf of our Membership Council, Governing Body and our Chair, Dr Nick Balac, I particularly want to record our thanks to our dedicated staff in the CCG and in our member GP practices, partner organisations and patient groups, for their incredibly hard work and contribution over this year.

We look forward to continuing our journey together over the coming year.

Lesley Smith

Chief Officer, NHS Barnsley Clinical Commissioning Group

Making a difference

Residents across Barnsley are rightly and justifiably very proud of their local NHS services. They tell us they like services that are high-quality, that are easy to use and easy to find. And they say to make things even better they want health professionals to work together more across services or organisations and to work in partnership with patients and carers to meet their needs.

Below are highlights of some of the ways we have been doing that this year.

This year our focus has been on ensuring we have services which have a good clinical outcome, make the most effective use of our resources and are provide seamless care designed around the people who use them, not the organisation who provide them.

We have seen some great results already and we have highlighted just a few of them in this report.

Working with Care Homes

In 2017/18 we built on the work from the review of the community nursing service by aligning the neighbourhood nursing service to care homes across Barnsley and 'wrapping around' community services to care homes.

We talked to people living in local care homes, their family and carers, care homes teams and GP practices to gain an understanding of what works well and what needed to be improved.

A new neighbourhood nursing service 'Core Offer to Care Homes' has been developed and includes training for care homes based on an identified need. To enable timely access to healthcare services if a resident becomes unwell and at risk of admission to hospital, care homes can now directly access telephone support between the hours of 8am and 8pm.

Outside of these hours clear guidelines have been put into place for care homes to access services via the same telephone number.

Data collected indicates that over an eight month period there was a significant reduction in the number of people from a care home being admitted to hospital compared to the same eight months in the previous year. The number admissions of care home residents decreased by 34% (774) during this period.

The care homes 'Red Bag Scheme' has also been developed and will be rolled out across Barnsley in March and April 2018. The red bags are a way of transporting and sharing patient information to and from the hospital when a resident attends A&E or is admitted to the hospital.

BREATHE

This year we launched a new Barnsley respiratory service which will enhance the patient experience and reduce the number of hospital trips for patients.

The Barnsley REspiratory Assessment and THErapy (BREATHE) service invests in more respiratory nurses, who rotate working between Barnsley Hospital, out in people's homes and in GP surgeries.

The service aims to improve the patient's journey, enabling them to receive more treatment in their own home and GP surgery, avoiding hospital visits where possible. Where a hospital visit is necessary the team will work with the patient to get them discharged as soon as possible with the correct follow up care at home.

As well as working with patients in their homes and community the BREATHE team also supports A&E staff by assessing respiratory patients who may be suitable for early supported discharge, allowing them to get back to their own home with the support of the community nurses.

Development of primary care services

General practice is at the heart of health care in the NHS.

We have ambitious plans for primary care services in Barnsley and this year the 33 practices across the borough have been rising to that challenge. As part of our plans to implement the General Practice Forward View, we have looked at the needs for a changing workforce building the apprenticeship programme and employing physicians associates. We have been working with practices to look at different ways to manage workload and sharing best practice across the borough.

As part of these ambitious plans, the 33 practices have been looking at the benefits of not only working together across the borough but also in smaller geographical areas. This gives a greater sensitivity to work on the needs of the local population.

Groups of GP practices are now working across six neighbourhoods covering the whole borough and are starting develop plans for the priorities for health and care in their areas. With more and more health services being offered in GP practice buildings they are quickly developing their role as a hub in their local communities.

This year we have also secured additional funding for seven GP practices from the national General Practice Resilience programme. The purpose of the fund is to deliver support that will help practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and secure continuing high quality care for patients.

This year we have introduced best practice clinical pathways as the standard for all our GP practices to follow. This provides clinical consistency and the highest standards of evidence based care for all patients across the borough.

We have also introduced the Get Fit First programme to improve people's health by being a healthy weight or stopping smoking before surgery. This will improve outcomes and decrease the risk of unnecessary complications during or after surgery.

Our social prescribing service, called My Best Life, has now been embedded into all our GP practices and has proved very popular, supporting people with holistic care and social needs. It is heartening to hear that My Best Life is reaching out to support people beyond

the traditional boundaries of primary care and really helping to make a difference to people's lives.

Our clinical pharmacist programme has been rolled out to all Barnsley CCG practices to build the role into general practice. The programme has seen 15 pharmacists, supported by a strategic support team, employed to work within GP practices across Barnsley.

The aim of the programme is to increase the capacity of GPs and practice nurses through the principle of patients being supported by the right clinician at the right time. The addition of clinical pharmacists also increases quality and safety in prescribing; maximising cost effective prescribing and reduce prescribing queries, complementing and enhancing the existing successful medicines management team. Here is an overview of the benefits we have seen this year.

- Clinical pharmacists have undertaken 4119 medication reviews which has freed approximately 687 GP hours so they can focus on people with more complex needs.
- 6037 patient's medicines have been reconciled which has freed approximately 1006 GP hours so they can focus on people with more complex needs.
- 2322 requests for medication and queries have been actioned which has reduced GP workload by approximately 290 hrs.
- Overall the programme has freed-up 11898 GP appointments.

We have worked alongside Healthwatch Barnsley this year who have been collecting feedback on access to GP services in the Dearne area and also looking at the links with this and the high number of people who book an appointment but don't attend at some practices in that area.

Over the past year we have seen the percentage of people signed up to use GP services online grow to just over 23% across the borough. This means even more people have the ability to book or cancel an appointment online, order a repeat prescription or view their health care record – all 24/7.

The GP dementia champion programme has gone from strength to strength with a member of staff from each GP practice taking on additional training and responsibility to make the practice dementia friendly. This might be about raising awareness, signposting to support and local groups or even physical changes on the building to make the environment more accessible. The CCG has also been an active member of the local Dementia Action Alliance group.

The number of trained care navigators has grown to 150 across Barnsley. This is a fantastic support which makes finding your way around the services and support available to you, easier.

The care navigator will help you and your family to engage with decisions about care and treatment. They can also assist you to find out what voluntary and local services are available.

And finally, GP practices have worked really hard again this year to encourage and provide flu vaccinations for all those in the at-risk groups. The number of people having their flu vaccination, from any type of health professional, is higher this year. This is both compared to Barnsley figures last year and the national target this year. Nearly 4,000 more

Barnsley people who have a condition which puts them at higher risk such as diabetes, over-65-year-olds and two and three year olds had their vaccination this year.

Mental health and wellbeing

This year our local young mental health commissioner programme, called OASIS which stands for Opening Up Awareness & Support & Influencing Services, has gone from strength to strength this year with the support of local organisation Chilypep. The young volunteers have come together because of and interest in changing and influencing mental health services in Barnsley. OASIS has published a manifesto for mental health services this year and they were shortlisted for a national award for their mental health first aid kit.

We have also seen the launch of MindSpace across all Barnsley secondary school this year. MindSpace is a ground-breaking multi service mental health provision for children and young people in schools.

This initiative links mental health professionals, educators, families and young people to provide early intervention, prevention and resilience training. We're extremely proud that MindSpace has been grown and developed in Barnsley.

Performance Report

Performance overview

Our role: As a clinically-led statutory NHS body, NHS Barnsley CCG is responsible for planning and commissioning health care services for our local area to achieve the best possible health outcomes for our local population of 250,000, and in doing so acting effectively, efficiently and economically. We do this by assessing local needs, agreeing priorities and strategies, and then buying services on behalf of our population from a range of providers whilst constantly responding and adapting to changing local circumstances.

NHS Barnsley CCG is led by local doctors and elected members; lay members; a specialist consultant and nurse; and a practice manager member, all of whom are close to patients and their needs. We believe that this enables us to improve the quality of care provided to all the people of Barnsley. We are supported by a very experienced team of NHS professionals.

Vision and values: We have set out our vision for Barnsley which is underpinned by our values and principles. This vision will guide and inform our work, along with the local population's health needs and experience of health care.

The vision for NHS Barnsley CCG is:

"We are a clinically led commissioning organisation that is accountable to the people of Barnsley. We are committed to ensuring high quality and sustainable health care by putting the people of Barnsley first."

Our values underpin everything we do as commissioners and an employing organisation. They are:

- Equity and fairness
- Services are designed to put people first
- They are needs led and resources are targeted according to needs
- Quality care delivered by vibrant primary and community care or in a safe and sustainable local hospital
- Excellent communication with patients.

Our strategy: Our five-year commissioning strategy *Putting the NHS Five Year View into Action* sets out our clear and credible plans for delivering our vision for health care services in partnership to meet the needs of the Barnsley population. It recognises the challenge in ensuring healthcare services are affordable and sustainable in the context of continuing demand for services and a reduction in funding for other public services. As an organisation we understand that we must deliver transformational change in order to achieve greater efficiency and effectiveness of spend on health services whilst continuously improving quality.

Our objectives are:

- To have the highest quality of governance and processes to support our business
- To commission high quality health care that meets the needs of individuals and groups
- Wherever it makes safe clinical sense to bring care closer to home
- To support safe and sustainable local hospital services, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley
- To develop services through real partnerships with mutual accountability and strong governance that improves health and health care and effectively use the Barnsley pound.

Achievements related to the performance of areas outlined in our strategy are highlighted in our performance report.

Our Constitution: Through our constitution, our 33 member practices delegate responsibility for running the organisation to our Governing Body, which in turn is supported by a range of strategic committees. Our Governing Body's role is to set the strategic direction of the organisation, seek assurance that the strategy is being delivered, and to set the culture of the organisation.

Our partnerships: We believe that we can achieve more when we work in partnership across the health and social care system, and across sectors within the system. We are active members of the Health and Wellbeing Board in Barnsley and play a key role, working with our partners in delivering the Health and Wellbeing Vision for Barnsley as set out in the recently refreshed Health and Wellbeing Strategy 2016-2020.

In 2014 organisations from all across the borough came together to look at the wide-ranging needs of Barnsley people including in housing, education, police, community, energy, transport and health and care. This resulted in the Barnsley Plan in 2016 which outlines how organisations will work together more closely:

> "Our vision is an integrated joined up health and care system in Barnsley. A system where the people of Barnsley don't see organisational boundaries. Instead, they experience continuity of care; they see familiar faces that are clearly connected to each other across services regardless of where they are seen, be that in hospital, in the community or at home. Patients and their families are supported and empowered by what feels like 'one team', each delivering their part without duplication. Our goal is to dismantle boundaries at the point of delivery of care."

Since 2016 health and care senior leaders have been meeting regularly to agree principles and oversee progress towards deeper collaborative working through a partnership board now known as the Barnsley Health and Care Together (BHCT) Partnership Board.

November 2017 saw the first meeting in public of the BHCT Delivery Board. The board is chaired by the Chair of the CCG and comprises clinical and managerial leaders from across primary, community and secondary care, local authority and mental health.

The role of the Board is to:

- develop the integrated care provider model
- oversee the alliance contract which includes new models of integrated intermediate care services, neighbourhood nursing and BREATHE (integrated respiratory services)
- delivery of Barnsley plan work streams for frailty, cardiovascular disease and neighbourhoods
- delivery of the place-based requirements of the South Yorkshire & Bassetlaw Integrated Care System.

Key issues and challenges

The following issues and challenges have been high on our agenda during the year 2017/18.

Urgent and emergency care: All local NHS and social care organisations have been working really hard throughout the year and particularly over the winter to provide safe, excellent care. It has been challenging due to the increased numbers of people attending A&E and requiring hospital admission when compared to previous years. We have however started to see improvements in waiting times at A&E towards the end of winter, as we started to see the plans put in place before and during winter working. This is despite a number of periods of very cold and wintry weather, right up to March.

More people are using the additional I HEART Barnsley GP services, freeing up appointments in GP practices for those people who may have more long term or complex needs.

The way the hospital teams work on the wards has developed too, using the latest information to assess people, and where appropriate getting them cared for by the excellent intermediate care and neighbourhood nursing services in the community and wherever possible in their own homes.

Support for people coming out of hospitals needing social care has worked well in Barnsley. In 2017/18 using Improved Better Care funding we have been able to work with the local authority to ensure there is ongoing access to social care assessment seven days per week, to support patients who need it to access ongoing care following a period in hospital.

Access to psychological therapies (IAPT) or talking therapies: Being able to deliver the IAPT waiting time standard has been challenging during 2017/18. We have worked with the service provider to review the service and identify sustainable improvements to achieve these targets. There were some improvements during the year however achieving the target of 75% of patients waiting less than six weeks from referral to first treatment appointment has been challenging and the service has not consistently been able to deliver the target for moving patients to recovery.

The CCG has ambitious plans for IAPT services and initiated a further review of the service to identify a new model which would provide improved access and better outcomes for those people requiring the service. As a result of this there will be a re-procurement of this service in 2018/19.

Performance summary

CCG Assurance Framework

During 2017/18 NHS England has continued to oversee the performance and development of the CCG through its continuous assurance process.

The CCG Improvement and Assessment Framework (CCG IAF) was introduced by NHS England in 2016/17 to replace the previous CCG assurance framework. The new framework aligns with the NHS mandate, constitution and planning requirements and aims to support improvement in a number of areas, bringing together constitution, performance and finance metrics. The framework is the focal point for CCG assurance and is therefore a key area of focus for the CCG.

The framework covers a wide range of performance indicators across four domains. These being:

- Better Health – looking at how we are contributing towards improving the health and wellbeing of the local population.
- Better Care – focusing on care redesign, performance against constitutional standards, and outcomes including important clinical areas.
- Sustainability – looking at financial plans and performance and how we are securing good value for patients and the public from the money we spend.
- Leadership – assessing the quality of leadership, the quality of plans, our partnership working and our governance arrangements.

As part of the CCG performance management framework there is a focus upon the indicators included within the CCG IAF with most recent performance against each of the indicators included in our monthly performance reports to our Finance and Performance Committee and Governing Body.

An overall rating of the CCG is expected to be made in July 2018 which will enable us to assess our overall performance assessment in comparison to the previous rating of 'Good' under the 2016-17 CCG assurance framework. The 2017/18 year-end assessment for the CCG will be available on www.nhs.uk/service-search/Performance/Search from July 2018.

Financial Performance

NHS Barnsley CCG achieved all of its financial duties in 2017/18. This is demonstrated in the table on page 17 and within the Annual Accounts. In addition, the CCG ended the year with a surplus of £2.382 million, in line with NHS England expectations.

The Annual Accounts have been prepared under International Financial Reporting Standards (IFRS) and in accordance with the Annual Reporting Guidance issued by NHS England and the Department of Health Manual for Accounts.

The financial landscape for 2018/19 and beyond is challenging. Nationally, CCG average growth allocations for 2018/19 are 2.98%, Barnsley will receive 2.51% as a result of funding being above national target level. Pressures nationally on CCG budgets are expected to continue due to increasing demands for Health Services. In order to manage within allocated resources for 2018/19, the CCG will need to deliver an efficiency programme of £11.5 million (2.7% of notified allocation).

Performance analysis

How we measure performance

NHS Constitution Rights and Pledges and NHS England's CCG Improvement and Assessment Framework	We monitor our performance against the NHS constitution measures domains within the NHS England CCG Improvement and Assessment framework on an ongoing basis, and we meet with NHS England to formally take stock of our performance against the domains. The outcomes from these meetings are formally reported to our Governing Body via our Chief Officer Report.
Financial performance	Our finance and contracting team monitors our financial performance on an ongoing basis. Our financial performance is overseen at the Finance and Performance Committee and is reported to our Governing Body on a monthly basis in the integrated performance report.
Provider performance including NHS Constitution standards	We measure the performance of providers using contractually agreed schedules of key performance indicators and quality indicators. The quality and completeness of the data received is continually assessed by our business intelligence team. Where performance is below the required standard for a single, or for multiple measures, the provider is asked for an explanation including actions and timeframes to bring the performance or quality of care back up to the required standard. Performance is reported and monitored monthly to the Finance and Performance Committee and to the Governing Body via the monthly Integrated Performance report. Exceptions are highlighted in the coversheet to the report. The Committee is supported in the role by the Contract Management Executive, the forum in which senior managers from the CCG and its main providers discuss and monitor contract issues.
Better Care Fund	The Better Care Fund (BCF) is intended to transform local health and social care services so that they work together to provide improved and joined up care and support. It is a government initiative, bringing existing resources from the NHS and local authorities into a single pooled budget. Performance against the pooled budget is monitored with local authority colleagues, through a sub-committee of the Health and Wellbeing Board. The CCG's Finance and Performance Committee receives reports on operational and financial performance of the BCF. The schemes supported by the BCF are an inherent part of the overall integrated performance report to Governing Body.

Progress on NHS Constitution Targets

The table below sets out the NHS Constitution measures and shows whether local services are meeting the target or standards from April 2017 to March 2018.

Referral To Treatment waiting times for non-urgent consultant-led treatment	
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – target 92%	**Achieved**
Diagnostic test waiting times	
Patients waiting for a diagnostic test should have been waiting less than six weeks from referral – target 99% (In 2017/18 98.9% of Barnsley patients waited less than 6 weeks from referral for diagnostic tests. The marginal under achievement is due to specific pressures late in 2017/18 relating to a small number of specific tests).	**Not Achieved**
A&E waits	
Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department – target 95% (90.33% of Barnsley patients were seen within 4 hours during 2017/18)	**Not Achieved**
Cancer waits – 2 week wait	
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – target 93%	**Achieved**
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – target 93%	**Achieved**
Cancer waits – 31 days	
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – target 96%	**Achieved**
Maximum 31-day wait for subsequent treatment where that treatment is surgery – target 94%	**Achieved**
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – target 98%	**Achieved**
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – target 94%	**Achieved**
Cancer waits – 62 days	
Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment for cancer – target 85%	**Achieved**
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – target 90%	**Achieved**
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set	**Achieved**

Category A ambulance calls	
Ambulance Response Times – In 2017/18, ambulance services have moved to a new way of categorising and responding to 999 calls aimed at ensuring all those who contact the ambulance service receive an appropriate and timely clinical and transport response. The aim being to increase 'hear and treat' and 'see and treat' Therefore performance has not been reported against the constitution standards for Category A (Red calls) or the new measure which is to respond to the most urgent calls within an average of 7 minutes for the full year. Whilst this is the case, response times through the year (against both the old and new measures) have been below the expected targets and therefore performance has been assessed as 'not achieved'.	**Not Achieved**
Mental health waiting times	
Patients referred for Improving Access to Psychological Therapies (IAPT) services should receive their first treatment appointment within 6 weeks - target 75%. (In 2017/18 79.4% of patients waited less than 6 weeks to receive treatment)	**Achieved**
Patients referred for Improving Access to Psychological Therapies **(**IAPT) services should receive their first treatment appointment within 18 weeks – target 95% (In 2017/18 99.6% of patients received their first treatment appointment within 18 weeks)	**Achieved**

Development and performance in-year

Financial Performance

CCGs have a number of financial duties under the National Health Service Act 2006 (as amended). Full details of the CCG's financial performance are available in the Annual Accounts section. The CCG's performance against those duties in 2017/18 was as follows:

Duty	**Target** £'000s	**Actual Performance** £'000s	**Achievement**
Expenditure not to exceed income	413,762	411,380	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	Yes
Revenue resource use does not exceed the amount specified in NHS Directions	413,063	410,681	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in NHS Directions	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in NHS Directions	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions– **running costs**	5,637	5,052	Yes

Provider Performance

This section provides an overview of the key performance issues of the main NHS healthcare providers for Barnsley patients.

Barnsley Hospital NHS Foundation Trust

Barnsley Hospital NHS Foundation Trust (BHNFT) key performance issues for this year have been as follows.

Overall 18 week waiting times targets for referral to treatment (RTT) have been achieved consistently although there have been a small number of patients waiting over 52 weeks.

As described earlier in this report, delivery of the A&E four hour waiting times standard has been a challenge throughout the year due to increases in the number of people attending A&E and the number of emergency admissions to hospital, which have both increased from 2016/17.

This has resulted in the 95% target for patients to be admitted, transferred or discharged within four hours of their arrival at an A&E department not being achieved in eleven months of 2017/18.

The number of patients attending A&E at Barnsley Hospital during 2017/18 was 85,587.

77,458 were seen within four hours. Performance for the year shows that 90% of patients were seen within four hours. The CCG has supported a number of initiatives during the year to reduce the number of attendances, improve the flow of patients through the hospital and improve discharge from hospital.

Achieving of the waiting times targets for cancer treatment at Barnsley Hospital has been consistently good with performance targets against all cancer standards achieved in 2017/18.

South West Yorkshire Partnership NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provides both community and mental health services in Barnsley.

Performance of mental health services has been good overall however there are some key areas to improve.

Access to a psychiatric liaison service is in place ensuring early support for patients attending the acute trust. Over 95% of patients are screened or triaged by the psychiatric liaison service in less than four hours and services for children and young people have improved.

One of the key areas for improvement is talking therapies, or IAPT, services, where work has been undertaken to improve waiting times. The number of people completing treatment who are deemed to be moving to recovery has not met the national standard on a consistent basis and the proportion of people accessing services has not consistently achieved the percentage required.

Yorkshire Ambulance Service

In 2017/18, ambulance services moved to a new way of categorising and responding to 999 calls aimed at ensuring all those who contact the ambulance service receive and appropriate and timely clinical and transport response.

The aim being to decrease conveyance and increase ‘hear and treat’ and ‘see and treat’.

Therefore performance has not been reported against the constitution standards for Category A (Red calls) or the new measure which is to respond to the most urgent calls within an average of 7 minutes for the full year.

Whilst this is the case, response times through the year (against both the old and new measures) have been below the expected targets and therefore performance has been assessed as ‘not achieved’.

Primary Care

This year, the additional and extended hours I HEART Barnsley GP service has continued to grow.

Ongoing development of the service to increase capacity has seen the number of clinical consultations increase by over 40% (telephone and face to face) and the number of appointments provided increase by over 30% between October 2016 and March 2017.

The IHEART service has also commenced the provision of the GP out-of-hours service and a primary care streaming service in hospital, adjacent to the A&E department to see patients who do not require emergency medicine or surgery.

Better Care Fund Performance

The Better Care Fund (BCF) was established from 1 April 2015, in line with NHS England and Local Government Association directions.

The aim of the BCF is to support transformation and integration of health and social care in line with the Health and Wellbeing Strategy for Barnsley.

The total value of the fund in 2017/18 is £27,937,966.

£2,544,576 of this is provided from grants made directly to the local authority for disabilities facilities and social care adaptations and £6,803,033 from the Improved Better Care Fund. The remaining £18,590,357 is provided from the CCG baseline allocation.

Note 16, page 22 of the financial statements details the contributions and services commissioned as per the pooled budget arrangement.

Quality, engagement, health inequality and strategy

We work to ensure that we comply with the statutory duties laid down in the *National Health Service Act 2006 (as amended).* In this section, we have reflected on our duties under:

- Duty as to improvement in quality of services
- Patient and public involvement and consultation
- Contribution to the delivery of joint health and wellbeing strategies
- Duties as to reducing inequalities

Improvement in quality of services

The NHS Constitution places a requirement on all providers of healthcare to strive to deliver high quality and safe care to patients. Commissioners of healthcare have an important role in driving quality improvement and gaining assurance around the quality of care delivered by the provider organisations that they commission.

Clinical Quality Boards

Clinical Quality Boards (CQB) have now been in place since 2015 with each main NHS provider. The Clinical Quality Boards focus on the three domains of quality: patient experience, patient safety and clinical effectiveness. We have continued to develop the work of the CQB and reviewed progress and impact at the end of the first year with a view to further working together to identify what more can be done to improve quality and safety within available resources.

Quality Assurance Visits

The purpose of the clinically led visits is to assist in gaining assurance about the quality and safety of healthcare services the CCG commissions. It provides an opportunity for commissioners to engage directly with patients, clinicians and management to hear what they feel works well, their ideas for improvement and for the CCG to recommend any areas for further development. The visits are developmental in nature with a supportive and enabling focus.

Feedback will be aimed at highlighting good practice and identifying ways in which safety, experience and effectiveness can be improved. This can be through actions by the provider and through collaboration with other partners.

In September 2017 senior clinicians from the CCG visited inpatient orthopaedics at Barnsley Hospital NHS Foundation Trust. This visit provided assurance regarding

compliance with venous thromboembolism assessments.

Benchmarking against national reports

There is a high level of ambition for quality in Barnsley and we regularly review national reports with our providers to do a 'true for us' review to identify improvement opportunities.

These are the reports we have benchmarked ourselves against this year. For example, we reviewed Barnsley Hospital NHS Foundation Trust's performance against benchmarking data in the National Bowel Cancer Audit.

Care Quality Commission (CQC) Inspections in GP practices

Throughout 2017/18 the CQC completed all their inspections in GP practices across the borough. The CCG's Quality and Patient Safety Committee has received headline assurance in relation to the outcomes of the inspections.

CQC Inspections – Acute hospital, community and mental health service

Both the main NHS providers were inspected by CQC. The CCG was actively involved in the submission of evidence to CQC as part of the inspection process. Barnsley Hospital NHS Foundation Trust (BHNFT) was rated 'overall good' and South West Yorkshire Partnership Foundation Trust (SWYPFT) was also rated 'overall good' in 2017.

Serious Incidents

The CCG has a responsibility to hold providers to account for their responses to serious incidents. The CCG is informed of all serious incidents and near misses within any of its commissioned services, the key providers are BHNFT and SWYPFT. The CCG receives regular updates from these providers regarding serious incidents and provider assurance documents to demonstrate there is a continued focus on lessons learned which are shared with the Quality and Patient Safety Committee.

The Clinical Quality Boards introduced with each provider during 2015-16 provide high level communication at a senior level between provider and commissioner and we work together to identify and action potential or actual serious quality failures in the interests of patients.

Serious incidents involving independent contractors whose services we commission are also reported to the CCG. Yorkshire Ambulance Service reports all serious incidents that involve Barnsley patients.

Patient Experience

Friends and Family Test (FFT) scores and patient opinions from the NHS England Choices website are assessed alongside local information in order to understand health services from a patient experience. Themes and trends are analysed and taken into account alongside regional and national comparisons.

Complaints

The CCG welcomes all comments and feedback about the CCG and its role in commissioning services on behalf of the people of Barnsley. We strive to resolve complaints through a personal, accessible and flexible approach, ensuring lessons are learned and good practice is shared.

The CCG also has a role in signposting people to the appropriate providers of NHS care regarding complaints and ensuring people are aware of both the provider's advocacy systems and the local independent advocacy service DIAL.

The majority of contacts made to the CCG are of a signposting nature, with only a minority of contacts and complaints referring specifically to the CCG's role. These have tended to be queries and clarifications regarding clinical procedures that the CCG commissions. We have considered the national report by the Parliamentary Health Service Ombudsman in relation to complaints handling. We are satisfied that our current policy is fit for purpose and we continue to review and improve as required.

Compliments

In addition to using complaints and comments to support its role in commissioning services, the CCG is delighted to receive compliments and positive feedback that help to demonstrate where things have gone well and where lessons about good practice can be shared.

The majority of compliments received by the CCG this year have been the result of the work of the Continuing Healthcare Team, in particular in relation to the care and compassion they have shown to those receiving end of life care.

Never Events

NHS Improvement describes a never event as *Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.*

There have been two never events at Barnsley Hospital NHS Foundation Trust in 2017/18. Both never events related to the insertion of an incorrect intraocular lens. Intraocular lenses are lenses inserted in the eye to treat cataracts or short-sightedness. At the time that our Annual Report was prepared the investigations into the events were still ongoing.

Safeguarding – Adults

As commissioners of care and partners in the Barnsley Safeguarding Adults Board the CCG has a key role in the safeguarding of adults including the prevention of abuse and neglect. The CCG continues to be an active partner in the Barnsley Safeguarding Adults Board with regular attendance at meetings of the Board in addition to holding the position of Chair of one of the Board subgroups.

Collaborative working with key partners is imperative in the CCG successfully discharging its safeguarding adult responsibilities. The CCG is member of the Domestic Homicide

Review and Safeguarding Adult Review Executive Panel supporting both the Safeguarding Adults Board and the Barnsley Community Safety Partnership in the commissioning of reviews to ensure that lessons are learned from the way in which local services and individuals work to safeguard adults. In addition, the CCG is a member of the Silver Prevent Board and attends the Channel Panel meetings to support the local authority in meeting the obligations of the Counter Terrorism and Security Act 2015.

Care homes continue to feature in adult safeguarding concerns raised by CCG staff. The CCG works in partnership with the local authority and provides professional advice to support contractual actions they may need to take in relation to the standards of care provided by care home services. In addition, safe and well checks are undertaken for any continuing healthcare patients in a home where there are concerns about standards of care. We have structured and proportionate approaches to identify and address concerns within care homes and where appropriate, the CCG will support the home in planning and implementing changes to enhance care through provision of expert advice such as that relating to care planning, medicines management and infection prevention and control measures.

The Quality and Patient Safety Committee has received regular targeted reports on adult safeguarding activity on behalf of the Governing Body and is fully sighted on current opportunities and challenges.

Safeguarding – Children

As with adult safeguarding, the CCG is a key partner in the multi-agency arrangements to safeguard children and promote their welfare, and is a committed and active member of the Barnsley Safeguarding Children Board (BSCB) and its sub groups. As a CCG we work in partnership, with other BSCB members, to ensure that good governance arrangements are in place to safeguard children. Ensuring that staff in all agencies understand their role and responsibilities and are well supported by robust policies, training, supervision and support. The CCG supports the BSCB in delivering a comprehensive audit programme to ensure these objectives are being achieved.

This year has seen the Government consult on new arrangements for the structure and functioning of Local Safeguarding Children Boards. The CCG has been, and will continue to be, a key partner in these discussions and influencing local arrangements going forward.

In order to learn lessons and improve services, the BSCB undertakes Serious Case Reviews or Learning Lessons events following the death/serious harm to a child, where abuse/neglect is a factor. The CCG is a crucial partner in this process and is represented on the serious case review panel. In the period of this report, there has been no necessity to undertake any reviews. We continue, however, to take a proactive stance; reflecting on the learning from other area reviews and challenging ourselves against these. The CCG is actively engaged in the child death process and ensuring any potential learning is captured and acted upon.

The CCG continues to work with partner agencies to ensure we offer help to children and families at the earliest signs of support being required. Additionally, that we have a shared understanding of those children that may be more vulnerable and are taking proactive steps to jointly recognise and respond. Moreover, the CCG plays a key leadership role in ensuring that those working with children and young people keep abreast of the changing

nature of the threats posed to children's safety. This year has also seen the launch of a neglect strategy for Barnsley, ensuring a proactive and robust response to its management and prevention.

As with adults, the Quality and Patient Safety Committee receives regular reports on safeguarding children to ensure they are well informed regarding opportunities, challenges and the work being done to safeguard the children of Barnsley and improve their outcomes.

Engaging people and communities

In order to effectively commission the right services on behalf of our local community, we need to find out the views and experiences of members of the public, patients, and their carers, especially those people who are less likely to speak up for themselves.

In April 2017 NHS England published revised statutory guidance for CCGs and NHS England commissioners on Patient and Public Participation in Commissioning Health and Care. It set out ten key actions and links to the Guide to annual reporting on the legal duty to involve patients and the public in commissioning.

Following the new guidance NHS England carried out its first assessment of CCG's approach to patient and community engagement, with Barnsley achieving an overall rating of 'Green'. Our patient and public involvement strategy is available on our website.

As the people who use and pay for the local NHS, it is really important for us to hear comments, experiences, ideas and suggestions from local people from across Barnsley about the ways in which we can develop and improve services to benefit our local communities.

As well as holding formal consultations as and when required, we encourage people who want to work with us in the development of new and existing services to join our public membership database – OPEN (Our Public Engagement Network). There are other ways people have got involved in local health services and sharing their views. These include but are not limited to: local GP Practice Patient Reference Groups (PRGs); Barnsley Patient Council; Barnsley Service User and Carer Board, Barnsley equality forums. People have been involved in a range of activities from service developments, procurement panels, consultations through to monitoring of services.

As a CCG, we continue to build upon the strong foundations of the existing partnerships and relationships in place across Barnsley with both our statutory partners working across health and social care and our local community and voluntary sector organisations.

During 2017/18 we have talked to people about:

- Consultation on hyper acute stroke services in South Yorkshire, Bassetlaw and North Derbyshire
- Consultation on children's surgery and anaesthesia services in South and Mid Yorkshire, Bassetlaw and North Derbyshire
- Review of hospital services
- Talking therapies (Improving Access to Psychological Therapy IAPT)
- Minor eye conditions
- Diabetes services
- Musculoskeletal services
- GP and nursing support for people in care homes
- Pain management service
- Mental health and wellbeing support for children and young people.

Full reports highlighting what people told us and the impact they had are available on the CCG website or on request from the CCG.

Reducing health inequality

The joint strategic needs assessment (JSNA) published for Barnsley in 2016, helps to inform where our inequalities exist across the borough and within different groups of people and communities.

Health and wellbeing is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. These 'broader determinants of health' are more important than health care services in ensuring a healthy population, and therefore this is where, together with partners on the Health and Wellbeing Board, we will focus our efforts.

There are marked inequalities in health which exist between Barnsley and England as a whole and within Barnsley itself, which is not acceptable. A gap also exists between people with severe mental illness, learning disabilities and autism, and the general population. Our approach will therefore be to target our resources to achieve equality of outcomes for all.

This will mean:

- Children start life healthy and stay healthy
- People live happy, healthier and longer lives
- People have improved mental health and wellbeing
- People live in strong and resilient families and communities
- People contribute to a strong and prosperous economy

The Barnsley Plan priorities will all help to reduce health inequalities and include enhancing support for people who have dementia, preventing falls, minimising harm from alcohol, reducing prevalence of smoking, early help for people with low level mental health problems and enhancing health literacy and people's ability to self-care.

We continued our work with general practices this year through our practice delivery agreement (PDA). The PDA has been developed to have a targeted, consistent approach to the demographic health challenges on a Barnsley footprint and on a local practice basis. The PDA provides investment in the capacity needed to deliver a consistently high standard of General Practice across Barnsley, as referenced in the Primary Care Strategy and the GP Forward View, focusing on demand management, medicines optimisation, workforce, and the Health Inequalities Target Scheme (HITS).

As part of the PDA's Health Inequalities Targeted Scheme (HITS), our focus in 2017/18 has been on enhancing care for people with dementia, identifying and supporting people early who are drinking alcohol excessively and improving the management of risk factors for cardiovascular disease.

The CCG has been working closely with public health colleagues and Barnsley Hospital to enhance the hospital's contribution to reducing health inequalities, with work currently focused on smoking, alcohol and reducing high consumption of sugar. The CCG has a health improvement nurse for Cardio Vascular Disease (CVD) and via the national diabetes transformation funding has just received funding for a similar post for diabetes.

The nurses will work with primary care practices to reduce variations and improve care for

patients in Barnsley.

The CCG is an active member of the local Stronger Communities Partnership, the Tobacco Alliance and will have representatives on the developing Alcohol Alliance. The CCG is leading the Barnsley Plan work on improving health literacy.

This year we have introduced best practice clinical pathways as the standard for all our GP practices to follow. This provides clinical consistency and the highest standards of evidence-based care for all patients across the borough.

We have also introduced the Get Fit First programme this year to improve people's health by being a healthy weight or stopping smoking before surgery. This will improve outcomes and decrease the risk of unnecessary complications during or after surgery.

Health and wellbeing strategy

Barnsley's Health & Wellbeing Board aims to improve health and wellbeing for the residents of Barnsley and reduce inequalities in health outcomes. The Board approved the latest Joint Strategic Needs Assessment (JSNA) in 2016 as well as the Joint Health and Wellbeing Strategy 2016/20. It is the focal point for health and wellbeing decision making, and drives collaboration, integration and joint commissioning.

This year we reviewed and refreshed the 'Feel Good Barnsley' Health and Wellbeing strategy also taking into account the new NHS Five Year Forward View. We also used this review as an opportunity to talk to local communities to help shape and develop the Barnsley Plan, setting out those areas that together, we think we can make the most difference to health and wellbeing.

Sustainability report

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. At Barnsley CCG we acknowledge our responsibility to our patients, local communities and the environment and are committed to work hard to minimise our carbon footprint.

The CCG has put in place a Sustainable Development Strategy and Management Plan, available on our website, which describes our commitment to promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner. We also use our influence as a commissioner to ensure our providers are delivering their own stretching carbon reduction targets. The overall direction of travel in terms of our commissioning priorities is towards a reduction in secondary care admissions, with more services being delivered closer to home in primary or community settings, which should reduce costly journeys as well as being better for local people.

NHS Property Services (NHSPS) owns Hillder House on Gawber Road, which is the head office for Barnsley CCG. We work closely with NHS Property Services to improve our building. For example modern electronic fittings have been renewed throughout the building, and low energy lighting installed, to reduce consumption. Facilities have been provided for staff to recycle paper, toner, and printer cartridges. For more information visit our website.

Emergency Planning, Resilience & Response (EPRR) and Business Continuity

Working jointly with other South Yorkshire and Bassetlaw CCGs the CCG has completed the self-assessment against applicable NHS England core standards in recognition of the joint approach in place to EPRR. The Local Health Resilience Partnership (LHRP) has confirmed the CCG's self-assessment of 'substantial assurance.'

During 2017/18 we strengthened our governance arrangements with respect to business continuity. The remit of the Health and Safety Group was extended to include business continuity and EPRR, and the membership was extended to include the CCG's Accountable Emergency Officer. The frequency of meetings has been increased, and the Governing Body representative who attends these meetings is the nominated portfolio holder for this function. A range of activities have been undertaken in year to provide assurance that the CCG's arrangements are robust including:

- The Barnsley Business Continuity Contingency Plan has been updated
- The database of emergency contact details for CCG staff has been updated and a procedure established to ensure it remains up to date
- Cascade and desktop test exercises have been undertaken to assess the robustness of the CCG's arrangements.

Signature of the Performance Report by the Accountable Officer

Lesley Smith Accountable Officer, 24 May 2018

Accountability Report

Corporate Governance Report

Members' Report

Member Profiles

Profiles of the Governing Body members, details of conflicts of interest they have declared, and other relevant information can be found on the CCG's website www.barnsleyccg.nhs.uk/about-us/governing-body.htm

Member Practices

Clinical commissioning groups are member organisations and representatives from the 33 Barnsley GP practices form the NHS Barnsley CCG Membership Council. Details of all our practices are on our website http://www.barnsleyccg.nhs.uk/about-us/membership.htm

Composition of the Governing Body

As set out in the Health and Social Care Act 2012, each CCG must have a Governing Body. The Governing Body of the CCG provides oversight and assurance as well as giving strategic direction to the CCG's activities.

The Governing Body is made up of 17 people including nine members elected by the Membership Council; three Lay Members; a GP Practice Manager; a Secondary Care Clinician; a Chief Nurse; and two other senior executive officers.

The members of our Governing Body during 2017-18 are shown below:

Name	Position on the Governing Body	Appointment dates	Attendance record*
Dr Nick Balac	Elected Member & Chair of the CCG	1 April 2013, reappointed 1 April 2017	14/14**
Dr Mehrban Ghani	Elected Member & Medical Director	1 April 2013, reappointed 1 April 2017	13/14
Dr John Harban	Elected Member	1 April 2013, reappointed 1 April 2015, 1 April 2018	13/14
Dr Sudhagar Krishnasamy	Elected Member	1 April 2013, reappointed 1 April 2017	12/14
Dr Madhavi Guntamukkala	Elected Member	1 April 2015, reappointed 1 April 2018	12/14
Dr Mark Smith	Elected Member	1 April 2015, reappointed 1 April 2018	13/14
Dr Adebowale Adekunle	Elected Member	18 July 2016	11/14
Dr James Holloway	Elected Member	1 April 2017 – 4 March 2018	9/13

Name	Position on the Governing Body	Appointment dates	Attendance record*
Dr Mohammed Hussain Kadarsha	Elected Member	1 April 2017	11/14
Nigel Bell	Lay Member for Governance (Conflicts of Interest Guardian)	20 July 2017	9/9
Chris Millington	Lay Member Representative for Patient and Public Engagement and Primary Care Commissioning	1 April 2015, reappointed 1 April 2018	13/14
Sarah Tyler	Lay Member for Accountable Care	1 April 2017	13/14
Marie Hoyle	Practice Manager Member	1 April 2013, reappointed 1 April 2017 - 31 December 2017	11/11
Mike Simms	Secondary Care Clinician	1 September 2013, reappointed 1 April 2017	12/14
Brigid Reid	Chief Nurse	1 April 2013	13/14**
Lesley Smith	Chief Officer (and Accountable Officer)	28 July 2014	11/14**
Heather Wells	Chief Finance Officer	23 February 2015 – 2 July 2017	4/4
Roxanna Naylor	Acting Chief Finance Officer	19 June 2017	10/10

*In 2017/18 there have been 12 monthly Governing Body meetings, 1 extraordinary meeting, and the AGM.

**In one instance the Governing Body Member was present only for the private but not the public session of the Governing Body due to inclement weather.

Committees, including Audit Committee

During 2017/18 the following members of the Governing Body were members of the CCG's Audit Committee: Nigel Bell (from July 2017), Dr Madhavi Guntamukkala, Chris Millington, and Marie Hoyle (to December 2017). John Barber, Audit Committee Chair from Rotherham CCG, served as Acting Chair in the period April-July 2017 prior to Nigel Bell's appointment.

There was a vacancy for a Member of the Membership Council to serve as a Member of the Audit Committee throughout 2017/18.

All CCG's are required by statute to have an Audit Committee and a Remuneration Committee (for details see remuneration report, page 64) In addition, although not stipulated in legislation, we have established a:

- Primary Care Commissioning Committee
- Quality & Patient Safety Committee
- Finance and Performance Committee, and an
- Equality and Engagement Committee.

Details of the functions, membership, and attendance records of each of these Committees can be found in the Governance Statement.

Register of Interests

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship.

We require interests to be declared on appointment in writing, at meetings, on changing roles or responsibilities, on any other change of circumstances, and at specific points during the procurement process.

Profiles of the Governing Body members (http://www.barnsleyccg.nhs.uk/about-us/governing-body.htm), details of conflicts of interest they have declared (http://www.barnsleyccg.nhs.uk/about-us/), and other relevant information can be found on our website.

Personal data related incidents

We have had no Information Governance Serious Incidents Requiring Investigation (IG SIRI) reportable to the Information Commissioner in the past year.

Statement of Disclosure to Auditors

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

- So far as the Member is aware, 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 to make themselves aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Officer to be the Accountable Officer of NHS Barnsley 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 Section 14R 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;
- 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 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.

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 auditor is 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 judgements required for determining that it is fair, balanced and understandable.

Lesley Smith,
Accountable Officer
24 May 2018

Governance Statement

Introduction and context

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

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

As at 1 April 2018, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

The CCG has continued to develop and enhance its governance arrangements. Most notably the CCG has:

- Reviewed and updated its arrangements in response to NHS England's *Managing Conflicts Of Interest: Revised Statutory Guidance For CCGs* (June 2017)
- Agreed that, where the Governing Body is unable to take a decision due to conflicts of interest, the matter will be delegated to the Primary Care Commissioning Committee for approval or consideration
- Had a *Review of Committee Governance* undertaken by the internal auditors, 360 Assurance – the review gave significant assurance over the existing arrangements but identified a number of areas where terms of reference could be clarified and the functioning of the Committees enhanced
- Appointed to the Governing Body a third Lay Member in accordance with statutory conflicts of interest guidance, and an additional GP Member to strengthen still further clinical leadership and insight
- Implemented an enhanced process for tracking internal audit recommendations, thereby providing greater assurance to Audit Committee that agreed actions are being taken forward in a timely manner
- Introduced PMO arrangements for oversight of key projects and the achievement of QIPP targets, including the creation of a Clinical Forum to ensure appropriate clinical input at all stages of business case development.

During 2017/18 NHS England has continued to oversee the performance and development of the CCG through its Improvement and Assessment Framework, which considers the CCG's performance in four domains (Better Health, Better Care, Sustainability, and Leadership). The 2017/18 year-end assessment for the CCG will be available on www.nhs.uk/service-search/Performance/Search from July 2018.

The Governing Body continues to oversee the CCG's performance through the engagement of its members in the work of the CCG and the performance & risk management arrangements described in this Statement.

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 for internal control within the CCG as set out in this Governance Statement.

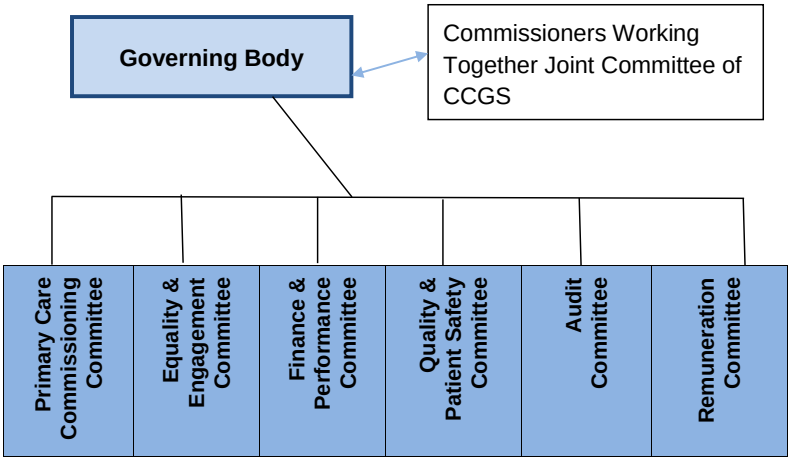
Governance Arrangements and Effectiveness

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. This section provides details of how this has been achieved.

Key features of the CCG's Constitution

CCGs are member organisations. The 33 Barnsley General Practitioner (GP) Practices each nominate one representative to the **Membership Council,** which elects 9 Members to the Governing Body. The Membership Council has met 5 times during 2017/18. The functions reserved to the Membership Council are to agree the vision, values and overall strategic direction of the CCG; approval of the CCG's Annual Commissioning Plan and supporting Financial Plan; and approval of changes to the Constitution. Details of the CCG's member practices can be found on the CCG's website http://www.barnsleyccg.nhs.uk/about-us/membership.htm .

The Membership Council has delegated the responsibility for carrying out the remaining functions of the CCG to the Governing Body and its Committees:



Information about the Governing Body

The **Governing Body** has responsibility for leading the development of the vision and strategy, and for agreeing the Annual Commissioning Plan in collaboration with the Membership Council. It also retains overall responsibility for financial management, quality improvement, and monitoring and reporting performance against the plan. The 2017/18 Annual Report provides highlights of the Governing Body's work over the year (see Performance Report), details of the Governing Body members including their attendance records and declared interests (page 30), and the remuneration paid to senior managers (in the Remuneration Report, page 65).

Information about the Committees of the Governing Body

Some of the Governing Body's functions are exercised on its behalf by its Committees. Terms of Reference for all Committees are available via the CCG's website (http://www.barnsleyccg.nhs.uk/about-us/committees.htm). Minutes of all Committees are reported to the Governing Body, significant matters are escalated through the Risk Management Framework (described on page 47), and Governing Body Members sit on the Committees.

Each Committee produces and presents to the Governing Body an Annual Assurance Report setting out how it has discharged its responsibilities as set out in its Terms of Reference, its key achievements in the year, how it has assessed its own effectiveness, and the key risks it has been responsible for managing. In this way the Governing Body remains fully sighted on all key risks and activities across the CCG, as described in the tables on the next pages.

Audit Committee

Function

Provides assurance and advice to the Governing Body on the entirety of the CCG's control and integrated governance arrangements. This includes the proper stewardship of resources and assets, including value for money; financial reporting; the effectiveness of audit arrangements (internal and external); and risk management arrangements.

Assurance provided to the Governing Body

The Committee receives and reviews the Risk Register and Assurance Framework on a regular basis. It considers reports and opinions from internal audit, external audit, and the Local Counter Fraud Service. Reports on tender waivers, declarations of interest, gifts & hospitality are considered at every meeting. It reviews the annual accounts and annual governance statement and recommends these for approval to the Governing Body. This enables the Audit Committee to assure the Governing Body that the system of internal control set out in the constitution and corporate manual is being implemented effectively.

Membership and attendance

Role	*Name*	*Meetings attended*
Interim Governance Lay Member (Acting Chair – April to May 2017)	John Barber	2/2 (100%)
Lay Member for Governance (from July 2017)	Nigel Bell	5/5 (100%)
Lay Member for PPE & Primary Care Commissioning	Chris Millington	7/7 (100%)
Elected Governing Body Member	Dr Madhavi Guntamukkala	5/7 (71%)
Practice Manager Governing Body Member	Marie Hoyle	5/5 (100%)
Member of the Membership Council	Vacant	

Finance and Performance Committee

Function		
Advises and supports the Governing Body in scrutinising and tracking of key financial and service priorities, outcomes and targets.		
Assurance provided to the Governing Body		
An Integrated Performance Report is taken to every Governing Body meeting, providing assurance that the CCG is delivering its key performance targets and statutory financial duties and providing early warning where this is not the case.		
Membership and attendance		
Role	*Name*	*Meetings attended*
Chair of the Governing Body (Chair)	Dr Nick Balac	11/12 (92%)
Interim Governance Lay Member (April-May 2017)	John Barber	1/2 (50%)
Governance Lay Member (from July 2017)	Nigel Bell	7/7 (100%)
Elected Governing Body Member	Dr John Harban	12/12 (100%)
Elected Governing Body Member (April 2017 – February 2018)	Dr James Holloway	9/10 (90%)
Elected Governing Body Member	Dr Madhavi Guntamukkala	10/12 (83%)
Member of the Membership Council	Dr Andy Mills	11/12 (92%)
Chief Officer	Lesley Smith	10/12 (83%)
Chief Finance Officer (April 2017- June 2017)	Heather Wells	3/3 (100%)
Acting Chief Finance Officer (from July 2017)	Roxanna Naylor	8/9 (89%)
Head of Planning, Performance and Delivery	Jamie Wike	9/12 (75%)

Quality & Patient Safety Committee

Function

Advises the Governing Body with a view to ensuring that effective quality arrangements underpin all services commissioned on behalf of the CCG, regulatory requirements are met and safety is continually improved to deliver a better patient experience.

Assurance provided to the Governing Body

The Committee receives monthly Quality Metrics reports covering quality, patient safety, serious incident reviews, safeguarding, infection control, mortality rates, and other relevant issues. Quality Highlights reports are provided to the Governing Body after every meeting.

Membership and attendance

Role	*Name*	*Meetings attended*
Medical Director (Chair)	Dr Mehrban Ghani	7/8 (88%)
Chief Nurse (Deputy Chair)	Brigid Reid	7/8 (88%)
Deputy Chief Nurse, Head of Patient Safety	Martine Tune	5/8 (63%)
Governing Body Secondary Care Clinician	Mike Simms	6/8 (75%)
Governing Body Member	Dr Mark Smith	5/8 (63%)
Governing Body Member	Dr Sudhargar Krishnasamy	7/8 (88%)
PPE Lay Member	Chris Millington	8/8 (100%)
Head of Medicines Optimisation	Chris Lawson	5/8 (63%)
Head of Quality for Primary Care Commissioning (Joined Committee in May 2017)	Catherine Wormstone	5/7 (71%)
GP (Clinical Advisor)	Dr Ibrar Ali from January 2018	0/2

Equality & Engagement Committee

Function

Advises the Governing Body to ensure that effective systems are in place to manage and oversee the implementation of a strategic vision for equality, diversity and human rights across all services commissioned on behalf of the CCG. It also provides advice to the Governing Body on communication and patient, carers and public engagement, ensuring that Patient and Public Engagement is central to the business of the CCG.

Assurance provided to the Governing Body

This group establishes and monitors the CCG's action plan related to its equality duties. The group has ensured a process for equality impact assessments is in place, supported staff briefings, and leads on the approval and review of human resources policies. In addition the Committee develops and reviews the Patient & Public Engagement Strategy and Plan, and receives regular updates on all PPE related activities across the CCG to ensure these are aligned to the commissioning priorities.

Membership and attendance

Role	*Name*	*Meetings attended*
Lay Member for Public and Patient Engagement (Chair)	Chris Millington	4/4 (100%)
Chief Nurse (Deputy Chair)	Brigid Reid	3/4 (75%)
Governing Body Secondary Care Clinician	Mike Simms	4/4 (100%)
Practice Manager Governing Body Member (post vacant from January 2018)	Marie Hoyle	3/3 (100%)
Member of the Membership Council	Dr I Saxena	4/4 (100%)
Head of Communications and Engagement	Kirsty Waknell	3/4 (75%)
Head of Commissioning for Partnership & Integration (Return from Maternity leave October 2017)	Jade Rose	1/1 (100%)
Elected Governing Body Member	Dr A Adekunle	2/4 (50%)
Healthwatch Barnsley (joined February 2018)	Susan Womack	1/1 (100%)
Equality and Diversity Lead (joined February 2018)	Colin Brotherston	1/1 (100%)

Remuneration Committee

Function

Advises the Governing Body on determinations about the appropriate remuneration, fees and other allowances; terms of service for employees and for people who provide services to the CCG; and provisions for other benefits and allowances under any pension scheme.

Assurance provided to the Governing Body

Drawing on benchmarking and expert HR advice, the Remuneration Committee has advised the Governing Body on appropriate remuneration and contractual arrangements for Governing Body members and others not covered by Agenda For Change terms and conditions.

Membership and attendance

Role	*Name*	*Meetings attended*
Lay Member for Governance (Chair, from July 2017)	Nigel Bell	3/3 (100%)
Lay Member for PPE and Primary Care Commissioning (Deputy Chair)	Chris Millington	4/4 (100%)
Chair of the Governing Body	Dr Nick Balac	3/4 (75%)
Elected Governing Body Member	Dr John Harban	4/4 (100%)
Elected Governing Body Member (April 2017 – February 2018)	Dr James Holloway	2/3 (66%)
Practice Manager Governing Body Member (to December 2017)	Marie Hoyle	3/3 (100%)
Governing Body Secondary Care Clinician	Mike Simms	3/4 (75%)

Primary Care Commissioning Committee

Function
Makes collective decisions on the review, planning and procurement of primary care services in Barnsley, including functions under delegated authority from NHS England. The Committee manages the delegated allocation for commissioning of primary care services in Barnsley. In addition, where the Governing Body is unable to take a decision due to conflicts of interest, the matter will be delegated to the Primary Care Commissioning Committee for approval or consideration.
Assurance provided to the Governing Body
Provides assurance to the Governing Body that the functions delegated to the CCG have been appropriately discharged, with regard to outcomes for patients, the management of any conflicts of interest, primary care procurement and contract management, and the availability of services.
Membership and attendance

Voting Members	*Name*	*Meetings attended*
Lay Member for PPE and Primary Care Commissioning (Chair)	Chris Millington	11/12 (92%)
Lay Member for Accountable Care (Vice Chair)	Sarah Tyler	10/12 (83%)
Lay Member for Governance (from July 2017)	Nigel Bell	6/7 (86%)
Chief Officer	Lesley Smith	9/12 (75%)
Governing Body Secondary Care Clinician	Mike Simms	9/12 (75%)
Head of Governance & Assurance	Richard Walker	11/12 (92%)
Clinical Advisers	*Name*	*Meetings attended*
Chair of the Governing Body	Dr Nick Balac	7/10 (70%)
Medical Director	Dr Mehrban Ghani	8/10 (80%)
Elected Governing Body member	Dr Madhavi Guntamukkala	7/10 (70%)

Information about the Health and Wellbeing Board

The CCG's Chair and Chief Officer are also members of the Barnsley Health & Wellbeing Board, a Committee of Barnsley Metropolitan Borough Council which was set up in April 2013 as a requirement of section 194 of the Health and Social Care Act 2012. The objective of the Health & Wellbeing Board is to promote integrated working across health and care services and to redesign health and wellbeing services across organisational

boundaries so that services are joined up and health outcomes are improved for local people.

The Health and Wellbeing Board also has very senior representatives from a range of other stakeholders including Barnsley Metropolitan Borough Council, Barnsley Hospital NHS Foundation Trust, South West Yorkshire Partnership Foundation Trust, NHS England, Barnsley Healthwatch, and South Yorkshire Police. The Board produces and regularly updates a Joint Strategic Needs Assessment, which underpins the 'Feel Good Barnsley' Health and Wellbeing Strategy 2016-20 which was approved by the Board in October 2016. The Health and Wellbeing Board also agreed the Barnsley Place Based Plan as part of the model for delivering the Borough's Health and Wellbeing Strategy. Barnsley CCG's Strategic Commissioning Plan is fully aligned with the Health & Wellbeing Strategy and Barnsley Plan.

Better Care Fund

The Better Care Fund (BCF) was established from 1 April 2015, in line with NHS England and Local Government Association directions. The aim of the BCF is to support transformation and integration of Health and Social Care in line with the Health and Wellbeing Strategy for Barnsley.

A governance structure and pooled budget arrangements for the BCF has been agreed with Barnsley MBC and formalised in a Section 75 agreement which provides for reporting on BCF indicators through the CCG's Committee structure to the Governing Body.

The Senior Strategic Development Group (SSDG), the executive group reporting to the Health & Wellbeing Board, oversees progress with the Better Care Fund and its role includes escalation of risks and issues to the Health and Wellbeing Board and the CCG's Governing Body through its membership. There is clear CCG senior management ownership and leadership of the BCF and clinical involvement through GP membership of the Governing Body and as Vice Chair of the Health and Wellbeing Board.

In December 2017 the CCG Governing Body received the final Barnsley *Health and Wellbeing Board Integration and Better Care Fund narrative plan* as agreed at Health & Wellbeing Board and approved by NHS England.

Information about South Yorkshire Commissioners and Providers Working Together

Commissioners Working Together

Since 2015, we have been a partner of Commissioners Working Together, a collaborative of eight clinical commissioning groups and NHS England working across South and Mid Yorkshire, Bassetlaw and North Derbyshire. Depending on where people live across our region, experiences, outcomes and access to services can vary. By working together we can better understand, plan and commission services for the combined population – no matter where people live.

In 2016-17 Commissioners Working Together consulted on business cases for some out of hours Children's Surgery and Anaesthesia and Hyper Acute Stroke services. As a result of that work, this year the Joint Committee of Clinical Commissioning Groups made the decision to jointly commission out of hours Children's Surgery & Anaesthesia (June 2017) and Hyper Acute Stroke Services (November 2017).

All information on the work of Commissioners Working Together can be found at www.smybndccgs.nhs.uk

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 & Bassetlaw Integrated Care System / Sustainability & Transformation Plan

The CCG is also a partner in the South Yorkshire & Bassetlaw Sustainability and Transformation Partnership (STP), which in June 2017 was named as one of the first 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/workstream lead.

Effectiveness of the Governing Body

The Governing Body has been proactive in improving its effectiveness during the year. For example:

- A workshop on Patient & Public Involvement run by the Consultation Institute was provided for Governing Body members and other CCG staff
- Development sessions have been held at regular intervals through the year covering issues such as cyber security, the 0-19 service, IAPT, accountable care, locality working arrangements, and procurement

- Statutory and Mandatory training has been provided for Governing Body members in counter fraud, equality and diversity, infection control, fire safety, and safeguarding
- Individual personal development reviews (PDRs) have been undertaken with Governing Body members by the CCG Chair
- Following an internal audit review of Committee Governance the Governing Body and its Committees all now include a reflection on the conduct of the meeting at the end of every agenda
- A specific development session was held with Governing Body Members to consider the effective conduct of Governing Body business
- The capacity and capability of the Governing Body has been further strengthened by the addition of a third Lay Member and an additional GP Member.

Compliance with the UK Corporate Governance Code

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

We have self-assessed our arrangements against the UK Corporate Governance Code and are satisfied we are compliant with those aspects relevant to the CCG.

Discharge of Statutory Functions

During establishment, the arrangements put in place by the CCG and documented in the Constitution, Corporate Manual, and Prime Financial Policies were developed with extensive expert external input, to ensure compliance with all relevant legislation. That expert advice also informed the matters reserved for Membership Council and Governing Body decision and the Scheme of Delegation.

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.

Compliance with statutory functions is delivered through the CCG's management structure and monitored through the CCG's committee structure and work plans, as described on pages 36 to 43. These arrangements have been subject to external scrutiny through a range of processes, including the NHS England CCG Improvement & Assessment Framework, as highlighted on page 35.

Since 1 April 2015 the CCG has had delegated responsibility from NHS England for commissioning primary medical services under a signed Delegation Agreement. In 2015/16 Internal Audit reviewed the CCG's arrangements for discharging its delegated functions and found them to be robust.

During 2017/18 the Constitution has been subject to further review and amendments have been made. The changes were necessary to reflect:

- The CCG's decision to remove the Clinical Transformation Board (CTB) from its committee structure, given the development of the CCG's new arrangements for QIPP delivery and oversight, coupled with the progress being made towards the establishment of an Integrated Care Partnership in Barnsley
- The decision to decouple the full Standards of Business Conduct, Managing Conflicts of Interest, and the Acceptance of Gifts & Hospitality Policy from the CCG's Constitution, in order to facilitate simpler and quicker updating of this Policy in future, and
- A number of changes to Section 8 of the Constitution which summarises the CCG's policy for Standards of Business Conduct and Managing Conflicts of Interest.
- All of the above changes were reviewed and approved by NHS England in July 2017 and October 2017.

Risk management arrangements and effectiveness

Overall risk and control arrangements

In accordance with its intention of achieving the highest standards of governance and accountability, since its authorisation on 1 April 2013 the CCG has worked hard to implement, embed, and enhance its risk and control arrangements.

Identifying, rating, and managing risks

The Integrated Risk Management Framework sets out the CCG's approach to scoring risks and the risk appetite. Any risks identified in the course of the CCG's business are scored using the National Patient Safety Agency's 5 by 5 matrix, which takes account of both the likelihood and consequence of a risk occurring.

This results in an overall risk rating of between 1 and 25. Risks are then included on the risk register and prioritised as follows:

RAG	Score	Risk description	Managerial Action
	1 - 3	Low risk	Can be managed locally by routine controls.
	4 - 6	Moderate risk	Managed locally with individual risk treatment plans
	8 - 12	High risk	Senior Management attention required. Detailed planning and controls
	15 - 25	Extreme risk	Immediate action Chief Officer or nominated Deputy level management

A Lead Officer (Risk Owner) for each risk is identified, and the Risk Register is shared with risk owners monthly for review and revision.

The Governing Body's risk tolerance is a score of 12 or below. These risks are managed by the appropriate Chief Officer or Manager and monitored at the CCG's Committees. Extreme risks (scores of 15 or higher) are considered to represent a threat to the delivery of the CCG's strategic objectives. These risks are:

- Subject to immediate Chief Officer action
- Considered and reviewed at every meeting of the Governing Body, and are
- Escalated to the Assurance Framework as gaps in control against the relevant corporate objective(s).

In addition, Committees receive and consider extracts of both the Assurance Framework and Risk Register, and escalate significant matters to the Governing Body. Red and amber risks are considered at every meeting, yellow and green risks twice a year. The Governing Body receives reports summarising the current position with respect to extreme risks on the Assurance Framework at every meeting, and reviews the entire document on a quarterly basis.

These arrangements have continued to evolve and become further embedded in 2017/18:

- When refreshing the Governing Body Assurance Framework (GBAF) for 2017-18 is was felt that it would enhance its clarity and relevance if the risks were related directly to the seven key priorities and deliverables in the Next Steps on the NHS Five Year Forward View - Urgent & Emergency Care, Primary Care, Cancer, Mental Health, STP & Integrated Care, Efficiency Plans, and Patient Safety. The GBAF maps each of these priority areas onto the CCG's corporate objectives (highest quality governance, high quality health care, care closer to home, safe & sustainable local services, strong partnerships, effective use of £) in order to provide assurance that, in delivering the Priority Areas, we will also be delivering the CCG's corporate objectives. The updated GBAF was reviewed by internal audit as part of the Head of Internal Audit Opinion Stage 1 work and no recommendations were made.
- To support the Head of Internal Audit Opinion Stage 2 work 360 Assurance undertook a survey and benchmarking exercise of the Governing Body and found a very high degree of understanding of and engagement in the risk management process at Barnsley CCG in comparison with other organisations.
- A 360 Assurance Internal Audit review of the CCG's Risk Management – Risk Identification Process gave a significant assurance opinion and raised no significant issues for the CCG to address.

How risk management is embedded in the activity of the CCG

A range of systems and processes are in place to embed risk management more broadly in the CCG's activities. These arrangements are described briefly below.

- There is a well-established system of **incident reporting** which ensures that incidents are managed appropriately and that learning takes place and is shared across the organisation.

- The CCG is fully committed to **complying with the public sector equality duty set out in the Equality Act 2010**, both as an employer and a commissioner of health services for the people of Barnsley. Details of how the CCG complies are available on its website http://www.barnsleyccg.nhs.uk/about-us/public-sector-equality-duty.htm .

- The CCG has robust arrangements to ensure its **Health and Safety** responsibilities are effectively discharged. A Health and Safety and Business Continuity Group, reporting to the Audit Committee, is supported by experts from a local shared service hosted by Rotherham CCG. This group is also attended by staff side, and a GP Member of the Governing Body, as well as CCG employees, and meets three times a year. The Group reviews the annual fire and health and safety risk assessments, as well as any incidents reported, and ensures appropriate actions are being taken. It also maintains oversight of the CCG's corporate business continuity arrangements and the annual EPRR self-assessment process. The CCG's risk assessments indicated a low risk in respect of fire and health and safety. All CCG staff receive mandatory training in fire safety, health and safety, infection control and manual handling.

Involvement of public stakeholders

The CCG has taken steps through the year to develop and embed arrangements by which **public stakeholders** can influence the work of the CCG and therefore be involved in managing the risks which impact on them. For example:

- The CCG has a Governing Body Lay Member for Patient and Public Engagement and an Equality and Engagement Committee responsible for overseeing the CCG's arrangements in this area
- Members of the public are able to attend meetings of the Governing Body and Primary Care Commissioning Committee
- The Annual General Meeting, held in September 2017, was held at the Digital Media Centre in Barnsley and was attended by 36 members of the public from a wide range of stakeholders
- The Our Public Engagement Network (OPEN) has been created, enabling the CCG to gather views of carers, patients, and members of the public to inform key commissioning decisions
- The CCG works closely with Healthwatch Barnsley, which has a standing invitation to attend the Equality & Engagement Committee and the Primary Care Commissioning Committee
- Barnsley Patient Council has been established to act as an independent advisory panel. It is made up of Barnsley residents and PRG representatives who offer the views and expectations of members of the public and local communities served toward improving, delivering and maintaining health care services for Barnsley people.

Capacity to handle risk

The overall responsibility for the management of risk lies with the Chief Officer as Accountable Officer. The Governing Body collectively ensures that robust systems of

internal control and management are in place. These arrangements, and the enhancements that have been made to them during 2017/18, are described in detail on pages 53 to 55 of this Statement.

The Integrated Risk Management Framework was originally approved by the Governing Body in October 2012, and has subsequently been revised and updated most recently in September 2016. The framework sets out the CCG's commitment to the management of all risk using an integrated approach covering clinical, non-clinical and financial risk. Accountability arrangements for risk management are clearly set out and roles and responsibilities in terms of key committees and individuals are identified, as follows:

- The *Governing Body* on behalf of the Membership Council ensures that the organisation consistently follows the principles of good governance applicable to the NHS organisation.
- The *Audit Committee* oversees the risk management function and ensures that systems of internal control exist and are functioning correctly.
- The *Committees of the Governing Body* are responsible for identifying risks to the delivery of corporate objectives, and ensuring appropriate actions are in place to mitigate them (see Risk Register and Governing Body Assurance Framework below).
- The specific responsibilities of the *Chief Officer*, *Lay Members, other senior officers, and all other staff of the CCG* are clearly articulated.
- The *Risk Register* provides an ongoing identification and monitoring process for operational risks, as well as strategic risks that may adversely impact on the delivery of the Annual Commissioning Plan, and the CCG's strategic objectives.
- The *Governing Body Assurance Framework* is a high level report which enables the Governing Body to demonstrate how it has identified and met its assurance needs focused on the delivery of its objectives through the annual Commissioning Plan. The Assurance Framework identifies the key risks to the delivery of corporate objectives, and sets out the controls in place to mitigate those risks and the assurances (both internal and external) available to give the Governing Body confidence that the risks are being managed.

Risk management capacity has been developed across the CCG in a number of ways during the year. The statutory and mandatory training programme includes numerous elements relevant to risk management, including information governance, health and safety, fire safety, safeguarding adults and children, infection control, and counter fraud.

A new word and excel-based incident reporting system has been introduced in-year and is now well established. Governing Body and Committee reporting arrangements prompt authors to confirm that all aspects of potential risk – financial, contractual, quality, equality and diversity, information governance, human resources, and sustainability – have been appropriately considered in the preparation of committee reports and business cases.

How do the control mechanisms work?

The CCG has a robust internal control mechanism to allow it to prevent, manage and mitigate risks. Page 36 describes the governance structure of the CCG, page 53 describes the approach to risk management, and explains the key components of the internal control

structure. Taken together these arrangements underpin the CCG's ability to control risk through a combination of:

- *Prevention* – the CCG's structures, governance arrangements, policies, procedures, and training minimise the likelihood of risks crystallising.
- *Deterrence* – staff are made aware that failure to comply with key policies and procedures, such as the Standards of Business Conduct Policy or the Fraud, Bribery and Corruption Policy, will be taken seriously by the CCG and could lead to disciplinary action, or dismissal.
- *Management of risk* – once risks are identified the arrangements for ongoing monitoring and reporting of progress through the Committee structure to the Governing Body ensure appropriate action is taken to manage risks.

Risk Assessment

The CCG's process for identifying, rating, and responding to risks was described in sections 1.9 and 1.10 above. The number and severity of the risks on the Corporate Risk Register during the year is summarised in the table below:

Date	Extreme (red)	High (Amber)	Moderate (Yellow)	Low (Green)
April 2017	8	19	7	2
Sept 2017	7	18	7	2
March 2018	8	17	5	3

In accordance with the CCG's Integrated Risk Management Framework any risk rated as extreme (red) is deemed to exceed the Governing Body's risk tolerance, since they are considered to threaten the delivery of the CCG's strategic objectives.

Such risks are escalated to the Governing Body as gaps in control against relevant objectives in the assurance framework. The table below sets out how the CCG's extreme risks have been (and where relevant continue to be) managed or mitigated:

Risk	How managed / mitigated	How assessed	Status at March 2018
Accident and Emergency (A&E) 4 hour wait target not delivered by BHNFT	Actions are in place to deliver improved performance going forward, overseen by the A&E Delivery Board. IHEART Barnsley service, offering out of hours GP appointments on evenings and Saturdays, now well established. Strengthened GP Streaming adjacent to ED in place and working well.	Delivery of targets in the commissioning plan	**5x4 = 20**
If the 0-19 path- way re-procurement by Public Health leads to a reduction in service there is a risk of:	Between October 2017 and February 2018 there have been three meetings attended by senior representatives from Public Health and the CCG's Governing Body. Discussions have focused on how	Review at Governing Body	**3 separate risks all scored 4x4=16**

• negative impact on primary care workforce & capacity • service quality and safeguarding provided for the 0-19 population being adversely affected • reputational damage to the CCG.	the service was being mobilised and seeking ways of improving communication between primary care and public health nursing. An initial action plan was agreed following the first meeting in October 2017 and has been updated at subsequent meetings. Although it is recognised that good progress has been made in delivering the agreed actions Governing Body agreed in March 2018 to maintain these risks at their current level whilst continuing to observe and evaluate the impact of the new service model.		
Risks arising if the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce	The CCG continues to invest in primary care capacity. The PDA enables practices to invest in the sustainability of their workforce. The successful PMCF (now known as GP Access Fund) has enabled additional capacity to be made available outside normal hours via the iHeart Barnsley Hubs. BHF is also actively developing physicians' associate roles. The CCG has funded 15 Clinical Pharmacists to provide support to all Practices in Barnsley. The CCG has also funded 14 Apprentices to provide additional capacity in Primary Care. GP Forward View includes a section on workforce, with additional funding being made available to support Primary Care sustainability.	A workforce baseline assessment will be monitored via the Primary Care Quality Improvement Tool to identify any capacity issues or pressure points. Oversight at PCCC.	**4x4=16**
Risk of negative consequences if BMBC commissioned Health Checks service experiences a decline in uptake among eligible Barnsley residents	This risk was newly added in March 2018. Concerns regarding the proposed operating model have been raised with the Commissioner (BMBC) by the CCG, local Practice Managers, and via the LMC. A further update will be provided to Governing Body in April 2018.	Monitoring via PCCC and Governing Body	**4x4=16**
Discharge medication risks related to poor or incomplete D1 discharge letters	Audit of discharge letters currently underway. Outcomes will be considered by Quality & Patient safety Committee.	Audit of discharge letters	**3x5 = 15**
YAS non achievement of response and turnaround time targets – quality impacts	Regular consideration of YAS incident reporting by QPSC and GB to understand the frequency and severity of incidents associated with ambulance response.	Ongoing assessment of impact of breaches on quality and patient safety	**3x5 = 15**
The risk that if the CCG does not develop a clear and robust QIPP programme, then it will not achieve its statutory financial duties	Risk was scored as 4x4=16 at the start of 2017/18. Early in 2017/18 a PMO was established with monthly reports on progress against targets through revised organisational governance arrangements : QIPP Delivery Group reporting to Finance and Performance Committee	Monitoring via QIPP Delivery Group, F&P Committee, and Governing Body	**3x4=12**

	and onward to Governing Body. In year monitoring has consistently shown the CCG to be on track to deliver its QIPP requirement thus allowing the risk to be reduced in September 2017.		

As well as being escalated to the Governing Body as gaps in control against relevant objectives in the assurance framework these risks have been allocated to the appropriate Committee and Chief Officer within the governance structure, with mitigating actions being monitored by the Committee on an ongoing basis. Risk and Assurance reports to the Governing Body will enable it to monitor the effectiveness of the mitigating actions in 2017/18 for those risks which remain open.

The Assurance Framework will be subject to a detailed review early in 2018/19 by the CCG's senior management to ensure it continues to focus on the key risks to the delivery of the Five year Forward View priority areas, and the CCG's objectives, going forward.

Any new risks will be reflected in the 2018/19 Governing Body Assurance Framework and Risk Register and appropriate mitigating actions will be put in place to address them.

Other sources of assurance

Internal Control Framework

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

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

The governance and risk management sections have already explained how important elements of the system of internal control work. Other key components of the internal control framework include:

- An overarching governance structure set out in the Constitution, Standing Orders, Scheme of Reservation and Delegation, and Prime Financial Policies (the Constitution and Corporate Manual have both been reviewed and updated during 2017/18)
- Beneath the Constitution and Corporate Manual, the CCG has a range of Corporate Policies in place to support the delivery of its statutory and other functions which have been communicated to staff, made easily available via the website, and supported by training and briefings as appropriate
    - The Standards of Business Conduct Policy, setting out the CCG's policies and procedures for managing Conflicts of Interest, including maintaining and publishing registers of interests, gifts and hospitality
- The Governing Body & Committee Structure, underpinned by clear Terms of Reference and work plans (see page 37)

- The CCG's management structure, with responsibilities clearly allocated to teams and individuals
- The Risk Management Framework (see page 47)
- Robust arrangements to ensure effective financial control including budgetary control and contract monitoring
- Ongoing monitoring of the delivery of key performance targets and commissioning priorities by the Finance & Performance Committee and the Governing Body
- The Equality & Diversity Working Group, reporting to the Equality & Engagement Committee, oversees the CCG's compliance with the requirements of the Equality Act 2010
- The Equality & Engagement Committee also ensures appropriate consultation and engagement takes place with stakeholders including users of health services in Barnsley
- The CCG seeks continually to develop the skills and competencies of its employees through regular performance and development reviews, the statutory and mandatory training programme, organisational development activities including regular development sessions for the Governing Body and the 'Investment In Excellence' programme which has been provided to all CCG staff
- Objective oversight of the internal control framework by the Audit Committee, drawing on reports from internal and external auditors
- External scrutiny by NHS England through the Improvement and Assessment Framework.

Annual audit of conflicts of interest management

The CCG has robust arrangements for managing Conflicts of Interest. The CCG maintains a Register of Interests covering Membership Council, Governing Body Members, and all CCG staff. The Register is publicly available on the CCG's website http://www.barnsleyccg.nhs.uk/about-us/). It is also considered at the public session of the Governing Body twice a year. The Audit Committee receives and reviews the Register twice a year and updates on new or changed declarations are taken to every meeting.

The CCG's Conflicts of Interest Policy requires interests to be declared within 28 days. Declarations are recorded on a form which is returned to the Head of Governance & Assurance who enters the interest on the Register. Declarations of Interest are requested at the commencement of all meetings of the Governing Body and its Committees. On at least an annual basis all staff are requested to review and update their entries in the Register.

The CCG's Conflicts of Interest Policy, which sets out the approach to managing conflicts, is incorporated within the Standards of Business Conduct Policy which was reviewed, clarified and strengthened in January 2015 to address the requirements of new statutory guidance issued by NHS England in December 2014. Key enhancements included:

- The establishment of a Primary Care Commissioning Committee with a Lay and Executive majority to enable effective management of Conflicts of Interest arising in respect of the CCG's delegated responsibility for commissioning primary medical services

- The creation of a publicly available Register of Procurement Decisions setting out how any conflicts arising in the course of the CCG's procurement activity had been managed
- The use of a primary care procurement checklist provided by NHS England giving detail of how conflicts have been managed, and
- The extension of the CCG's Register of Interests to cover senior staff working in member Practices.

In June 2016 NHS England issued updated statutory guidance for CCGs on the management of conflicts of interest. In response to this guidance further enhancements have been made to the CCG's arrangements, including:

- Adding the role of Lay Member for Accountable Care to the membership of the Governing Body, to provide additional capacity to manage conflicts of interest both at Governing Body and Primary Care Commissioning Committee
- Designating the Chair of the Audit Committee as the CCG's 'Conflicts of Interest Guardian'
- GP members of the Primary Care Commissioning Committee are now clinical advisers to the Committee but do not have the right to vote
- The format of the Registers and other documentation has been reviewed and updated to comply with the guidance
- Training has been provided to Committee Chairs and minute takers.
- In June 2017 NHS England published further revised statutory guidance. The CCG reviewed its *Standards of Business Conduct, Managing Conflicts of Interest, and the Acceptance of Gifts & Hospitality Policy* and has made a number of changes required to ensure the Policy is consistent with the revised guidance, most notably the rules around accepting gifts and hospitality have been clarified. The *Standards of Business Conduct, Managing Conflicts of Interest, and the Acceptance of Gifts & Hospitality Policy* has also been 'de-coupled' from the CCG's Constitution in order that the process for future updates is more streamlined.

The revised statutory guidance on managing conflicts of interest for CCGs requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The CCG's annual audit of conflicts of interest has recently concluded. The review provided significant assurance over the CCG's arrangements, and concluded that the CCG has a well-defined process in place for managing conflicts of interest. At the time of finalising the report just three low risk recommendations required action, relating to:

- Ensuring staff complete a new declaration form within 28 days when their roles change
- Ensuring start dates for all interests are recorded in the Register
- Ensuring any remaining gaps in the Register are filled as part of the annual refresh in March 2018.

The recommendations have been accepted and actioned.

Data Quality

Quality data is essential for commissioning effective, relevant and timely care, efficient administrative processes, management and strategic planning, establishing acceptable service agreements/contracts for healthcare provision, identification of local priorities and health needs assessments, ensuring that the organisation's expenditure is accurately calculated, providing reliable intelligence regarding local providers, and delivery of local and national priorities. Data therefore needs to be accurate, credible, reliable and secure.

The majority of the data used by the CCG for these purposes is derived from external sources, such as providers' systems and national IT systems, and much is processed by third parties. There are a wide range of sources of assurance available to the CCG to monitor the quality of this data – national datasets, local audits, data quality targets, contractual requirements etc.

During 2016/17, in response to an Internal Audit report, the CCG developed and approved a data quality policy which clarifies roles and responsibilities and makes provision for an annual data validation exercise to be undertaken on key data flows.

Information Governance

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

Barnsley CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and supporting processes and procedures in line with the Information Governance Toolkit. We require all staff to undertake annual information governance training to ensure they are aware of their information governance roles and responsibilities. There are processes in place for incident reporting and investigation.

Based on these arrangements the CCG was able to report full compliance across all standards in its 2013/14, 2014/15, 2015/16 and 2016/17 IG Toolkit submissions.

Internal Audit finalised its annual review of the CCG's arrangements for ensuring compliance with a sample of the requirements of the IG Toolkit in March 2018. There were just two low risk recommendations which were actioned in advance of the submission of the Toolkit. The CCG submitted a fully compliant IG Toolkit assessment for 2017/18 in advance of the 31st March 2017 deadline.

Business Critical Models

The CCG has no business critical models which meet the required threshold for reporting to the Department of Health (via NHS England) in line with the recommendations from the MacPherson report.

Commissioning Support

During 2017/18 the CCG has obtained commissioning support functions from a variety of sources:

Scope of Service	Provider	Sources of Assurance
Business Intelligence IT / IG	eMBED Health Consortium	• Services provided under contract • Review of KPIs • Monthly contract review meetings • Monthly service leads meetings • Annual assurance report
Financial Services	Rotherham CCG provides accounting processes (overall control and decision making remains within Barnsley CCG)	• 360 Assurance provides internal audit services for both CCGs • KPMG provides external audit services for both CCGs • It has been agreed to utilise the joint audit scope to allow Barnsley CCG transactions to be tested and assured across the boundary between the two organisations • The report from this testing provided significant assurance over the CCG's controls
Human Resources	Joint service hosted by Sheffield CCG	• Memorandum of Understanding • Regular meetings with HR Service Lead • Annual assurance report presented to Audit Committee (March 2018) • Internal Audit reviews on a cyclical basis
Health and Safety	Joint service hosted by Rotherham CCG	• Memorandum of Understanding • Regular meetings with H&S Lead • Oversight by CCG Health & safety Group and SY&B Governance Leads
IFR	Joint service hosted by Sheffield CCG	• Memorandum of Understanding • Oversight by host organisation and by IFR Leads at each CCG • Internal Audit reviews on a cyclical basis – review undertaken in 2017/18 provided significant assurance • 7 low risk recommendations are being addressed by the IFR team
Procurement	Joint service hosted by Sheffield CCG	• Memorandum of Understanding • Regular meetings between CCG procurement lead and shared service manager • Oversight of all procurement activity by Finance & Performance Committee • Internal Audit reviews on a cyclical basis
Equality & Diversity	Shared resource with BHNFT	• Memorandum of Understanding • Oversight by the Equality & Diversity Working Group and the Equality & Engagement Committee

Third party assurances

Service Organisations (including CSUs) 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.

Service Auditor Reports that are of relevance to CCGS are:

- From NHS Shared Business Services for the provision of Financial Accounting Services
- From Capita – Type II report on Primary Care Services
- From NHS Business Service Authority on the operation of prescription services and dental services
- From NHS Digital on the operation of GP payments, CQRS, and SUS
- From NHS ESR on the operation of the Electronic Staff Record.

The Chief Finance Officer has received and reviewed all relevant SARs, which were received during April / May 2018, and considered the implications of any deficiencies in control they highlight. None of the reports identified any relevant control issues, with the exception of the Capita – Type II report on Primary Care Services. Interim reports on the design and operation of controls over primary care services payments by Capita found inconsistencies in the application of some controls in the period to 31 December 2017. The final report covering the period to 31 March 2018 recognised that good progress had been made in remediating the identified inconsistencies, but nevertheless identified exceptions with respect to 7 out of 16 control objectives covered by the report, resulting in a qualified opinion. This means the report does not provide the CCG with complete assurance over the controls within this system.

However, the CCG takes assurance from its own internal control procedures that primary care co-commissioning expenditure has been correctly reflected in the financial statements. The CCG completes all journal adjustments each month. Expenditure is monitored against budgets on a monthly basis, and is reported to the Primary Care Commissioning Committee, Finance and Performance Committee and Governing Body. Internal audit has provided significant assurance on Budgetary Controls, Financial Reporting and Key Financial Systems for 2017/18. In addition, since similar issues have been identified in the previous two years, KPMG included significant additional substantive testing and review in the external audit plan and which was undertaken as part of the external audit process. This provides assurance that the figures presented are a true and fair view of primary care co-Commissioning expenditure.

Control Issues

No significant control issues have arisen in 2017/18 which require disclosure in this report.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

Throughout 2017/18 the Governing Body has built upon the experience of the first four years of operation with regard to making investment decisions and identifying efficiency programmes. The Governing Body has exercised control via Management Team for decisions to commit funding below £100k and reserved the right to decide on investments over this level to the Governing Body as a whole.

In order to ensure the efficient and effective use of the Barnsley pound, recurrent investments have been approved after consideration of alignment with strategic objectives and non-recurrent investment has been deployed to secure operational imperatives, such as winter resilience.

Stronger emphasis has been placed in the last year on delivering efficiencies, which will continue in 2018/19 and beyond. The CCG undertook monthly assessment and reporting of the in-year efficiency programme, and where delivery risks were identified, mitigating actions were recommended to the Finance and Performance Committee and Governing Body. This approach to early reporting of risks and shared ownership of the challenge secured in-year savings which mitigated the risk to non-achievement of financial duties and targets.

The scale of the efficiency programme for 2018/19 and beyond is significant: whilst financial plan submissions to NHS England demonstrate compliance with financial duties and targets, the CCG will need to deliver £11.5 million of efficiency savings. Robust arrangements continue to be in place through a Project Management Office (PMO) approach including Clinical Forum which will support achievement of the CCG's statutory financial duties and continuous quality improvement. NHS England commissioned a review of CCGs Efficiency programmes from Deloitte. This review was undertaken in March 2018 and assessed the governance, planning, stakeholder engagement and capacity to deliver projects. The CCG was rated 'green' in all areas of governance. Six of the ten projects assessed were rated 'green' overall, with the four remaining projects rated 'amber' with minor recommendations.

As part of NHS England's Improvement and Assessment Framework for 2017/18, the CCG has submitted a self-assessment for the Quality of Leadership Indicator. This set out the CCG's robust system of financial control and leadership and proposed the highest rating, 'green star'. The latest results for the CCG (quarter 3 2017/18) are 'green' and the year-end results for the Quality of Leadership Indicator will be available from July 2018 at www.nhs.uk/service-search/performance/search.

As part of budgetary control, the Finance and Performance Committee and Governing Body have received regular Integrated Performance Reports which highlight financial performance in the context of activity, projected year-end position and the identification and proposed management of key risks. The CCG contained expenditure within allocated resources, both for Programme and Running Costs and has ended the year with a surplus of £2.382 million, in line with NHS England expectations.

This in year surplus is as a result of NHS planning guidance at the start of the year requiring CCGs to hold a 0.5 percent national risk reserve which for Barnsley CCG totalled £1.868M this was to remain uncommitted for the year and was created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. In addition CCGs were also instructed (in year) by NHS England that the benefit of category M drugs was to show an improvement in CCGs bottom line position (£514K).

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.

Delegation of functions

Page 45 explained how the CCG is a member of the Working Together Joint Committee of CCGs (JCCC), with its own Terms of Reference and Scheme of Delegation. In addition to this arrangement the CCG is also a participant in the following arrangement:

- 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 Joint Strategic Commissioning Board.

Counter Fraud Arrangements

Overall executive responsibility for counter fraud arrangements rests with the Acting Chief Finance Officer.

The **Local Counter Fraud Specialist (LCFS)** supports the CCG in mitigating the risks associated with fraud. Working to a risk-based annual plan approved by the Audit Committee, the LCFS undertakes a wide range of proactive work to promote and embed counter fraud arrangements across the CCG. This has included fraud awareness training for all staff, publicity, fraud alerts, reviews of policies and systems, ad hoc guidance, etc. The LCFS also undertakes proactive detection exercises, and investigations into potential frauds. The LCFS presents reports to every Audit Committee, and also prepares an Annual Report.

The LCFS supports the CCG to complete and submit a self-review of our level of compliance with NHS Counter Fraud Authority's *Standards For Commissioners*. In March 2017 and again in March 2018 the CCG was judged to be at 'green,' which means it has appropriate arrangements in place and that evidence of their effectiveness is in place.

Head of Internal Audit Opinion

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

The Head of Internal Audit Opinion received in March 2018 concluded that:

*"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:

Audit Assignment	**Status**	**Assurance Level/*Comment***
Governance – Committee Effectiveness	Issued	Significant
Patient & Public Engagement	Issued	Significant
Risk Management – Risk Identification	Issued	Significant
Performance Management	Issued	Significant
Procurement process – Intermediate Care	Issued	N/A
Commissioning Strategy	Issued	Significant
Review of Individual Funding Requests	Issued	Significant
Conflicts of Interest	Issued	Significant
Information Governance Toolkit	Issued	Significant
Integrity of the General Ledger and Key Financial Systems	Issued	Significant

All audit reports from assurance reviews in the 2017/18 Internal Audit Plan that have been issued to management and the Audit Committee to date have reported Significant Assurance on systems and processes. However two audit assignments undertaken in the 2016/17 Audit Plan, but not reported to the Audit Committee until 2017/18, received a 'limited assurance' opinion. These were:

- Primary Care Quality Monitoring (received April 2017)
- Personal Health Budgets (received July 2017).

Both of these limited assurance opinions were reported to Audit Committee and the Governing Body in the Annual Governance Statement 2017/18.

In response to the recommendations in the *Primary Care Quality Monitoring* report the Primary Care Team undertook an extensive piece of work to develop a Primary Care Quality Improvement Tool, which was approved by the Governing Body in November 2017. Oversight will be via a newly established Primary care Quality Improvement Group reporting into the Quality and Patient Safety Committee. All actions are now complete.

The *Personal Health Budgets* report coincided with the CCG's decision to withdraw from the IPC national programme and therefore the Committee accepted that the landscape

had changed. The CCG remains committed to the PHBs however follow up of this report has been postponed until 2018/19 to enable further consideration regarding what is now appropriate in relation to the management of PHBs.

Review of the Effectiveness of Governance, Risk Management, and Internal Control

The Accountable Officer's review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework.

The Accountable Officer has drawn on performance information available to her.

Her review is also informed by comments made by the external auditors in their management letter and other reports.

The Governing Body Assurance Framework provides the Accountable Officer with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principal objectives have been reviewed.

The Accountable Officer has been advised on the implications of the result of her review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, and other Committees of the CCG. In carrying out her review the Accountable Officer has relied specifically upon:

- The outcomes from assurance checkpoint meetings with NHSE and the annual assessment of the CCG's performance under the Improvement and Assessment Framework
- The CCG's overall governance, risk management, and internal control arrangements outlined in this report
- Reviews undertaken by the CCG's internal auditors, 360 Assurance, on a range of significant financial and other systems
- Performance, equality, sustainability, and other information incorporated within the Annual Report and other performance information available to her
- Results of national staff and stakeholder surveys
- The statutory external audit undertaken by KPMG, who provide an opinion on the financial statements and form a conclusion on the CCG's arrangements for ensuring economy, efficiency, and effectiveness in its use of resources during 2017/18.

The 'Control Issues' section (page 59) confirms that no significant control issues were identified in the year.

Conclusion

As Accountable Officer and based on the review process outlined above, the CCG has identified and is taking action on the control issues arising in year which have been identified in detail in the body of the Governance Statement above.

My review confirms that NHS Barnsley CCG has a generally sound system of risk management and internal control that supports the achievement of its policies, aims and objectives.

Lesley Smith
Accountable Officer
24 May 2018

Remuneration and staff report

Remuneration Committee

The details of the remuneration committee can be found on page 42.

Remuneration Policy

The CCG has not developed a specific remuneration policy but used the guidance outlined in the Department of Health July 2012 Pay Framework for Very Senior Managers in Health Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts where appropriate in the absence of specific guidance for CCG's for some VSM roles.

The CCG has utilised the CCG specific guidance in relation to Chief Officer and Chief Finance Officer remuneration.

The CCG has not implemented any performance related pay.

Remuneration of Very Senior Managers

The CCG has no Governing Body Members on Very Senior Manager contracts who have been paid more than £150,000 per annum. GPs and clinicians on the Governing Body are employed on a sessional basis and so their remuneration has not been grossed up on an annualised basis.

Senior manager remuneration (including salary and pension entitlements) [SUBJECT TO AUDIT]

Name and title	(a) Salary (bands of £5,000)		(b) Expense payments (taxable) to nearest £100		(c) Performance pay and bonuses (bands of £5,000)		(d) Long term performance pay and bonuses (bands of £5,000)		(e) All pension-related benefits (bands of £2,500)*		(f) TOTAL (a to e) (bands of £5,000)	
	£0		£0		£0		£0		£0		£0	
	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18
Governing Body Members:												
Dr N Balac, Chairman ****	90-95	**95-100**	0	**0**	0	**0**	0	**0**	30-32.5	**22.5-25**	125-130	**115-120**
L J Smith, Chief Officer	135-140	**85-90**	0	**0**	0	**0**	0	**0**	0	**0**	135-140	**85-90**
Dr M Ghani, Medical Director	75-80	**80-85**	0	**0**	0	**0**	0	**0**	30-32.5	**32.5-35**	110-115	**110-115**
H Wells, Chief Finance Officer (to 02.07.17) ****	95-100	**25-30**	0	**0**	0	**0**	0	**0**	35-37.5	**5-7.5**	130-135	**30-35**
B Reid, Chief Nurse	85-90	**90-95**	0	**0**	0	**0**	0	**0**	30-32.5	**60-62.5**	115-120	**150-155**
Dr J Harban, Governing Body Member	25-30	**25-30**	0	**0**	0	**0**	0	**0**	0	**0**	25-30	**25-30**
Dr N Luscombe, Governing Body Member (to 26.12.16)	20-25	**0**	0	**0**	0	**0**	0	**0**	0	**0**	20-25	**0**
M Hoyle, Governing Body Member (Practice Manager) (renew from 01.04.17 to 31.12.17)	15-20	**10-15**	0	**0**	0	**0**	0	**0**	0	**0**	15-20	**10-15**
Dr S Krishnasamy, Governing Body Member & Appointed as Associate Medical Director (from 01.08.16)	35-40	**45-50**	0	**0**	0	**0**	0	**0**	12.5-15	**22.5-25**	50-55	**65-70**
Dr M Guntamukkala, Governing Body Member	25-30	**25-30**	0	**0**	0	**0**	0	**0**	0	**0**	25-30	**25-30**
Dr M Smith, Governing Body Member	25-30	**25-30**	0	**0**	0	**0**	0	**0**	0	**0**	25-30	**25-30**
Dr M Simms, Secondary Care Clinician, Governing Body Member	20-25	**25-30**	0	**0**	0	**0**	0	**0**	0	**0**	20-25	**25-30**
Dr L King, Governing Body Member (to 15.07.16)	20-25	**0**	0	**0**	0	**0**	0	**0**	0	**0**	20-25	**0**
Dr Adebowale Adekunle, Governing Body Member (from 18.07.16)	20-25	**30-35**	0	**0**	0	**0**	0	**0**	0	**0**	20-25	**30-35**
C Millington, Lay Member	10-15	**10-15**	0	**0**	0	**0**	0	**0**	0	**0**	10-15	**10-15**

Name and title	(a) Salary (bands of £5,000)		(b) Expense payments (taxable) to nearest £100		(c) Performance pay and bonuses (bands of £5,000)		(d) Long term performance pay and bonuses (bands of £5,000)		(e) All pension-related benefits (bands of £2,500)*		(f) TOTAL (a to e) (bands of £5,000)	
	£0		£0		£0		£0		£0		£0	
	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18
Governing Body Members:												
Mr Brian Roebuck, Lay Member for Governance (from 18.07.16 to 05.04.17)	5-10	**0-5**	0	**0**	0	**0**	0	**0**	0	**0**	5-10	**0-5**
Dr M H Kadarsha, Governing Body Member (from 01.04.17)	0	**30-35**	0	**0**	0	**0**	0	**0**	0	**0**	0	**30-35**
Dr J Holloway, Governing Body Member (from 01.04.17 to 04.03.18)	0	**25-30**	0	**0**	0	**0**	0	**0**	0	**70-72.5**	0	**95-100**
S Tyler, Lay Member for Accountable Care (from 01.04.17)	0	**5-10**	0	**0**	0	**0**	0	**0**	0	**0**	0	**5-10**
N Bell, Lay Member for Governance (from 20.07.17)	0	**5-10**	0	**0**	0	**0**	0	**0**	0	**0**	0	**5-10**
R Naylor, Acting Chief Officer (from 19.06.17)	0	**75-80**	0	**0**	0	**0**	0	**0**	0	**195-197.5**	0	**270-275**
Other Senior Staff:										**0**		
V Peverelle, Chief of Corporate Affairs (to 02.10.16)	40-45	**0**	0	**0**	0	**0**	0	**0**	25-27.5	**0**	65-70	**0**
Richard Walker, Head of Governance & Assurance (from 01.09.16)	30-35	**55-60**	0	**0**	0	**0**	0	**0**	20-22.5	**22.5-25**	50-55	**80-85**
Jamie Wike, Director of Strategic Planning and Performance (from 01.09.16)	30-35	**60-65**	0	**0**	0	**0**	0	**0**	62.5-65	**50-52.5**	95-100	**110-115**

*All pension related benefits: For defined benefit schemes, the amount included here is the annual increase in pension entitlement determined in accordance with the HMRC method: Increase=((20xpension as at 31.3.18)+pension lump sum as at 31.3.18)-((20xpension as at 31.3.17 adjusted by inflation)+pension lump sum as at 31.3.17 adjusted by inflation.

** Clinicians on the Governing Body are employed on a sessional basis. The Chair is employed for 3 days per week; the medical director is employed for 2.5 days per week; the associate medical director for 1.5 days per week; the secondary care clinician for 3 days per month; and other Governing Body member GPs for 1 day per week.

*** The Chief Officer's time is partly recharged (38%) to the South Yorkshire and Bassetlaw Integrated Care System so the salary band disclosed above in the senior management remuneration table relates only to the duties for the CCG.

**** NHS Pensions Authority have provided restated opening pension figures.

Pension benefits as at 31 March 2018 [SUBJECT TO AUDIT]

Name and title	(a) Real Increase in pension at pension age (bands of £2,500)	(b) Real Increase in pension lump sum at pension age (bands of £2,500)	(c) Total Accrued pension at pension age at 31 March 2018 (bands of £5,000)	(d) Lump sum at pension age at 31 March 2018 (bands of £5,000)	(e) Cash Equivalent transfer value at 01 April 2017	(f) Real Increase in cash equivalent transfer value	(g) Cash Equivalent transfer value at 31 March 2018	(h) Employers contribution to stakeholder pension
Governing Body Members:	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Dr N Balac, Chairman *****	0-2.5	2.5-5	10-15	40-45	268	21	292	0
L J Smith, Chief Officer **	0	0	0	0	0	0	0	0
Dr M Ghani, Medical Director	0-2.5	0-2.5	10-15	30-35	171	20	193	0
H Wells, Chief Finance Officer (to 02.07.17) *****	0-2.5	0	15-20	40-45	339	4	357	0
B Reid, Chief Nurse	2.5-5	7.5-10	30-35	95-100	555	85	646	0
Dr J Harban, Governing Body Member	0	0	0	0	0	0	0	0
Dr N Luscombe, Governing Body Member (to 26.12.16) ***	0	0	0	0	0	0	0	0
M Hoyle, Governing Body Member (Practice Manager) (renew from 01.04.17 to 31.12.17) ***	0	0	0	0	0	0	0	0
Dr S Krishnasamy, Governing Body Member & Appointed as Associate Medical Director (from 01.08.16)	0-2.5	0-2.5	5-10	20-25	105	14	120	0
Dr M Guntamukkala, Governing Body Member **	0	0	0	0	0	0	0	0
Dr M Smith, Governing Body Member **	0	0	0	0	0	0	0	0
Dr M Simms, Governing Body Member **	0	0	0	0	0	0	0	0
Dr L King, Governing Body Member (to 15.07.16) ***	0	0	0	0	0	0	0	0
Dr Adebowale Adekunle, Governing Body Member (from 18.07.16) ****	0	0	0	0	0	0	0	0
C Millington, Lay Member *	0	0	0	0	0	0	0	0

Name and title	(a) Real Increase in pension at pension age (bands of £2,500)	(b) Real Increase in pension lump sum at pension age (bands of £2,500)	(c) Total Accrued pension at pension age at 31 March 2018 (bands of £5,000)	(d) Lump sum at pension age at 31 March 2018 (bands of £5,000)	(e) Cash Equivalent transfer value at 01 April 2017	(f) Real Increase in cash equivalent transfer value	(g) Cash Equivalent transfer value at 31 March 2018	(h) Employers contribution to stakeholder pension
Governing Body Members:	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mr Brian Roebuck, Lay Member for Governance (from 18.07.16 to 05.04.17)	0	0	0	0	0	0	0	0
Dr M H Kadarsha, Governing Body Member (from 01.04.17) ****	0	0	0	0	0	0	0	0
Dr J Holloway, Governing Body Member (from 01.04.17 to 04.03.18)	2.5-5	0	5-10	0	29	34	66	0
S Tyler, Lay Member for Accountable Care (from 01.04.17) *	0	0	0	0	0	0	0	0
N Bell, Lay Member for Governance (from 20.07.17) *	0	0	0	0	0	0	0	0
R Naylor, Acting Chief Officer (from 19.06.17)	7.5-10	0	20-25	0	134	80	237	0
Other Senior Staff:								
V Peverelle, Chief of Corporate Affairs (to 02.10.16)	0	0	0	0	538	0	0	0
Richard Walker, Head of Governance & Assurance (from 01.09.16)	0-2.5	0	0-5	0	32	15	47	0
Jamie Wike, Director of Strategic Planning and Performance (from 01.09.16)	2.5-5	0	20-25	0	181	38	221	0

Notes:
*Lay Members do not receive pensionable remuneration from the CCG; there are no entries in respect of pensions for those members.
**Member has opted out of the NHS pension scheme.
***Payment for this individual's work within the CCG is paid directly to the GP practice. The amount paid over includes an element for employer's pension contribution and the Practice accounts for all pension contributions with payment made to NHS England.
****Payment for this individual's work within the CCG is paid directly to them. The amount includes an element for employer's pension contribution and the CCG accounts for all pension contributions with payment made to NHS England.***** NHS Pensions Authority have provided restated opening pension figures.

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 member's accrued benefits and any contingent spouse's (or other allowable beneficiary'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 benefits 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.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Compensation on early retirement of for loss of office [SUBJECT TO AUDIT]

No payments have been made in compensation for early retirement or for loss of office.

Payments to past members [SUBJECT TO AUDIT]

No payments were made to past members in 2017/18 (2016/17: £1,313).

Pay multiples [SUBJECT TO AUDIT]

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

The banded remuneration of the highest paid member in NHS Barnsley CCG in the financial year 2017/18 was £135,000 - £140,000 (2016/17: £140,000). This was 3.9 times (2016/17: 4.3) the median remuneration of the workforce, which was £35,577 (2016/17: £32,023).

In 2017/18, No employees received remuneration in excess of the highest-paid member. Remuneration ranged from £6,844 to £137,714 (2016/17: £5,692 to £136,500).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The highest paid member used to calculate the ratio of the median salary to the highest paid member is the Accountable Officer. The Accountable Officer's time is partly

recharged to the South Yorkshire and Bassetlaw Integrated Care System so the salary band disclosed in the senior management remuneration table relates only to the duties for the CCG.

Staff Report

The table below shows the average number of whole time equivalent staff permanently employed in the CCG.

	2017-18					2016-17
	Total		Permanently employed		Other	Total
	Number		Number		Number	Number
Total (average Whole Time Equivalent WTE staff)	105		101		4	93
Of the above:						
Number of whole time equivalent people engaged on capital projects	0		0		0	0

Staff numbers and costs [SUBJECT TO AUDIT]

Employee benefits	2017-18	Total			Admin			Programme		
	Total	Permanent Employees		Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits										
Salaries and wages	4,602	4,308		294	2,375	2,335	40	2,227	1,973	254
Social security costs	462	456		6	260	256	4	202	200	2
Employer Contributions to NHS Pension scheme	566	559		7	300	295	5	266	264	2
Other pension costs	0	0		0	0	0	0	0	0	0
Apprenticeship levy	8	8		0	8	8	0	0	0	0
Other post-employment benefits	0	0		0	0	0	0	0	0	0
Other employment benefits	0	0		0	0	0	0	0	0	0
Termination benefits	0	0		0	0	0	0	0	0	0
	5,638	**5,332**		**307**	**2,943**	**2,894**	**49**	**2,695**	**2,437**	**258**
Gross employee benefits expenditure										
	(456)	(456)		0	(185)	(185)	0	(271)	(271)	0
Less recoveries in respect of employee benefits	**5,182**	**4,875**		**307**	**2,758**	**2,709**	**49**	**2,424**	**2,166**	**258**
Total - Net admin employee benefits including capitalised costs										
	0	0		0	0	0	0	0	0	0
Less: Employee costs capitalised	**5,182**	**4,875**		**307**	**2,758**	**2,709**	**49**	**2,424**	**2,166**	**258**
Net employee benefits excluding capitalised costs										

Employee benefits											
	2016-17	Total				Admin				Programme	
	Total	Permanent Employees		Other	Total	Permanent Employees		Other	Total	Permanent Employees		Other
	£'000	£'000		£'000	£'000	£'000		£'000	£'000	£'000		£'000
Employee Benefits												
Salaries and wages	4,464	3,741		723	2,477	2,214		263	1,987	1,527		460
Social security costs	387	387		0	234	234		0	153	153		0
Employer Contributions to NHS Pension scheme	465	465		0	266	266		0	199	199		0
Other pension costs	0	0		0	0	0		0	0	0		0
Other post-employment benefits	0	0		0	0	0		0	0	0		0
Other employment benefits	0	0		0	0	0		0	0	0		0
Termination benefits	0	0		0	0	0		0	0	0		0
Gross employee benefits expenditure	**5,316**	**4,593**		**723**	**2,977**	**2,714**		**263**	**2,339**	**1,879**		**460**
Less recoveries in respect of employee benefits	(366)	(366)		0	(283)	(283)		0	(83)	(83)		0
Total - Net admin employee benefits including capitalised costs	**4,950**	**4,227**		**723**	**2,694**	**2,431**		**263**	**2,256**	**1,796**		**460**
Less: Employee costs capitalised	0	0		0	0	0		0	0	0		0
Net employee benefits excluding capitalised costs	**4,950**	**4,227**		**723**	**2,694**	**2,431**		**263**	**2,256**	**1,796**		**460**

The increase in total cost of employees from the prior year is £560K. This is the net effect of a reduction in the cost of admin staff of £85K and an increase in the cost of programme staff of £645K: the latter relates to the past year impact of recruitment of 15 WTE clinical pharmacists.

Staff composition

As at 31 March 2018 the composition of the CCG's workforce was as follows:

The definition of senior managers was agreed at Band 8A and above for the purposes of this data.

	Male	Female	Total
Governing Body	10	5	15
Very Senior Manager	2	0	2
Consultant	0	1	1
GP	1	1	2
Band 8D	0	2	2
Band 8C	1	4	5
Band 8B	3	6	9
Band 8A	11	17	28
Other staff	9	60	69
Total	**37**	**96**	**133**

Sickness absence and ill health retirements data

As during 2017/18, the average annual sick days per whole time equivalent member of staff was 5.6 (2016/17: 4.6).

	2017-2018	2016-2017
Total days lost	592	700
Total staff years	106	152
Average working days lost	5.6	4.6

	2017-2018	2016-2017
Number of persons retired early on ill health grounds	0	0
	£'000	£'000
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme.

Staff policies

Consultation and engagement with employees is a fundamental principle of good employment practice. The CCG holds regular staff briefings open to all staff and heads of service hold individual team meetings with their teams. Staff are engaged through their meetings and open staff briefings on the strategic direction, delivery and performance of the CCG. The CCG actively welcomes suggestions and ideas from all staff on the ways the CCG can improve the overall performance of the organisation. The CCG policies can be found at http://www.barnsleyccg.nhs.uk/strategies-policies-and-plans.htm

Disabled Employees

The CCG always aims to strive to be an inclusive organisation which is fully committed to a culture and environment which actively promotes equality of access and treatment for all employees, visitors, contractors and members of the general public. The CCG has published its policies covering Equality, Diversity and Human rights. The policies are monitored and updated to ensure that best practice is incorporated with regards to all aspects of recruitment and selection including the fair treatment of disabled people.

The CCG has the “Two Ticks” Disability award which means the organisation has agreed to take action to meet the five commitments regarding the employment, retention, training and career development of disabled employees.

The CCG is fully committed to ensuring that all employees with a disability have equal access to opportunities to develop to their full potential. All career promotion opportunities are made widely available to all employees in line with best practice, whilst ensuring that any unfair bias and discrimination is eliminated. Monitoring is undertaken to ensure that the CCG remains compliant.

All employees are assessed for the training needs to ensure they are compliant with the job designation, these assessments will incorporate any reasonable adjustments required to ensure that learning and development is fully accessible for all employees.

Other employee matters

This year our staff volunteer group, the Radiators, has introduced a whole range of improvements and activities focused on staff wellbeing and improving performance. Through suggestions from across the organisation, Radiator members have carried out the following changes this year: change from a fixed pay day of the month to a fixed date of the month, allowing staff to manage their personal budgets better; introduced a staff-only car park to reduce the number of bumped vehicles on very busy days with lots of external visitors; hosted a monthly fundraising day; designed the staff conference; and finally launched the Barnsley CCG staff health and wellbeing week, which contributed to the positive staff survey results, highlighted earlier in this report.

Trade Union (Facility Time Publication Requirements) regulations 2017

Under the Trade Union (Facility Time Publication Requirements) regulations 2017, the CCG has to disclose the relationship of Trade Union official’s employment costs and time to the whole CCG.

The CCG does not employee any Trade Union officials. We do however have union representatives representing CCG staff from a shared service and the disclosure below reflects that arrangement.

The relationship with them this year has continued to be positive. They have provided regular support to members either on site, via email or telephone.

Relevant Union Officials
What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent number*
1	0.166

Percentage of time spent on facility time
How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99%, d) 100% of their working hours on facility time?

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

Percentage of pay bill spent on facility time
Provide the figures requested in the first column of the table below to determine the percentage of your total paybill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	*Figures*
Provide the total cost of facility time	£4,607
Provide the total pay bill	£4,308,000
Provide the percentage of the total paybill spent on facility time, calculated as: (total cost of facility time ÷total pay bill) × 100	0.11%

Paid Trade Union activities
As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

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%

Expenditure on consultancy

Consultancy expenditure is the provision to management of objective advice and assistance relating to the CCG's strategy, structure, management or operations. Such assistance will be provided outside the "business as usual" environment when in-house skills are not available and will be of no essential consequence and time-limited. Services may include the identification of options with recommendations and/or assistance with (but not delivery of) the implementation of solutions.

No payments were made for consultancy in 2017-18 (2016-17: £91K).

Off-payroll engagements

It is the Treasury requirements for public sector bodies to report arrangements whereby individuals are paid through their own companies and so are responsible for their own tax and national insurance arrangements. Payments to GP practices for the services of employees and GP's are deemed to be 'off payroll' engagements and are therefore subject to these disclosure requirements.

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

Table 2 (overleaf): New off-payroll engagements

There are no new off-payroll engagements in 2017/18, for more than £245 per day and that last longer than six months (2016/17: Nil).

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which…	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review.	0

Table 3: Off-payroll engagements / senior official engagements

Off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2017 and 31 March 2018 are as follows:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	3

The Clinical Chair, Chief Officer (as Accountable Officer) and the (Acting) Chief Finance Officer are the three members of the Governing Body deemed to have significant financial responsibility for the purposes of the table above. All three were paid through the payroll throughout 2017/18.

Exit packages, including special (non-contractual) payments [SUBJECT TO AUDIT]

Table 1: Exit Packages

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

Redundancy and other departure cost have been paid in accordance with the provisions of NHS terms and conditions of service (Agenda for Change). Exit costs in this note are accounted for in full in the year of departure. Where the NHS Barnsley CCG has agreed early retirements, the additional costs are met by the NHS Barnsley CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
TOTAL	0	0

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in table 1 which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, and amounts relating to non-contractual payments in lieu of notice.

No non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary.

The remuneration report includes disclosure of exit packages payable to individuals named in that report.

Signature of the Accountability Report by the Accountable Officer

Lesley Smith, Accountable Officer, 24 May 2018

Parliamentary Accountability and Audit Report

NHS Barnsley 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 at notes 12, 21 and 2.

An audit certificate and report is also included in this Annual Report at the end of the Annual Report and Financial Statements.

Financial Statements & Notes

Foreword to the accounts

The Clinical Commissioning Group was licenced from the 1 April 2013 under provisions enacted in the Health and Social Act 2012, which amended the National Health Service Act 2006.

These accounts for the year ended 31 March 2018 have been prepared by NHS Barnsley Clinical Commissioning Group under c. 7, Schedule 2, S. 17 CCG Annual Report Directions (chapter A1 of part 2 of the National Health Service Act 2006 as amended by 14Z15 of the Health and Social Act 2012 Reports by Clinical Commissioning Groups) in the form which the Department of Health and Social Care has directed.

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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	(32)	(2,662)
Other operating income	2	(667)	(1,180)
Total operating income		**(699)**	**(3,842)**
Staff costs	4	5,638	5,316
Purchase of goods and services	5	405,226	402,693
Depreciation and impairment charges	5	13	49
Provision expense	5	0	0
Other Operating Expenditure	5	503	435
Total operating expenditure		**411,380**	**408,493**
Net Operating Expenditure		**410,681**	**404,651**
Total Net Expenditure for the year		**410,681**	**404,651**
Other Comprehensive Expenditure		0	0
Comprehensive Expenditure for the year ended 31 March 2018		**410,681**	**404,651**

The notes on pages 6 to 25 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	0	13
Total non-current assets		0	13
Current assets:			
Trade and other receivables	9	3,484	2,742
Cash and cash equivalents	10	77	48
Total current assets		**3,561**	**2,790**
Total assets		**3,561**	**2,803**
Current liabilities			
Trade and other payables	11	(29,571)	(25,529)
Total current liabilities		**(29,571)**	**(25,529)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(26,010)**	**(22,726)**
Assets less Liabilities		**(26,010)**	**(22,726)**
Financed by Taxpayers' Equity			
General fund		(26,010)	(22,726)
Total taxpayers' equity:		**(26,010)**	**(22,726)**

The notes on pages 6 to 25 form part of this statement

The financial statements on pages 2 to 5 were approved by the Governing Body on 24 May 2018 and signed on its behalf by:

Lesley Smith
Chief Officer/Accountable Officer
Date 24 May 2018

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

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18		
Balance at 01 April 2017	**(22,726)**	**(22,726)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18		
Net operating expenditure for the financial year	(410,681)	(410,681)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(410,681)**	**(410,681)**
Net funding	407,397	407,397
Balance at 31 March 2018	**(26,010)**	**(26,010)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17		
Balance at 01 April 2016	**(19,739)**	**(19,739)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17		
Net operating costs for the financial year	(404,651)	(404,651)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(404,651)**	**(404,651)**
Net funding	401,664	401,664
Balance at 31 March 2017	**(22,726)**	**(22,726)**

The notes on pages 6 to 25 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		(410,681)	(404,651)
Depreciation and amortisation	5	13	49
(Increase)/decrease in trade & other receivables	9	(742)	559
Increase/(decrease) in trade & other payables	11	4,042	2,347
Net Cash Inflow (Outflow) from Operating Activities		**(407,368)**	**(401,696)**
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(407,368)**	**(401,696)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		407,397	401,664
Net Cash Inflow (Outflow) from Financing Activities		**407,397**	**401,664**
Net Increase (Decrease) in Cash & Cash Equivalents	10	**29**	**(32)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**48**	**80**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**77**	**48**

The notes on pages 6 to 25 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on 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

Barnsley Clinical Commissioning Group has entered into pooled budget arrangements under Section 75 of the National Health Service Act 2006 for activities relating to Children's Services and the Better Care Fund. A memorandum note to the accounts provides details of the joint income and expenditure (note 16, Page 22).
The Children's Services pool is hosted by Barnsley Metropolitan Borough Council; the Better Care Fund operates on an aligned budget basis. The CCG makes contributions to the pools, which are then used to purchase healthcare services. The CCG accounts for its share of assets, liabilities, income and expenditure of the pools as determined by the pooled budget agreement.

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 - The CCG has in substance a property lease arrangement with NHS Property Services Ltd relating to the headquarters site. NHS England determined that the CCG has not obtained substantially all the risks and rewards of ownership of this property; the lease has been classified as an operating lease and accounted for accordingly.
Legacy balances in respect of assets and liabilities arising for transactions or delivery of care prior to 31st March 2013 are accounted for by NHS England. The clinical commissioning group's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in Notes to these financial statements

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:
The CCG has included certain accruals within the financial statements which are estimates. The key accruals being healthcare contracts, continuing healthcare and prescribing for which the basis of the estimation of the accruals was approved by the Chief Finance Officer.

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.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements on the basis of 2.5 days per whole time equivalent employee.

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 any such 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.

Notes to the financial statements

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.

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

1.8.3 Depreciation, Amortisation & Impairments

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.

1.9 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.

1.9.1 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.

1.10 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.

1.11 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.

1.12 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.

1.13 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 group contributes annually to a pooled fund, which is used to settle the claims.

1.14 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.

The only category of Financial asset applicable to the CCG is Loans and receivables.

1.14.1 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 reflecting an assessment of the reasonable amount that is deemed recoverable.

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.

1.15 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.

1.16 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.

1.17 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).

Notes to the financial statements

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

The Department of Health and Social Care Group Accounting Manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to the Financial Reporting Manual 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	2017-18 Admin	2017-18 Programme	2016-17 Total
	£'000	£'000	£'000	£'000
Non-patient care services to other bodies	32	0	32	2,662
Recoveries in respect of employee benefits	456	185	271	366
Education, training and research	1	1	0	0
Non cash apprenticeship training grants revenue	2	2	0	0
Other revenue	208	0	208	814
Total other operating revenue	**699**	**188**	**511**	**3,842**

Revenue in this note does not include cash received from NHS England which is drawn down directly into the bank.

The 2016-17 Non-patient care services to other bodies primarily includes non recurrent contributions from other organisations to improving self-care and management in the community including Rightcare Barnsley, clinical pharmacists and community equipment.

3 Revenue

	2017-18 Total	2017-18 Admin	2017-18 Programme	2016-17 Total
	£'000	£'000	£'000	£'000
From rendering of services	699	188	511	3,842
Total	**699**	**188**	**511**	**3,842**

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	4,602	4,308	294
Social security costs	462	456	6
Employer Contributions to NHS Pension scheme	566	559	7
Other pension costs	0	0	0
Apprenticeship Levy	8	8	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**5,638**	**5,331**	**307**
Less recoveries in respect of employee benefits (note 4.1.2)	(456)	(456)	0
Total - Net admin employee benefits including capitalised costs	**5,182**	**4,875**	**307**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**5,182**	**4,875**	**307**

4.1.1 Employee benefits 2016-17 Total

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	4,464	3,741	723
Social security costs	387	387	0
Employer Contributions to NHS Pension scheme	465	465	0
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	0	0	0
Gross employee benefits expenditure	**5,316**	**4,593**	**723**
Less recoveries in respect of employee benefits (note 4.1.2)	(366)	(366)	0
Total - Net admin employee benefits including capitalised costs	**4,950**	**4,227**	**723**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**4,950**	**4,227**	**723**

4.1.2 Recoveries in respect of employee benefits

	2017-18 Total £'000	2017-18 Permanent Employees £'000	2017-18 Other £'000	2016-17 Total £'000
Employee Benefits - Revenue				
Salaries and wages	(397)	(397)	0	(357)
Social security costs	(32)	(32)	0	(5)
Employer contributions to the NHS Pension Scheme	(27)	(27)	0	(4)
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	**(456)**	**(456)**	**0**	**(366)**

4.2 Average number of people employed

	2017-18			2016-17
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**105**	**101**	**4**	**93**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

Other staff included above comprises agency staff and secondees from other organisations.

4.3 Exit packages agreed in the financial year

The CCG has not paid any exit packages in 2017-18 (2016-17: Nil)

There has been no non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.

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

Redundancy and other departure costs have been paid in accordance with the provisions of the agenda for change terms and conditions (section 16) and the CCG's organisation change policy.

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

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

For 2017-18, employers' contributions of £584,268 were payable to the NHS Pensions Scheme (2016-17: £488,490) at the rate of 14.38% (2016-17 14.3%) of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014.

5. Operating expenses

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	5,111	2,416	2,695	4,692
Executive governing body members	527	527	0	624
Total gross employee benefits	**5,638**	**2,943**	**2,695**	**5,316**
Other costs				
Services from other CCGs and NHS England	27	0	27	211
Services from foundation trusts	251,419	0	251,419	253,870
Services from other NHS trusts	14,340	0	14,340	14,339
Services from other WGA bodies	0	0	0	1
Purchase of healthcare from non-NHS bodies	33,529	0	33,529	41,069
Purchase of social care	10,568	0	10,568	0
Chair and Non Executive Members	462	462	0	411
Supplies and services – clinical	0	0	0	34
Supplies and services – general	5,488	856	4,632	2,868
Consultancy services	0	0	0	91
Establishment	2,329	506	1,823	2,058
Transport	187	7	180	244
Premises	1,310	266	1,044	643
Impairments and reversals of receivables	17	0	17	0
Depreciation	13	13	0	49
Audit fees	44	44	0	67
Prescribing costs	46,797	0	46,797	49,113
Pharmaceutical services	548	0	548	524
General ophthalmic services	200	0	200	231
GPMS/APMS and PCTMS	38,211	0	38,211	36,145
Other professional fees excl. audit	62	62	0	60
Legal fees	61	16	45	0
Research and development (excluding staff costs)	24	24	0	24
Education and training	104	39	65	191
CHC Risk Pool contributions	0	0	0	934
Non cash apprenticeship training grants	2	2	0	0
Total other costs	**405,742**	**2,297**	**403,445**	**403,177**
Total operating expenses	**411,380**	**5,240**	**406,140**	**408,493**

Auditor Liability

The total aggregate liability of KPMG is limited per the contract to £2 Million for all defaults, claims, losses or damages where arising from breach of contract, misrepresentation, tort, breach of statutory duty or otherwise.

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	14,702	86,019	13,169	78,836
Total Non-NHS Trade Invoices paid within target	14,669	85,878	13,089	78,699
Percentage of Non-NHS Trade invoices paid within target	**99.78%**	**99.84%**	**99.39%**	**99.83%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,555	270,734	2,556	270,236
Total NHS Trade Invoices Paid within target	2,550	270,698	2,551	270,196
Percentage of NHS Trade Invoices paid within target	**99.80%**	**99.99%**	**99.80%**	**99.99%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.
The target has been set at 95% for all of the above criteria, and which has been achieved by the CCG.
The CCG has not made any payments under the Late Payment of Commercial Debts (interest) Act 1998 during 2017-18 (2016-17: Nil)

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense

	2017-18				2016-17			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	0	784	2	**786**	0	500	2	**502**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**784**	**2**	**786**	**0**	**500**	**2**	**502**

The amount recognised above under Buildings has been paid to two organisations:
NHS Property Services Ltd £196K (2016-17: £190K)
Community Health Partnership Ltd £588K (2016-17: £310K)
Of the amount paid to NHS Property Services Ltd, £83K (2016-17: £146K) relates to the occupancy of Hilder House (CCG Headquarters) and £113K (2016-17: £44K) relates to void spaces for Health Centres that were transferred to the lessor on the abolition of the Primary Care Trust in 2013: this year the amounts charged represent market rents.

The £588K (2016-17: £310K) paid to Community Partnership Ltd relates to void, bookable and subsidiary cost in LIFT buildings that the CCG is held liable for.

The costs recognised in Other, relate to photocopier leases held by the CCG.

7.1.2 Future minimum lease payments

	2017-18				2016-17			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:								
No later than one year	0	0	0	**0**	0	0	2	**2**
Between one and five years	0	0	0	**0**	0	0	0	**0**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**2**

Whilst the CCG arrangements with Community Health Partnership Limited and NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for those arrangements.

8 Property, plant and equipment

2017-18	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2017	642	237	879
Cost or valuation at 31 March 2018	**642**	**237**	**879**
Depreciation 01 April 2017	629	237	866
Charged during the year	13	0	13
Depreciation at 31 March 2018	**642**	**237**	**879**
Net Book Value at 31 March 2018	**0**	**0**	**0**
Purchased	(0)	0	(0)
Total at 31 March 2018	**(0)**	**0**	**(0)**
Asset financing:			
Owned	(0)	0	(0)
Total at 31 March 2018	**(0)**	**0**	**(0)**

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	642	530
Furniture & fittings	237	237
Total	**879**	**767**

8.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	2	5
Furniture & fittings	5	10

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	1,682	0	990	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	1,160	0	1,137	0
NHS accrued income	0	0	0	0
Non-NHS and Other WGA receivables: Revenue	161	0	565	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	320	0	29	0
Non-NHS and Other WGA accrued income	0	0	0	0
Provision for the impairment of receivables	0	0	(19)	0
VAT	159	0	37	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	2	0	3	0
Total Trade & other receivables	**3,484**	**0**	**2,742**	**0**
Total current and non current	**3,484**		**2,742**	
Included above:				
Prepaid pensions contributions	0		0	

The great majority of trade is with NHS organisations. As NHS organsiations are funded by Government, no credit score is necessary.

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	3	45	46
By three to six months	0	0	0
By more than six months	0	9	0
Total	**3**	**54**	**46**

£32K of the amount above has subsequently been recovered post the statement of financial position date.

The CCG does not hold any collateral against receivable outstanding at 31 March 2018. (2016-17: Nil)

9.2 Provision for impairment of receivables	2017-18 £'000 DH Group Bodies	2017-18 £'000 Non DH Group Bodies	2016-17 £'000 All receivables prior years
Balance at 01 April 2017	0	(19)	(19)
Amounts written off during the year	0	19	0
Amounts recovered during the year	0	0	0
(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**	**(19)**

Impaired receivables represent a single receivable over six months old and was considered to be irrecoverable by the CCG

10 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	48	80
Net change in year	29	(32)
Balance at 31 March 2018	**77**	**48**
Made up of:		
Cash with the Government Banking Service	77	48
Cash in hand	0	0
Cash and cash equivalents as in statement of financial position	**77**	**48**
Balance at 31 March 2018	**77**	**48**
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
NHS payables: revenue	727	0	967	0
NHS accruals	785	0	2,999	0
Non-NHS and Other WGA payables: Revenue	3,753	0	4,127	0
Non-NHS and Other WGA accruals	23,528	0	16,556	0
Social security costs	70	0	66	0
VAT	0	0	0	0
Tax	60	0	62	0
Other payables and accruals	648	0	752	0
Total Trade & Other Payables	**29,571**	**0**	**25,529**	**0**
Total current and non-current	**29,571**		**25,529**	

There are no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2017: Nil).

Other payables include £488K outstanding pension contributions at 31 March 2018 (31 March 2017: £366K)

12. Provisions and Contingent liabilities

The CCG had no provisions or contingent liabilities as at 31 March 2018 (31 March 2017: Nil) However, under the Accounts Directions 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 CCG. However, the legal liability remains with the CCG.

The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG as at 31 March 2018 is £0K (31 March 2017: £441K).

The total value of legacy NHS Continuing Healthcare contingent liabilities accounted for by NHS England on behalf of this CCG as at 31 March 2018 is £4,106K (31 March 2017: Nil).

13.1 Capital commitments

The CCG has no contracted capital commitments not otherwise included in these financial statements as at 31 March 2018 (31 March 2017: Nil)

14. Financial instruments

14.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the CCG 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 CCG 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 CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG's internal auditors.

14.1.1 Currency risk

The CCG is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The CCG has no overseas operations. The CCG has therefore has low exposure to currency rate fluctuations.

14.1.2 Interest rate risk

The CCG 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 CCG therefore has low exposure to interest rate fluctuations.

14.1.3 Credit risk

Because the majority of the CCG's and revenue comes parliamentary funding, the CCG has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

14.1.4 Liquidity risk

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

14 Financial instruments cont'd

14.2 Financial assets

	Loans and Receivables 2017-18 £'000	Total 2017-18 £'000
Receivables:		
· NHS	1,682	1,682
· Non-NHS	161	161
Cash at bank and in hand	77	77
Other financial assets	2	2
Total at 31 March 2018	**1,922**	**1,922**

	Loans and Receivables 2016-17 £'000	Total 2016-17 £'000
Receivables:		
· NHS	990	990
· Non-NHS	565	565
Cash at bank and in hand	48	48
Other financial assets	3	3
Total at 31 March 2017	**1,606**	**1,606**

14.3 Financial liabilities

	Other 2017-18 £'000	Total 2017-18 £'000
Payables:		
· NHS	1,512	1,512
· Non-NHS	27,929	27,929
Other financial liabilities	0	0
Total at 31 March 2018	**29,441**	**29,441**

	Other 2016-17 £'000	Total 2016-17 £'000
Payables:		
· NHS	3,966	3,966
· Non-NHS	21,435	21,435
Other financial liabilities	0	0
Total at 31 March 2017	**25,401**	**25,401**

15. Operating segments

The CCG considers that it has only one segment in terms of Operating segments: the commissioning of Healthcare services

	2017-18 £'000
Total Gross Expenditure (as per note 5)	411,380
Total Gross Income (as per note 2)	(699)
Total Net Expenditure as at 31 March 2018	**410,681**
Total Assets (as per Statement of Financial Position)	3,561
Total Liabilities (as per Statement of Financial Position)	(29,571)
Total Net Assets as at 31 March 2018	**(26,010)**

During the year the CCG spent £405,629,000 on the commissioning of Healthcare and other services (net programme expenditure). This represents 98.8% of the CCG's net expenditure.

52.3% of the CCG's net programme expenditure was expensed with the two main local providers £146,971,000 (36.2%) to Barnsley Hospital NHS Foundation Trust and £65,318,000 (16.1%) to South West Yorkshire Partnership NHS Foundation Trust.

16. Pooled budgets

Children and Young People's Trust

The CCG has entered into a pooled budget arrangement with Barnsley Metropolitan Borough Council (BMBC) under S75 of the Health Care Act 2006.

Both parties contribute funds to a pooled commissioning budget, which is hosted by BMBC. The pooled budget is managed by the Executive Commissioning Group.

This group allocates the funds to the Children and Young People's Trust to commission Childrens services.

Summary of the pooled budget is shown below;

	2017-18 £'000	2016-17 £'000
Contribution to pooled commissioning budget:		
Opening balance as at 1 April	0	0
Barnsley Clinical Commissioning Group	6,328	6,245
Barnsley Metropolitan Borough Council	30,128	26,144
	36,456	**32,389**
Services Commissioned from the pooled budget:		
Barnsley Metropolitan Borough Council	30,918	26,574
South West Yorkshire Partnership NHS Foundation Trust	4,017	4,353
Barnsley Clinical Commissioning Group	1,521	1,462
Over/ (under) spend	909	3,190
Transfer / Use of Balances	(909)	(3,190)
Total Commissioned services	**36,456**	**32,389**
Closing balance as at 31 March	**0**	**0**

The £909K shortfall in the pool has been addressed by the relevant organisation at the year end under IAS 31 interests in joint ventures and is based upon each organisation taking its statutory obligations.

The CCG has recognised a surplus of £474K in its financial statements for 2017-18 this relates to the budgets the CCG has a statutory obligation for. BMBC has recognised a charge of £435K.

Barnsley Better Care Fund

In line with the national announcement of the creation of a Better Care Fund (BCF) in December 2013, the CCG has entered into a pooled budget arrangement with Barnsley Metropolitan Borough Council (BMBC) with effect from 1 April 2015. The aims of the BCF are to improve outcomes for the population of Barnsley by improving integration of health and social care services. This was underpinned by a Section 75 agreement between commissioners. Governance arrangements are in place through the Barnsley Senior Strategic Development Group and the Barnsley Health and Wellbeing Board. The CCG hosted the arrangement during 2017-18 and 2016-17 period.

A summary of the pooled budget is shown below;

	2017-18 £'000	2016-17 £'000
Contribution to pooled commissioning budget:		
Opening balance as at 1 April	0	0
Barnsley Clinical Commissioning Group	18,590	18,263
Barnsley Metropolitan Borough Council	9,348	2,331
	27,938	**20,594**
Services commissioned from the pooled budget:		
Barnsley Clinical Commissioning Group	8,676	8,323
Barnsley Metropolitan Borough Council	16,486	12,271
Total Commissioned services	**25,162**	**20,594**
Closing balance as at 31 March	**2,776**	**0**

The closing balance represents profile spend in future years of the Improved Better care Fund on non-recurrent Adult Social Care and is retained by the Barnsley Metropolitan Borough Council (BMBC).

17. Related party transactions

Details of related party transactions with individuals are as follows:

				Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
St Georges Medical centre	Dr Balac	Governing Body Chair	Practice Payments	1,199	3	137	1
White Rose Medical Centre	Dr Ghani	Medical Director	Practice Payments	1,259	1	136	1
Lundwood Medical Practice	Dr Harban	Governing Body Member	Practice Payments	905	2	78	0
Royston Group Practice	Dr Krishnasamy	Governing Body Member	Practice Payments	1,127	1	136	0
Victoria Medical Centre	Dr Smith	Governing Body Member	Practice Payments	1,436	5	165	1
Grove Medical Practice	Dr Guntamukkala	Governing Body Member	Practice Payments	710	3	85	0
Kakoty Practice	M Hoyle	Governing Body Member	Practice Payments	886	0	100	0
Wombwell Chapelfields Medical Centre	Dr Adekunle	Governing Body Member	Practice Payments	1,513	0	188	0
Woodgrove Surgery	Dr Holloway	Governing Body Member	Practice Payments	1746	1	199	1
Hollygreen Practice	Dr Kadarsha	Governing Body Member	Practice Payments	1965	1	235	0
Dodworth Medical practice	Dr Kadarsha	Governing Body Member	Practice Payments	763	0	102	0

The above payments to practices includes delegated Primary Care Co-commissioning arrangements which are contractual under General/Personal or Alternative Provider Medical service contracts. The figures represent all transactions with the related party for the financial year.

Dr Balac, Governing Body Chair for the CCG. St Georges Medical Centre is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 17.1

Dr Ghani, Medical Director for the CCG holds a position with SAAG Ltd: no transactions have been recorded with the entity in 2017-18. White Rose Medical Centre is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 17.1

Dr Harban, Governing Body Member for the CCG is a Director for Lundwood Surgical Services Ltd: no transactions have been recorded with the entity in 2017-18. Dr Harban & Partners is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 17.1. Dr Harban is also a partner at Kakoty Practice which is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 17.1

Dr Krishnasamy, Governing Body Member for the CCG is a Director for SKSJ Medicals Ltd: no transactions have been recorded with the entity in 2017-18. Royston Group Practice is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 17.1

Dr Smith, Governing Body Member is a Director of Janark Medical Ltd: no transactions have been recorded with the entity in 2017-18. Senior Partner at Victoria Medical Centre.

Dr Guntamukkala, Governing Body Member for the CCG. Grove Medical Practice is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 17.1. Dr Guntamukkala, Husband is a Partner at Grove Medical Practice and Lakeside Surgery.

M Hoyle, was a Governing Body Member until 31 December 2017. She is also a Director for Barnsley Enterprise for Living Well (CIC) and is a Director and Company Secretary for Jaxon's Gift a Charitable organisation: no transactions have been recorded with the entity in 2017-18. Kakoty Practice is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 17.1

Dr Adekunle, Governing Body Member for the CCG. Wombwell Chapelfields Medical Centre is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 17.1. He also provides clinical services to Local Care Direct Wakefield, no transactions have been recorded in 2017-18.

Dr Holloway, was a Governing Body Member for the CCG until 4 March 2018 and a salaried doctor at Woodgrove Surgery.

Dr Kadarsha, Governing Body Member for the CCG is a Director for YAAOZ Ltd: no transactions have been recorded with the entity in 2017-18. Hollygreen and Dodworth Medical practice are members of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 17.1

The Department of Health is regarded as a related party. During the year the CCG has had a number of material transactions with entities from which the Department
- NHS England and other Clinical Commissioning Groups
- NHS Foundation Trusts
- NHS Trusts
- NHS Litigation Authority and
- NHS Business Services Authority

In addition the CCG had a number of material transactions with other government departments and other central and local government bodies.
The majority of these transactions have been with Barnsley Metropolitan Borough Council.

Note 17.1 Barnsley Healthcare Federation (Community Interest Company)
The Barnsley Healthcare Federation was setup in 2015-16 to provide NHS Primary care services to the population of Barnsley.
The organisation is made up of a significant number of Barnsley GP practices. The Governing Body members mentioned above are related to practices that are part of the Barnsley Healthcare Federation.
During 2017-18 the CCG recognised income with the Community Interest Company for the recharge of £11,246 of expenditure.
The CCG also made expenditure transactions totalling £4,888,763 predominantly relating to contractual payments for the provision of primary medical services.

18. Events after the end of the reporting period

There are no events after the end of the reporting period which will have a material effect on the financial statements of the CCG. (2016-17: Nil)

19. Financial performance targets

The CCG has a number of financial duties under the NHS Act 2006 (as amended).
The CCG's performance against those duties was as follows:

NHS Act Section		2017-18 Target £'000	2017-18 Performance £'000	Duty Achieved	2016-17 Target £'000	2016-17 Performance £'000	Duty Achieved
223H (1)	Expenditure not to exceed income	413,762	411,380	Yes	420,793	408,493	Yes
223I (2)	Capital resource use does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
223I (3)	Revenue resource use does not exceed the amount specified in Directions	413,063	410,681	Yes	416,951	404,651	Yes
223J (1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
223J (2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	5,637	5,052	Yes	5,539	4,794	Yes

For the purposes of 223(H); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year and income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis)

Financial performance targets for 2017-18 represent the in year position compared to 2016-17 which showed the CCG's historic surplus. The CCG's historic surplus included within the 2016-17 figures and brought forward into 2017-18 was £12,300K. £550K of the historic surplus was drawndown and utlised within the year non-recurrently, leaving a historic surplus balance of £11,750K. The actual performance for 2017-18 was a surplus of £2,382K, which means that the carried forward surplus into 2018-19 is £14,132K.

20. Impact of IFRS

	2017-18 £'000	2016-17 £'000
Depreciation charges	0	0
Interest expense	0	0
Impairment charge: Annually Managed Expenditure	0	0
Impairment charge: Departmental Expenditure Limit	0	0
Other Expenditure	0	0
Revenue receivable from subleasing	0	0
Total IFRS Expenditure (IFRIC 12)	**0**	**0**
Revenue consequences of private finance initiative/LIFT schemes under UK GAAP/ESA95 (net of any sublease revenue)	0	0
Net IFRS Change (IFRIC 12)	**0**	**0**
Capital Consequences of IFRS: private finance initiative/LIFT and other		
Capital expenditure	0	0
UK GAAP capital expenditure	0	0

21. Losses and special payments

21.1 Losses

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

	Total Number of Cases 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	1	17	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	**1**	**17**	**0**	**0**

The CCG had no cases individually over £300,000 (31 March 2017: Nil)

21.2 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	0	0	0	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**0**	**0**	**0**	**0**

KPMG

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Barnsley 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 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 Trust 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 Group Accounting Manual 2017/18.

KPMG

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 36, 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 33, 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 Barnsley 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 Barnsley CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Rashpal Khangura
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA
24 May 2018