NHS
Barnsley
Clinical Commissioning Group

Annual Report and Accounts 2016/17

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 2016/17.

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

This year we have seen an important shift in our steps forward in transforming health and care services in Barnsley. We have played a central role in the emerging South Yorkshire and Bassetlaw Sustainability and Transformation Plan, bringing health and care organisations together to work together as a system as never before.

Our ambition to bring care closer to where people live took a significant step forward with the development of the neighbourhood nursing service. Community nursing teams, built around six areas of the borough, aligned to the Area Councils, starts to build resilient joined-up services around our local communities.

"I am particularly pleased to see the progress in support for children and young people's mental health and wellbeing this year. National *Future in Mind* funding has helped us to put in specialist, practical support for young people and families, based in the place they told us matters most: schools."

We have invested £821,000 over three years in a new service called My Best Life. The service will help support people who go to see their GP with social, emotional or practical needs, where a prescription for medication often doesn't help. This form of social prescribing will be available on a large scale, meaning access for everyone across the borough.

I am particularly pleased to see the progress in support for children and young people's mental health and wellbeing this year. National *Future in Mind* funding has helped us to put in specialist, practical support for young people and families, based in the place they told us matters most: schools. Comprehensive training for secondary school staff to help

identify and offer young people support is now in place and I'm very encouraged by the early feedback.

I am extremely proud to tell you we have won national awards this year for the RightCare Barnsley service, which has helped keep people out of hospital and supported them with more appropriate care, often at home. This is a real reflection of how we can work together in Barnsley to get the best for you and your loved ones.

This year we welcomed the national publication of the General Practice Forward View to improve patient care and access, and invest in new ways of providing primary care. As frontrunners of these national plans, we introduced a borough-wide clinical pharmacist team this year, adding specialist skills directly into GP practices.

We have also launched dementia friendly GP practices this year, which has been wonderful to see so many people volunteering to take on the role of dementia champion in their practice and make a real change to people's experience when they come to see their GP or nurse.

Taking this opportunity to look forward, as well as back over the past year, we recognise that there is still much to do as health and care organisations. The demand for services is growing. Doing nothing is not an option if we want to have flourishing and effective health and care services delivered by a skilled, resilient workforce.

We have started to explore a vision with local health and care organisations across Barnsley this year whereby services can become truly integrated, offering seamless care and being jointly accountable for the outcome of someone's health. This is something we'll be focusing on in 2017/18.

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 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.

Mental health and wellbeing

Supporting young people's emotional health and wellbeing

We have been working with partners this year to implement our transformation plan for Child and Adolescent Mental Health Services (CAMHS). The programme, drawn up in response to the National 'Future in Mind' report, which was approved in 2015, has grown significantly throughout 2016/17.

We have introduced a service called 4:Thought. The team is a multi-disciplinary mental health team working with the Barnsley CAMHS service based in secondary schools.

The team comprises of three primary mental health practitioners, one parent counsellor, one family practitioner and one teacher together with support from Barnsley's educational psychology team. One of the strengths of this team is that it will work throughout the year, not just term time.

Alongside this team, we have commissioned Chilypep to deliver a series of free mental health training sessions to anyone working in a secondary school, giving all staff the knowledge and skills to identify young people and families who may be in need of support.

The focus of the team is to promote the resilience of the young people within the Barnsley secondary schools to prevent either the development of mental health problems or the development of more intensive mental health problems. The team are there to also support the families of the young people who access the service.

As part of the funding we have received to deliver our local transformation plan, we have re-established the peer mentoring programme with Barnsley College students, following a successful pilot in 2014.

Women and families

This year we have introduced specialist mental health support to women during pregnancy and after their baby is born.

During pregnancy and for the first year after birth – called the perinatal period – is a uniquely stressful time for women and their families. There is now dedicated specialist support in place for Barnsley women. In addition, there is provision for 300 women, around

10% of women giving birth in Barnsley, to access talking therapies, often called psychological therapies, or IAPT for short.

Mental health services for Deaf people

Following feedback from the Barnsley DeaForum on access to IAPT services, we have introduced a mental health worker who is now available to offer this mental health support service specifically for Deaf people living in Barnsley who use British Sign Language (BSL). This avoids the use of different interpreters at each session.

Living well and independently

As part of our commitment to changing the way health and care services are delivered so that people can stay well and live independently in the community, we were extremely pleased this year to be chosen as one of the first five areas in the country to develop the Shared Lives Plus model.

Like the existing Shared Lives initiative in Barnsley, a trained and approved Shared Lives Plus carer would share their home and family life with an adult who needs short or longer term care or support. This can help them avoid stays in hospital and live well and benefit from the care, comfort and sense of independence that comes from living in a real family home.

Following confirmation of our success, the CCG has match funded this new approach to Shared Lives in partnership with the existing scheme in Barnsley.

Joining up services

We were very proud to receive our third national industry award for the development of the RightCare Barnsley service this year. To be recognised as leading the way in making a real difference to people's care and outcomes is something Barnsley can be proud of.

The RightCare Barnsley team is made up of nursing colleagues from both Barnsley Hospital and South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) coming together to offer a very flexible and responsive telephone brokerage service to GPs who have identified someone in their care as being at high risk of being admitted to hospital within 24 hours.

They are the eyes and ears of what clinical care and support is available to those patients at any one time, allowing many people to stay at home with the appropriate clinical care for their condition and avoiding unnecessary admittance to hospital.

My Best Life

As a clinical commissioning organisation our GP member practices have a unique insight into seeing how and why people use the NHS.

It is estimated around a fifth of visits to a GP are linked to problems in people's lives such as loneliness, debt, housing issues, work, relationships and unemployment - something that a prescription for medication isn't going to fix.

This year, along with colleagues from the council, local patient and community groups, we looked at how best to address this and took the step to invest £821,000 over the next three years on prescribing support that would help address any social, emotional or practical needs, where a prescription for medication often doesn't help.

The scheme, called My Best Life, is run by South Yorkshire Housing Association who run a similar successful scheme in Doncaster.

GPs put people who have non-medical need in touch with someone from My Best Life and the type of support will vary widely depending on the individual's needs - from putting people in touch with the local fishing club to getting advice on managing debt.

The two major benefits for people referred to the My Best Life service will be an improvement in their health, wellbeing and quality of life and a reduction in social isolation, exclusion and loneliness. With a special focus on improving mental health and wellbeing, the scheme hopes to enable people to manage their own health, improve social networks and develop their self-confidence.

Neighbourhood nursing

The Barnsley community nursing service has done a tremendous amount of work this year to change the way they work across the different communities in the borough by aligning their teams to local GP practices in the form of six neighbourhoods.

This means the service offers a more joined-up focus on care, using resources more effectively and working ever closer with other partners such as, social services and the third sector.

The new 'neighbourhood nursing service' brings together the district nursing and community matron service as part of a new service specification we issued this year.

The service provides high quality nursing care for adults who have short term needs and who are housebound, or who have long term conditions or complex needs from multiple conditions. It also includes people who require palliative care at end of life.

The new six neighbourhood model is based around the local authority's local area councils and the establishment of multi-disciplinary teams (MDT) across the borough, closely linked in to GP practices.

Barnsley neighbourhood nursing service receives more than 26,500 referrals annually and looks after more than 3,000 patients at any one time in their home environment. The team also now provides enhanced support to care homes including nursing homes.

Dementia friendly primary care

Barnsley is a dementia friendly town and this year, as a CCG, we launched the work to develop dementia friendly GP practices.

Within each GP practice, a member of staff has volunteered to take on the role of a dementia champion and is leading the way to create an environment where people living

with dementia and their families and carers can navigate more easily, feel safe and not feel stigmatised.

A borough-wide training and celebration event in 2016 was launched by the Mayor of Barnsley, Cllr Linda Burgess, who is raising awareness of dementia during her year in office.

There are now dementia champions in each Barnsley GP practice and across pharmacies, dentists and opticians.

Using technology to improve patient care

In 2015 we invested in an IT system which allows clinicians in different parts of the NHS and Barnsley Hospice to view key information in your GP record.

This year that system went live across all GP practices, the I HEART Barnsley GP service, SWYPFT, Barnsley Hospital and Barnsley Hospice.

This information includes things like current medications. This means that if you need to go into hospital your consultant and nursing team can see your latest GP summary record which will have list of medication, any allergies you may have or any other tests you are undergoing.

This new system is just one part of the new ambitious Barnsley wide digital strategy or which was published this year.

In Barnsley, we know from a range of engagement activity over the past few years that our communities are frustrated when communication between services and between services and patients fail – this also leads to waste in the system and poor experiences.

Simultaneously, as growing numbers of people have increasingly positive experiences of digital technology in everyday life, the disparity between commercial services and the health sector is becoming more and more apparent.

Improving patient experience

We introduced personal hearing amplifiers into GP surgeries to improve communication this year. These small bits of simple kit are now readily available for use by anyone attending their doctors who may have hearing loss.

We worked with Healthwatch Barnsley and local people who are Deaf or have some hearing loss, to identify some of the challenges they face when going for a GP or nurse appointment.

In addition to the amplifiers, the Barnsley sensory impairment services team, run by SWYPFT, provided training to GP practice staff across the borough in how to safely support both sight-impaired and hearing-impaired individuals during their surgery visits.

GP surgeries are busy environments and can be quite noisy, with telephones and conversations from multiple directions. People with a hearing impairment can sometimes find holding conversations in this environment very challenging.

There has been lots of really valuable feedback and ideas from people about some of these challenges and we hope that by providing these new bits of kit this year, as well as the training staff have had, it will vastly improve their experience.

Performance Report

Overview of the organisation

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, 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* was refreshed last year and 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 34 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 and the Barnsley Plan.

While working locally with partners and providers is helping us to improve local services, we also recognise that there are particular circumstances where it clearly makes sense, both financially and clinically, to work with neighbouring CCGs and NHS England to develop areas of work and commission services together. Our main mechanism for doing this is through the Working Together programme.

The scope of the Working Together collaboration extends and includes eight CCGs and NHS England, covering a population of approximately 2.3 million people.

This year, as part of that work, we have been consulting with people on a set of proposals for the future location of children's surgery and anesthesia and critical care when someone has had a stroke.

Key issues and challenges

The following issues and challenges have been high on our agenda during the year 2016/17.

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 but we started to see improvements towards the end of the year. Waiting times at A&E have improved towards to the end of winter, as we started to see the plans put in place before and during winter working.

Barnsley Hospital NHS Foundation Trust (BHNFT) has recruited new consultants to A&E. 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 neighbourhood nursing services in their own homes.

Support for people coming out of hospitals needing social care has worked really well in Barnsley. We have funded social workers in the hospital at weekends.

Access to psychological therapies (IAPT): Being able to deliver the new IAPT waiting time standards was challenging at the beginning of 2016/17 however there have been improvements to waiting times which has seen the target of 75% of patients to wait less than six weeks from referral to first treatment appointment being consistently achieved from September 2016.

There have however been challenges in achieving the required access rates and meeting the target for the number of people who complete treatment, who are deemed to be moving to recovery. Work in 2017/18 will therefore include working with the service provider to review the service and identify sustainable improvements to achieve these targets.

Barnsley Hospital NHS Foundation Trust: Our main local acute hospital provider, Barnsley Hospital NHS Foundation Trust (BHNFT), remained in breach of licence for their financial situation this year.

Throughout this period, we worked closely with BHNFT colleagues to understand the financial position and potential impact on the wider health and social care sector in line with both the immediate recovery plan and the longer term transformation plan. Risks associated with our financial duties are reflected on our assurance framework.

Performance summary

CCG Assurance Framework

During 2016/17 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

To reflect the NHS mandate the framework also identifies six clinical priority areas with CCG's being assessed and receiving a rating for each of the six areas on a four point scale; top performing; performing well; needs improvement; and greatest need for improvement. The detailed initial baseline assessments against each clinical priority were published on the My NHS website in September 2016.

Against the six clinical priority areas the summary baseline assessment rated the CCG as set out below:

Clinical Priority Area	Overall Rating
Cancer	Needs Improvement
Dementia	Needs Improvement
Diabetes	Performing Well
Learning Disabilities	Needs Improvement
Maternity	Performing Well
Mental Health	Needs Improvement

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.

During 2016/17 the CCG's plans have included initiatives aimed at improving on the baseline assessment.

An overall rating of the CCG is expected to be made in July 2017 which will enable us to assess our overall performance assessment in comparison to the previous rating of 'Good' under the 2015-16 CCG assurance framework. The 2016/17 year-end assessment for the CCG will be available on www.nhs.uk/service-search/Performance/Search from July 2017.

Financial Performance

NHS Barnsley CCG achieved all of its financial duties in 2016/17. This is demonstrated in the table on page 18 and within the Annual Accounts. In addition, the CCG ended the year with a surplus of £12.3 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 2017/18 and beyond is challenging. Nationally, CCG average growth allocations for 2017/18 are 2.14%, but Barnsley received 1.5% as a result of funding being above national target level. This has resulted in continued pressures on CCG budgets, which has been augmented by the impact of allocation reductions for the nationally modelled impact of changes to prices in the 2017/18 and 2018/19 national tariff (HRG4+). In order to manage within allocated resources for 2017/18, the CCG will need to deliver an efficiency programme of £11.5 million (2.8% of allocation).

Performance analysis

How we measure performance

NHS England's CCG Improvement and Assessment Framework	We monitor our performance against the 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 standard.

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%	**Achieved**
A&E waits	
Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department – target 95% (At Barnsley Hospital, 91.3% of patients were seen within 4 hours during 2016/17)	**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 2016/17 Yorkshire Ambulance Service have been participating in the national Ambulance Response Pilot. Therefore performance has not been reported against the constitution standards for Category A (Red calls). For the most urgent calls which require an 8 minute response however performance has been consistently below the constitution standard for similar calls (75% of responses within 8 minutes) with year to date performance at the end of February at 65.47%.	**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 March 2017 78.55% 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%	**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 of this report. The CCG's performance against those duties in 2016/17 was as follows:

Duty	**Target** £'000s	**Actual Performance** £'000s	**Achievement**
Expenditure not to exceed income	420,793	408,493	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	416,951	404,651	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–**programme**	411,412	399,857	Yes
Revenue administration resource use does not exceed the amount specified in Directions– **running costs**	5,539	4,794	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 2015/16.

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 nine months of 2016/17.

The number of patients attending A&E at Barnsley Hospital during 2016/17 was 83,545. 76,260 were seen within four hours. Performance for the year shows that 91% 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 and will continue to do so in 2017/18.

Achieving the waiting times targets for cancer treatment has historically been a challenge however improvements in 2016/17 have ensured performance against all cancer standards which has been achieved for 2016/17.

South West Yorkshire Partnership NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provides 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 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. Work in 2017/18 will focus on these areas.

Yorkshire Ambulance Service

Ambulance Response Times – In 2016/17 Yorkshire Ambulance Service (YAS) have been participating in the national Ambulance Response Pilot and therefore performance has not been reported against the constitution standards for Category A (Red calls)

For the most urgent calls which require an 8 minute response however performance has been consistently below the constitution standard for similar calls (75% of responses within 8 minutes) with year to date performance at the end of February at 65.47%.

These figures relate to its performance across the whole of the Yorkshire and Humber region it serves. NHS Wakefield CCG is the collaborative contract lead for the YAS emergency response contract across our region. Together with them, we continue to work with YAS to ensure that the service commissioned is in line with the requirements of the NHS Constitution.

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.

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 2016/17 is £20,594,378. £2,330,936 of this is provided from grants made directly to the local authority for disabilities facilities and social care adaptations. The remaining £18,263,442 is provided from the CCG baseline allocation.

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

Performance against our statutory duties

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.

Visits have included the children and young people's mental health services (CAMHS).

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.

Examples of this would be the Mazars report, which was published at the end of 2015, reviewing the deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust. Areas of existing positive practice are commended; gaps and areas for learning are identified. We work in partnership with our providers to pursue these improvements and provide assurance to the CCG governing body.

Persistent Pursuit of Medicine Reconciliation

The area of improving compliance with standards for discharge from hospital summaries, which includes medicines reconciliation within the first 24 hours of admission, continues to be an area of focus for the CCG. The quality and the medicines management team continue to drive these improvements with the providers. Constructive solutions have been shared and further audit will provide more robust evidence of improvement throughout 2016.

Care Quality Commission (CQC) Inspections in GP practices

Throughout 2016/17 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) were rated 'requires improvement' ('good' for three of the five areas) and South West Yorkshire Partnership Foundation Trust (SWYPFT) were rated 'overall good' (January 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

Barnsley intelligence sharing meetings allow the CCG to effectively triangulate the available intelligence across Barnsley to ensure there is a comprehensive overview of the quality, safety and people's experience of services that the CCG commission.

This forum provides an opportunity to share information about healthcare providers between CCG and the Barnsley Healthwatch, which is an independent consumer champion created to gather and represent the views of the public. This year Healthwatch has introduced a new online feedback form on their website, to encourage more people to feedback about their experiences of a range of health and care services, including care and residential homes.

Friends and Family Test (FFT) scores and patient opinions from the NHS England Choices website are assessed in order to understand health services from a patient experience. Yorkshire Ambulance Service and Primary Care Services have recently been included in the collection of FFT data. Themes and trends are analysed and taken into account alongside regional and national comparisons.

First Port of Call

The First Port Of Call training and development programme recognises the value of GP practice reception staff and their influence on a person's experience of that service. It has been developed using person centred interactive principles. The training was rolled out in 2016/17 following positive feedback.

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.

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 is an active partner in the Barnsley Safeguarding Adults Board with regular attendance at meetings of the Board and holds the position of Chair of one of the two Board subgroups.

This year the CCG has appointed a substantive post holder to the role of Named General Practitioner (GP) for Safeguarding Vulnerable People. This key role further enhances the CCG's ability to promote professional practice and to provide advice and expertise for fellow professionals.

The CCG Designated Nurses for safeguarding continue to meet the safeguarding leads in general practice on a quarterly basis to disseminate good safeguarding practice and provide an opportunity for shared learning.

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 and is fully sighted on current opportunities and challenges.

Safeguarding – Children

The CCG Designated Nurse continues to be integral to the multi-agency serious case reviews and learning events. Outcomes and lessons learned are reported to the CCG Quality and Patient Safety Committee.

This year the CCG delivered training on female genital mutilation (FGM) for Barnsley Hospital's Diversity Group, update training for school safeguarding leads and a FGM awareness raising stall was held in the town centre as part of Safeguarding week in July 2016.

The Child Sexual Exploitation Multi Agency Safeguarding Hub (MASH) commenced in July 2016, following a pilot. This has enabled multi-agency information sharing and joint decision making in relation to the vulnerabilities and risks for each young person which has resulted in target support via specialist services. All agencies know where the "hotspots" are in Barnsley and this has enabled the police to use disruption tactics, such as visible policing in areas where CSE is known or suspected to be taking place, to decrease the risk of child sexual exploitation to young people across Barnsley.

Patient and public involvement and consultation

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.

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 for people to get involved in local health services and sharing their views and these including but not limited to: local GP Practice Patient Reference Groups (PRGs); Barnsley Patient Council; Barnsley Service User and Carer Board and Healthwatch Barnsley.

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 2016/17 we have:

- Co-produced a new patient and public engagement strategy with Barnsley Patient Council
- Combined our patient and public engagement committee with our equality and diversity steering group
- Developed young commissioners

Members of the public, patients and carers have talked to us this year about:

- Consultation to change hyper acute stroke services in South Yorkshire, Bassetlaw and North Derbyshire
- Consultation to change children's surgery and anaesthesia services in South and Mid Yorkshire, Bassetlaw and North Derbyshire
- Mental health and wellbeing strategy action plan
- Heart failure services
- Ophthalmology procurement of new service

- Non-emergency patient transport procurement of new service
- Getting the best outcome from your treatment
- Care navigation and telehealth services
- Young people's services (via young commissioners)

There have been three significant strategies and plans developed this year and we have been having conversations with members of the public to help shape these:

- South Yorkshire and Bassetlaw Sustainability and Transformation Plan
- The Barnsley Plan
- Barnsley Health and Wellbeing Board strategy

Sustainability and Transformation Plan

Throughout March and April 2017, Healthwatch organisations across South Yorkshire and Bassetlaw were commissioned to have a range of conversations with local residents on the Sustainability and Transformation Plan, which included the broad elements of local place plans. In addition, partner agencies, including the CCG, held a range of workshops with and promoted the survey to staff.

Healthwatch Barnsley went out to talk to a wide variety of local people, mainly through existing groups such as local health charity groups, tenants and residents groups and local community groups. In addition they held two focus groups.

During the past year, members of the public and stakeholders within South Yorkshire, Bassetlaw and North Derbyshire have been consulted on proposals to change hyper acute stroke services and children's surgery and anaesthesia services (see below). Both of these proposals pre-date the Sustainability and Transformation Plan but are now included in that document.

Commissioners Working Together Public Consultations – Hyper acute stroke and Children's surgery and anaesthesia

Commissioners Working Together (CWT) is a collaborative of eight clinical commissioning groups and NHS England across South and Mid Yorkshire, Bassetlaw and North Derbyshire.

In 2016, CWT carried out a review of children's surgery and anaesthesia services and hyper acute (critical care) stroke services across the region. Pre-consultation engagement took place between January and April 2016 as part of this review, during which CWT gathered the views of key stakeholders, including patients and the public, to inform plans for the future of services.

Following this engagement, CWT proposed changes for both children's surgery and anaesthesia and hyper acute stroke services that aim to use what is available in the best possible way to get the best services for everyone.

All people living in Barnsley, Bassetlaw, Chesterfield, Doncaster, North Derbyshire, Rotherham and Sheffield were given the opportunity to have their say during the two public consultations that ran from 3 October 2016 to 14 February 2017.

A total of 1109 responses were received for the consultation to change hyper acute stroke services and 1268 responses for the consultation to change children's surgery and anaesthesia services. A full breakdown of the feedback received and respondent profile, with all demographics is available in the consultation analysis.

The full consultation feedback reports and the independent consultation analysis are available to view at http://www.smybndccgs.nhs.uk/you-said-we-did.

Health and wellbeing strategies

Barnsley's Health & Wellbeing Board aims to improve health and wellbeing for the residents of Barnsley and reduce inequalities in health outcomes. The Board commissions and approves the Joint Strategic Needs Assessment (JSNA), commissions and approves the Joint Health and Wellbeing Strategy and 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.

Reducing inequalities

There was a new joint strategic needs assessment (JSNA) published for Barnsley this year, helping 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 Place Based 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 2016/17 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. About 300 primary care practitioners received training in alcohol brief interventions last year. We have worked with public health colleagues and local GP practices, to develop a range of indicators for 2017/18 to increase quality and reduce inequalities in primary care.

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 has commissioned a new service called 'My Best Life' which is a scheme that supports people who see their GP with social or emotional needs where a prescription for medication often does not help. The service commenced on the 1 April 2017 and received 70 referrals in the first month.

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.

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 http://www.barnsleyccg.nhs.uk/strategies-policies-and-plans.htm

Signature of the Performance Report by the Accountable Officer

Lesley Smith
Accountable Officer
25 May 2017

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

CCGs are member organisations and representatives from the 34 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 15 people including eight members elected by the Membership Council; two 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 2016/17 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	15/15 (100%)
Dr Mehrban Ghani	Elected Member & Medical Director	1 April 2013	14/15 (93%)
Dr John Harban	Elected Member	1 April 2013	14/15 (93%)
Dr Sudhagar Krishnasamy	Elected Member	1 April 2013	13/15 (86%)
Dr Nick Luscombe	Elected Member	1 April 2013 - 26 December 2016	10/11 (91%)
Dr Madhavi Guntamukkala	Elected Member	1 April 2015	12/15 (80%)
Dr Mark Smith	Elected Member	1 April 2015	13/15 (86%)
Dr Lawrence King	Elected Member	1 April 2015 – 15 July 2016	3/5 (60%)
Dr Adebowale Adekunle	Elected Member	18 July 2016	9/10 (90%)

Name	Position on the Governing Body	Appointment dates	Attendance record*
Brian Roebuck	Lay Member for Governance (Conflicts of Interest Guardian)	18 July 2016	6/10 (60%)
Chris Millington	Lay Member Representative for Patient and Public Engagement and Primary Care Commissioning	1 April 2015	15/15 (100%)
Marie Hoyle	Practice Manager Member	1 April 2013	12/15 (80%)
Mike Simms	Secondary Care Clinician	1 September 2013	14/15 (93%)
Brigid Reid	Chief Nurse	1 April 2013	14/15 (93%)
Lesley Smith	Chief Officer (and Accountable Officer)	28 July 2014	13/15 (86%)
Heather Wells	Chief Finance Officer	23 February 2015	12/15 (80%)

*In 2016/17 there have been 12 monthly Governing Body meetings, 2 extraordinary meetings, and the AGM.

Committees, including Audit Committee

During 2016-17 the following members of the Governing Body were members of the CCG's Audit Committee: Anne Arnold (Acting Chair to June 2016), Brian Roebuck (Chair from July 2016), John Barber (Acting Chair from March 2017), Dr Madhavi Guntamukkala, Chris Millington, and Marie Hoyle. In addition one Member of the Membership Council, Dr Jeroen Maters, was also a Member of the Audit Committee.

All CCG's are required by statute to have an Audit Committee and a Remuneration Committee (for details see page 42). In addition, although not stipulated in legislation, we have established a:

- Primary Care Commissioning Committee
- Quality & Patient Safety Committee
- Finance and Performance Committee
- Equality and Engagement Committee (which operated from August 2016 following a merger of the Patient and Public Engagement Committee and the Equality Steering Group), and a
- Clinical Transformation Board.

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 CCG 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 CCG.

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 CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction);
- For safeguarding the CCG'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 CCG to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

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

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

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
25 May 2017

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

As at 1 April 2017, the 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:

- Strengthened its arrangements in response to NHS England's *Managing Conflicts Of Interest: Revised Statutory Guidance For CCGs* (June 2016);
- Reviewed and streamlined the Committee structure through the merger of two Committees to form a combined Equality and Engagement Committee;
- Worked with partner organisations to develop joint commissioning arrangements to support the Commissioners Working Together Programme.

During 2016/17 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 2016/17 year-end assessment for the CCG will be available on www.nhs.uk/service-search/Performance/Search from July 2017.

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 and risk management arrangements described in this Statement.

Scope of responsibility

As Accountable Officer, the Chief Officer has responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which she is personally responsible, in accordance with the responsibilities assigned to her in *Managing Public Money*. The Chief Officer acknowledges her responsibilities as set out under the National Health Service Act 2006 (as amended) and in her Clinical Commissioning Group Accountable Officer Appointment Letter.

The Accountable Officer is responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. She also has responsibility for reviewing the effectiveness of the system for internal control within the CCG as set out in this Governance Statement.

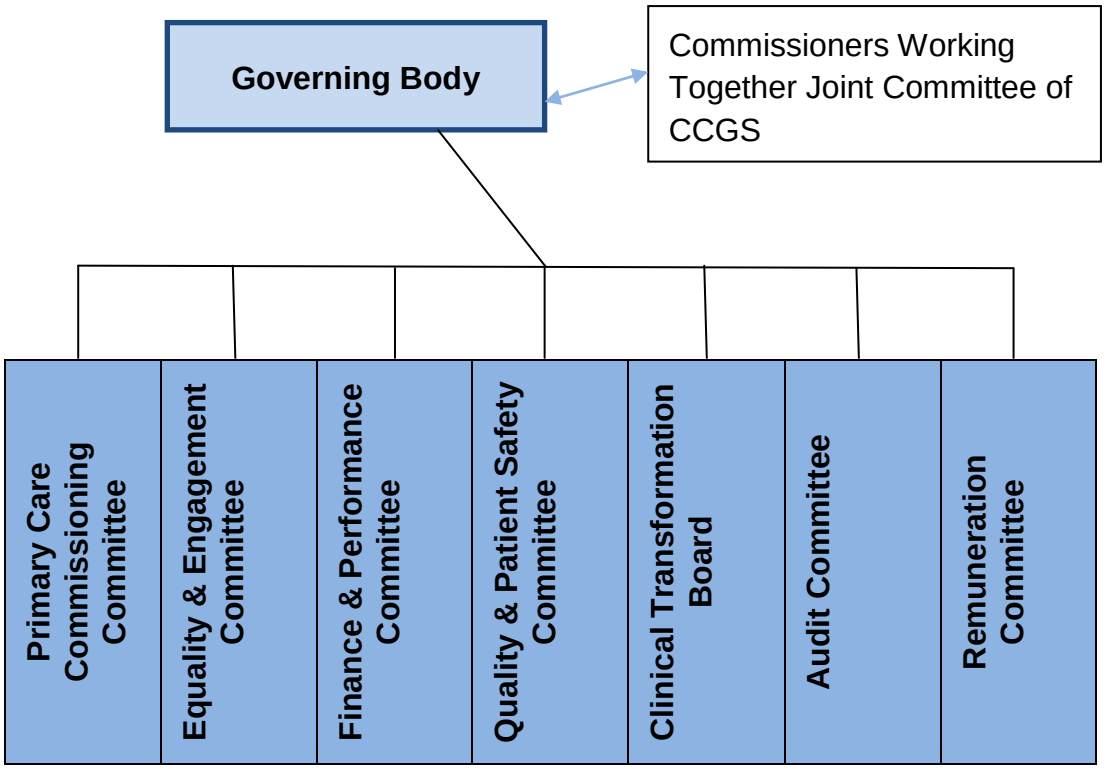
Governance Arrangements and Effectiveness

The main function of the Governing Body is to ensure that the CCG has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently, and economically and complies with such generally accepted principles of good governance 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 34 Barnsley General Practitioner (GP) Practices each nominate one representative to the **Membership Council,** which elects 8 members to the Governing Body. The Membership Council has met 5 times during 2016/17. 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 2016/17 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 31-3), and the remuneration paid to senior managers (in the Remuneration Report, page 66).

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 47-8), 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*
(Acting Chair – April to June 2016)	Anne Arnold	2/2 100%
Lay Member for Governance (Chair – July 2016 to March 2017)	Brian Roebuck	3/4 75%
Lay Member for Governance (Acting Chair March 2017)	John Barber	1/1 100%
EEC & Primary Care Commissioning Lay Member	Chris Millington	6/6 100%
Elected Governing Body Member	Dr Madhavi Guntamukkala	3/6 50%
Practice Manager Governing Body Member	Marie Hoyle	4/6 66%
Member of the Membership Council	Dr Jeroen Maters	2/6 33%

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*
The Chair of the Governing Body (Chair)	Dr Nick Balac	8/11 (73%)
Governance Lay Member (from July 2016)	Brian Roebuck	3/6 (50%)
Elected Governing Body Member	Dr John Harban	10/11 (91%)
Elected Governing Body Member (to December 2016)	Dr Nick Luscombe	7/8 (88%)
Elected Governing Body Member	Dr Madhavi Guntamukkala	9/11 (82%)
Member of the Membership Council	Dr Andy Mills	9/11 (82%)
The Chief Officer	Lesley Smith	8/11 (73%)
The Chief Finance Officer	Heather Wells	10/11 (91%)
Chief of Corporate Affairs (to September 2016)	Vicky Peverelle	5/5 (100%)
Head of Planning, Performance and Delivery (from October 2016)	Jamie Wike	6/6 (100%)

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 Patient Safety 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	5/8 (62%)
Chief Nurse (Deputy Chair)	Brigid Reid	5/8 (62%)
Governing Body Secondary Care Clinician	Mike Simms	5/8 (62%)
Member of the Membership Council (clinical advisor)	Dr Robert Farmer (to December 2016)	5/6 (83%)
Member of the Membership Council (clinical advisor)	Dr Mohammed Hossain Kadarsha	1/8 (12%)
Elected Governing Body Member	Dr Mark Smith	5/8 (62%)
Elected Governing Body Member	Dr Sudhagar Krishnasamy	6/8 (75%)
PPE & Primary Care Lay Member	Chris Millington	6/8 (75%)
Head of Medicines Management	Chris Lawson	3/8 (37%)
Deputy Chief Nurse	Martine Tune	5/8 (62%
Head of Quality for Primary Care Commissioning	Karen Martin/D Bailey (from July 2016)	3/8 37%

Patient and Public Engagement Committee

Function

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

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	1/1 (100%)
Chair or Chief Officer of the Governing Body	Dr Nick Balac	1/1 (100%)
	Lesley Smith	0/1 (0%)
Chief Nurse	Brigid Reid	0/1 (0%)
Governing Body Secondary Care Clinician	Mike Simms	0/1 (0%)
Elected Governing Body Member	Dr Lawrence King	0/1 (0%)
Practice Manager Governing Body Member	Marie Hoyle	1/1 (100%)
Member of the Membership Council	Vacant	
Chief of Corporate Affairs	Vicky Peverelle	1/1 (100%)
Head of Communications and Engagement	Kirsty Waknell	1/1 (100%)

**Note: this Committee met just once as a separate entity during 2016/17 before being merged with the Equality Steering Group to form the Equality & Engagement Committee.*

Equality Steering Group

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.

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.

Membership and attendance		
Role	*Name*	*Meetings attended*
Chief Nurse (Chair)	Brigid Reid	1/1 (100%)
Head of Contracting	Amanda Capper	1/1 (100%)
Head of Communications and Engagement	Kirsty Waknell	0/1 (0%)
Membership Council Elected Member	Dr Indra Saxena	1/1 (100%)
Elected Governing Body Member	Dr Lawrence King	1/1 (100%)
Practice Manager Governing Body Member	Marie Hoyle	1/1 (100%)
Lay Member for Public and Patient Engagement	Chris Millington	1/1 (100%)
Head of Governance and Assurance	Richard Walker	1/1 (100%)

**Note: this Committee met just once as a separate entity during 2016/17 before being merged with the Patient and Public Engagement Committee to form the Equality & Engagement Committee.*

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	3/3 (100%)
Chief Nurse (Deputy Chair)	Brigid Reid	2/3 (67%)
Governing Body Secondary Care Clinician	Mike Simms	2/3 (67%)
Practice Manager Governing Body Member	Marie Hoyle	1/3 (33%)
Member of the Membership Council	Dr Indra Saxena	2/3 (67%)
Chief of Corporate Affairs (left the organisation September 2016)	Vicky Peverelle	1/1 (100%)
Head of Communications and Engagement	Kirsty Waknell	3/3 (100%)
Head of Commissioning for Partnership & Integration (replaced Chief of Corporate Affairs)	Jade Rose	2/2 (100%)
Elected Governing Body Member	Dr Adebowale Adekunle	2/3 (67%)

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*
Governance Lay Member (Chair)	Brian Roebuck	2/2 (100%)
PPE Lay Member (Deputy Chair)	Chris Millington	3/3 (100%)
Chair of the Governing Body	Dr Nick Balac	3/3 (100%)
Elected Governing Body Member	Dr John Harban	2/3 (67%)
Elected Governing Body Member	Dr Nick Luscombe	2/2 (100%)
Practice Manager Governing Body Member	Marie Hoyle	2/3 (67%)
Governing Body Secondary Care Clinician	Mike Simms	2/3 (67%)

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.		
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		
Role	*Name*	*Meetings attended*
PPE and Primary Care Lay Member (Chair)	Chris Millington	10/10 (100%)
Governance Lay Member (vice Chair) (from July 2016)	Brian Roebuck	0/6 (0%)
Chief Officer	Lesley Smith	9/10 (90%)
Chief of Corporate Affairs (to September 2016)	Vicky Peverelle	3/4 (75%)
Chair of the Governing Body	Dr Nick Balac	9/10 (90%)
Medical Director	Dr Mehrban Ghani	7/10 (70%)
Elected Governing Body member	Dr Madhavi Guntamukkala	8/10 (80%)
Governing Body Secondary Care Clinician (from September 2016)	Mr Mike Simms	5/6 (83%)
Head of Governance & Assurance (from September 2016)	Mr Richard Walker	6/6 (100%)
ACO Lay Member	Vacant	

Clinical Transformation Board

Function		
Prioritises the commissioning and development work of the CCG to ensure interdependent projects are linked and have the required level of clinical evidence to be implemented.		
Assurance provided to the Governing Body		
Assurance that the CCG's Service Development resource is directed to key projects that will bring care closer to home and facilitate the achievement of CCG objectives.		
Membership and attendance		
Role	*Name*	*Meetings attended*
Chair of the Governing Body (Chair)	Dr Nick Balac	5/6 (83%)
Medical Director	Dr Mehrban Ghani	5/6 (83%)
Elected Governing Body Member	Dr John Harban	3/6 (50%)
Elected Governing Body Member	Dr Mark Smith	5/6 (83%)
Elected Governing Body Member	Dr Sudhagar Krishnasamy	5/6 (83%)
Governing Body Secondary Care Clinician	Mike Simms	6/6 (100%)
Chief Nurse	Brigid Reid	4/6 (66%)
PPE and Primary Care Lay Member	Chris Millington	5/6 (83%)
Chief Officer	Lesley Smith	5/6 (83%)
Chief of Corporate Affairs (to September 2016)	Vicky Peverelle	1/1 (100%)

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 (BMBC), 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. Barnsley CCG's Strategic Commissioning Plan is fully aligned with the Health & Wellbeing Strategy.

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 BMBC 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) as a sub-committee of 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.

Information about South Yorkshire Commissioners and Providers Forum

The role of Working Together Commissioners and the Acute Care Collaborative Vanguard Providers Forum is to enable the South Yorkshire and Bassetlaw and North Derbyshire CCGs, the Local Area Team of NHS England, and NHS provider organisations in South Yorkshire & Bassetlaw to collaborate and take joint actions in the areas where there is a common interest, including patient pathways. Working Together Commissioners and the Acute Care Collaborative Vanguard Providers Forum seeks to achieve enhanced patient experience, improved outcomes and more efficient service delivery through collaborating in the commissioning and provision of healthcare across primary care, public health services, non-specialised secondary care and specialised services.

In September 2015 this collaborative approach was formalised in a non-binding Memorandum of Understanding between the CCGs, which was approved by the Governing Body. From October 2016 the arrangements have been further developed through the creation of a Commissioners Working Together Joint Committee, with its own Terms of Reference and Scheme of Delegation. Initially the remit of the Joint Committee is limited to hyper acute stroke services, children's surgery and anaesthesia services, cancer and urgent and emergency care and collective strategy and sharing of best practice. As future plans are agreed through the South Yorkshire and Bassetlaw Sustainability and Transformation Plan, there will likely be further need to take joint decisions.

Effectiveness of the Governing Body

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

- Development sessions have been held at regular intervals through the year covering issues such as updating the Governing Body Assurance Framework, Intermediate Care, and Operational and Financial Planning
- Statutory and Mandatory training has been provided for Governing Body members in counter fraud, equality and diversity, health and safety, fire safety, moving and handling, and information governance

- Individual personal development reviews (PDRs) are undertaken with clinical Governing Body members by the CCG Chair
- Minutes of Governing Body meetings have been streamlined and clarified, and the reporting template has been redesigned.

Compliance with the UK Corporate Governance Code

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

The CCG has self-assessed its arrangements against the UK Corporate Governance Code and is satisfied it is 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, the CCG can confirm that it 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 from pages 37 to 44 above. These arrangements have been subject to external scrutiny through a range of processes, including the NHS England CCG Improvement and Assessment Framework, as highlighted on page 36.

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

During 2016/17 the Constitution has been subject to further review and amendments have been made. The changes were necessary to reflect:

- The requirements of the Managing Conflicts of Interest: Revised Statutory Guidance for CCGs (June 2016)
- Changes to the CCG's Committee Structure and Membership
- Changes identified through review of the CCG's Scheme of Reservation & Delegation, Standing Orders and Prime Financial Policies

- Amendments to the CCG's Standards of Business Conduct Policy recommended by the Local Counter Fraud Specialist
- Other miscellaneous updates to reflect changes in roles, membership etc.

All of the above changes were reviewed and approved by NHS England in January 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 in 2016/17. At a development session in April 2016 the Governing Body thoroughly reviewed and updated the risks to the CCG's strategic objectives in the Governing Body Assurance Framework. In addition, to support their Head of Internal Audit Opinion, the CCG's internal auditors 360 Assurance have undertaken a survey of members of the Governing Body to collect views on the robustness of the Governing Body Assurance Framework and its use within the organisation. On the basis of this work 360 Assurance has concluded that the CCG is making good progress with the Governing Body Assurance Framework and this is continuing to provide a useful tool to support the Governing Body.

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 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 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. 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 and health and safety.

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 2016, was held at the Digital Media Centre in Barnsley and was attended by 33 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 Patient Reference Group (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 2016/17, are described in detail on pages 37 to 49 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.

Incident reporting is done via an online system accessible through the CCG's intranet. 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 37 describes the governance structure of the CCG; page 47 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 on page 47.

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 2016	6	26	12	2
Sept 2016	6	23	11	2
March 2017	7	20	7	2

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 2017
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 has been established and is now operational offering out of hours GP appointments on evenings and Saturdays.	Delivery of targets in the commissioning plan	**5x4 = 20**
If the 0-19 pathway re-procurement by Public Health leads to a reduction in service there is a risk of negative impact on primary care workforce & capacity.	Regular liaison between CCG senior management and BMBC management. Post transition the service lead attended the CCG Membership Council. A new service model is currently being developed with input from CCG clinicians.	Review at Governing Body	**4x4=16**
If the 0-19 pathway re-procurement by Public Health leads to a reduction in service (or failure to improve outcomes) there is a risk that the service quality and safeguarding provided for the 0-19 population will be adversely affected.	As above	As above	**4x4=16**

Risk	How managed / mitigated	How assessed	Status at March 2017
Risks arising if the Barnsley area continues to experience a lack of GPs in comparison with the national average, due to GP retirements, inability to recruit etc.	The CCG continues to invest in primary care capacity through the PDA and HITS which enables practices to invest in the sustainability of their workforce. The CCG has also funded HCA Apprentices and Clinical Pharmacists for deployment in GP Practices. The successful PMCF has enabled additional capacity to be made available outside normal hours via the I Heart Barnsley Hubs.	Monitored by PCCC	**4x4=16**
The risk that if the CCG does not develop a clear and robust QIPP programme, then it will not achieve its statutory financial duties	CCG has worked with consultants to develop a robust Programme Management approach, with associated enhanced governance arrangements, to identify and deliver the necessary projects to deliver the QIPP requirement for 2017/18 and beyond.	Monitoring via QIPP Board and F&P Committee	**4x4=16**
Discharge medication risks related to poor or incomplete D1 discharge letters	Quality Review Meetings between CCG and the Trust secured agreement to include additional info on D1, use of MIG, provision of clear guidance to staff by end Dec 16, and to conduct an audit of March 17 data in April 17.	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**

In addition to the risks identified above a further red (extreme) risk was added to the Risk Register in April 2017 relating to potential breaches of the Referral To Treatment (RTT) standards owing to issues with the ophthalmology contract, however this risk did not crystallise and hence it was removed from the Risk Register in May 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 is currently being reviewed by the CCG's senior management to ensure it continues to focus on the key risks to the delivery of the CCG's objectives going forward. An updated 2017/18 Governing Body Assurance Framework will be put in place during May 2017.

Principal risks to compliance with the CCG licence

There are currently no principal risks to the CCG's licence as at 31 March 2017.

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, Corporate Manual, Prime Financial Policies, and suite of corporate policies (the Constitution and Corporate Manual have both been reviewed and updated during 2016/17)
- 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
- 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 continuous assurance process.

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 a six monthly 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.

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 has carried out its annual audit of conflicts of interest. The audit was completed in March 2017 and assessed the CCG against 26 lines of enquiry. The CCG was found to be fully compliant in 25 areas and partially compliant in one. However NHSE guidance in respect of determining overall compliance levels stated: '*If any of the criteria were considered partially or non-compliant, you could not rate the area as fully compliant*.'

On this basis the outcomes from the audit were:

Scope area	Compliance level
Governance arrangements	Compliant
Declarations of interest and gifts and hospitality	Compliant
Registers of gifts, interests, hospitality, and procurement decisions	Partially compliant
Decision making processes and contract monitoring	Compliant
Identifying and managing non compliance	Compliant

Internal Audit concluded that the CCG has made significant process in addressing the requirements and only raised one low risk recommendation to further enhance processes already developed. In response to the recommendation the CCG has:

- Undertaken a housekeeping review to ensure the Registers are complete and up to date
- Requested that staff, Governing Body members, practices and others update their declarations
- Improved the signposting of the registers on the website and removed old versions.

The housekeeping exercise was completed in April 2017 and all Governing Body declarations are now completed and published on the CCG's website.

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 has 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 which will take place during 2017/18

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 and 2015/16 IG Toolkit submissions.

Internal Audit undertook a review of the CCG's arrangements for ensuring compliance with a sample of the requirements of the IG Toolkit in early 2017 and provided a significant assurance opinion. The CCG subsequently submitted a fully compliant IG Toolkit assessment for 2016/17 on 21st March 2017.

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 2016/17 the CCG has obtained commissioning support functions from a variety of sources:

- Business Intelligence and Information Technology / Information Governance services are provided under a contract with eMBED Health Consortium
- Some Financial Services are delivered through joint arrangements with Rotherham CCG, and
- Human Resources (including payroll), Health and Safety, and Equality & Diversity are delivered under local shared service arrangements hosted by other CCGs.

The CCG achieves assurance over the **BI and IT services** provided by eMBED through a variety of means. Each service has a Service Lead who meets on a monthly basis with nominated officer(s) of the CCG. There is also a Relationship Manager through whom the CCG can raise any issues or concerns related to service delivery. A monthly contract monitoring meeting is attended by senior managers from the CCG and eMBED, which reviews a wide range of KPIs and identifies and seeks to resolve any contractual risks or issues related to these services.

With respect to the **shared service financial service**, whilst Rotherham CCG provides accounting processes, the overall control and decision making remains within Barnsley CCG. During 2016/17 the finance teams from Barnsley CCG and Rotherham CCG met with KPMG (External Audit) and 360 Assurance (Internal Audit) to explore options to meet the service assurance requirements. As 360 Assurance provides internal audit services for both CCGs it was agreed to utilise the joint audit scope to allow Barnsley CCG transactions to be tested and assured across the boundary between the two organisations. KPMG confirmed this approach was acceptable and meets their assurance requirements. 360 Assurance has completed its testing across the boundary and has identified no significant control issues.

For those services delivered through **local shared services** with CCGs in South Yorkshire & Bassetlaw, all arrangements were overseen by NHS England at establishment, and are supported by Memorandums of Understanding. Each hosted service has established formal arrangements through the Memorandum of Understanding for review and assurance of the service. For example, the Health & Safety hosted service is assured through the mechanism of the South Yorkshire & Bassetlaw Governance Leads meeting.

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.

NHS England has provided a number of such reports on the CCG's behalf:

- From NHS Shared Business Services for the provision of Financial Accounting Services
- From NHS Business Service Authority regarding Prescription Services and Dental Payments
- From NHS Digital for GP Payments, CQRS, and SUS
- From Capita for Primary Care Services.

The Chief Finance Officer has reviewed all relevant SARs. The reports relating to Financial Accounting Services, Prescription Services, and Dental Payments identified no material control issues.

The report relating to primary care services operated by Capita provided an adverse opinion meaning that it does not provide us with assurance over the controls within this system, and the report over the GP payments system operated by NHS Digital also identified some control issues. 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 receives and reviews the journal adjustments prepared by NHS England 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 2016/17. In addition this was identified as part of KPMG's external audit plan and has been subject to significant testing and review 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 2016/17 which require disclosure in this report.

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

Throughout 2016/17 the Governing Body has built upon the experience of the first three 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 has been brought into even sharper focus as we prepared plans for 2017/18 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. This approach to early reporting of risks and shared ownership of the challenge secured in-year savings which minimised the risk to non-achievement of financial duties and targets.

The scale of the efficiency programme for 2017/18 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 have been put in place through a Project Management Office (PMO) approach to support achievement of the CCG's statutory financial duties and continuous quality improvement. The development of these arrangements has involved external support from Attain to ensure that learning and good practice from elsewhere is embedded into Barnsley CCG's approach.

As part of NHS England's Improvement and Assessment Framework for 2016/17, 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'. NHS England has advised that the year end results for the Quality of Leadership Indicator will be available from July 2017 at www.nhs.uk/service-search/scorecard/results/1175. The latest available results on MyNHS (Quarter 2 2016/17) rate the CCG as 'green.'

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 £12.3 million, in line with NHS England expectations. At the beginning of the year the surplus required by NHS England was £8.3 million, however in addition the 2016/17 NHS Planning Guidance required CCGs to hold a 1 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Barnsley CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £4m. The CCG's cumulative surplus of £12.3m will be carried forward for drawdown in future years. The process for accessing the surplus is determined by NHS England and is subject to overall NHS affordability.

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 explains how since October 2016 the CCG has participated in a Commissioners Working Together Joint Committee, with its own Terms of Reference and Scheme of Delegation. In addition to this arrangement the CCG is also a participant in the following arrangements:

- 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.
- **Sustainability & Transformation Plan (STP) Collaborative Partnership Board**, a collaborative non-decision-making forum where commissioner and provider partners across South Yorkshire & Bassetlaw meet to discuss STP progress. Assurance is provided via Chief Officer representation at the Collaborative Partnership Board and receipt of minutes and recommendations by the Governing Body.

Counter Fraud Arrangements

Overall executive responsibility for counter fraud arrangements rests with the 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 supported the CCG to complete and submit a self-review of our level of compliance with NHS Protect's *Standards For Commissioners* in March 2017. Overall the CCG is judged to be at 'green,' which demonstrates improvement compared with 2015/16 when the overall rating was 'amber'. This means the CCG has appropriate arrangements in place and that evidence of their effectiveness is in place. An action plan will be developed to move the CCG towards a green rating for any remaining red or amber standards and will be implemented by the LCFS and CCG officers during 2017/18.

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 concluded that:

"*From my review of your systems of internal control, primarily through the operation of your Governing Body's Assurance Framework in the year to date, and the outcome of individual assignments also completed in the year, I am providing* ***Significant Assurance*** *that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.*

It should be recognised that the CCG's current systems of control and arrangements for governance and the management of risk will need to continue to develop in the coming year, particularly reflecting on increasing cross-organisation and sector partnerships, as these arrangements will bring additional challenges in terms of the management of risk and ensuring that all partners understand the inter-relationships."

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

Audit Assignment	**Status**	**Assurance Level**
Budgetary Control & Key Financial Systems	Complete	Significant
Payroll	Complete	Significant
Personal Health Budgets	Draft Report	*Indicative opinion* - Limited
Information Sharing	Complete	Significant
IG Toolkit	Complete	Significant
Cyber Security	Complete	Significant
QIPP	Complete	Split (Significant / Limited)
Primary Care Quality Monitoring	Complete	Limited
Quality Governance (Quality Assurance & Improvement)	Complete	Significant
Conflicts of Interest	Complete	N/A
Interim review of the Assurance Framework (stage 1 & 2)	Complete	N/A
Interim review of the Assurance Framework (stage 3)	Complete	N/A

All audit reports from assurance reviews that have been issued to management and the Audit Committee to date have reported Significant Assurance on systems and processes, with the exception of:

- The QIPP Phase 1 review which had a split significant / limited opinion. Significant Assurance was provided over the CCG's arrangements for incorporating the national commissioning initiatives into its local QIPP planning. However, as the audit was undertaken at an early stage of the year when the development of robust plans to deliver the identified QIPP opportunities was still underway, Limited Assurance was provided over the CCG's arrangements then in place to drive forward its QIPP requirements. The Governing Body was clearly informed of the risk to the delivery of 2016/17 QIPP schemes and the proposed actions.
- The Draft Personal Health Budgets review includes a limited assurance opinion, although no high risk issues were identified. The CCG accepts this opinion but the report requires amendments and updates in light of the recent decision not to continue as a demonstrator site taken at the Governing Body on 11th May 2017.

- The Primary care Quality Monitoring report also provides a limited assurance opinion. This opinion relates specifically to monitoring arrangements only and not to the quality of primary care services actually being provided. In this respect the CCG has been proactive in promoting high quality services through a locally agreed Quality Framework and indeed the CQC, having visited all GP practices in Barnsley, have rated the vast majority as 'good.' The report makes a number of medium and low priority recommendations to enhance the CCG's monitoring arrangements which the CCG has accepted and an action plan is in place to implement the agreed improvements.

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 CCG achieving its principal objectives have been reviewed.

The Accountable Officer has been advised on the implications of the results 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 (see pages 36 to 53).
- 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 2016/17.

Page 58 sets out the significant control issues identified in the year (if any) and the actions taken to address them.

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
25 May 2017

Remuneration and staff report

Remuneration Committee

The details of the remuneration committee can be found on page 42-3.

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 Manager

The CCG has no Governing Body Members on Very Senior Manager contracts who would have been paid more than £142,500 per annum

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		(c) Performance pay and bonuses (bands of		(d) Long term performance pay and		(e) All pension-related benefits (bands of £2,500)*		(f) TOTAL (a to e) (bands of £5,000)	
	£0		£0		£0		£0		£0		£0	
	15/16	16/17	15/16	16/17	15/16	16/17	15/16	16/17	15/16	16/17	15/16	16/17
Governing Body Members:												
Dr N Balac, Chairman	105-110	**90-95**	0	**0**	0	**0**	0	**0**	22.5-25	**30-32.5**	130-135	**125-130**
L J Smith, Chief Officer	130-135	**135-140**	0	**0**	0	**0**	0	**0**	0	**0**	130-135	**135-140**
Dr M Ghani, Medical Director	75 -80	**75-80**	0	**0**	0	**0**	0	**0**	52.5-55	**30-32.5**	130-135	**110-115**
H Wells, Chief Finance Officer	95 -100	**95-100**	0	**0**	0	**0**	0	**0**	30-32.5	**35-37.5**	125-130	**130-135**
B Reid, Chief Nurse	85-90	**85-90**	0	**0**	0	**0**	0	**0**	17.5-20	**30-32.5**	100-105	**115-120**
Dr J Harban, Governing Body Member	25-30	**25-30**	0	**0**	0	**0**	0	**0**	5-7.5	**0**	35-40	**25-30**
Dr N Luscombe, Governing Body Member (to 26.12.16)	35-40	**20-25**	0	**0**	0	**0**	0	**0**	0	**0**	35-40	**20-25**
M Hoyle, Governing Body Member (Practice Manager)	15-20	**15-20**	0	**0**	0	**0**	0	**0**	0	**0**	15-20	**15-20**
Dr S Krishnasamy, Governing Body Member + Appointed as Associate Medical Director from 01/08/16	25-30	**35-40**	0	**0**	0	**0**	0	**0**	5-7.5	**12.5-15**	30-35	**50-55**
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, Governing Body Member	10-15	**20-25**	0	**0**	0	**0**	0	**0**	0	**0**	10-15	**20-25**
Dr L King, Governing Body Member (to 15.07.16)	20-25	**20-25**	0	**0**	0	**0**	0	**0**	0	**0**	20-25	**20-25**
Dr Adebowale Adekunle, Elected Governing Body Member (from 18.07.16)	0	**20-25**	0	**0**	0	**0**	0	**0**	0	**0**	0	**20-25**
A Arnold, Lay Member	0-5	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0-5	**0**
C Millington, Lay Member	10-15	**10-15**	0	**0**	0	**0**	0	**0**	0	**0**	10-15	**10-15**
D O'Hara, Lay Member	5-10	**0**	0	**0**	0	**0**	0	**0**	0	**0**	5-10	**0**
Mr Brian Roebuck, Lay Member for Governance (from 18.07.16)	0	**5-10**	0	**0**	0	**0**	0	**0**	0	**0**	0	**5-10**
Other Senior Staff:												
V Peverelle, Chief of Corporate Affairs (to 02.10.16)	80-85	**40-45**	0	**0**	0	**0**	0	**0**	25-27.5	**25-27.5**	105-110	**65-70**
Richard Walker, Head of Governance & Assurance (from 01.09.16)	0	**30-35**	0	**0**	0	**0**	0	**0**	0	**20-22.5**	0	**50-55**
Jamie Wike, Head of Planning and Performance (from 01.09.16)	0	**30-35**	0	**0**	0	**0**	0	**0**	0	**62.5-65**	0	**95-100**

*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 31.3.17)+pension lump sum as at 31.3.17)-((20xpension as at 31.3.16 adjusted by inflation)+pension lump sum as at 31.3.16 adjusted by inflation).

Pension benefits as at 31 March 2017 [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 2017 (bands of £5,000)	(d) Lump sum at pension age at 31 March 2017 (bands of £5,000)	(e) Cash Equivalent transfer value at 01 April 2016	(f) Real Increase in cash equivalent transfer value	(g) Cash Equivalent transfer value at 31 March 2017	(h) Employers contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Governing Body Members:								
Dr N Balac, Chairman	0-2.5	2.5-5	15-20	45-50	268	42	310	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	152	19	171	0
H Wells, Chief Finance Officer	0-2.5	0	15-20	45-50	317	22	339	0
B Reid, Chief Nurse	0-2.5	2.5-5	25-30	85-90	514	41	555	0
Dr J Harban, Governing Body Member***	0	0	0	0	195	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)	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	91	14	105	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, Elected Governing Body Member****	0	0	0	0	0	0	0	0
C Millington, Lay Member*	0	0	0	0	0	0	0	0
D O'Hara, Lay Member*	0	0	0	0	0	0	0	0
Mr Brian Roebuck, Lay Member for Governance (from 18.07.16)*	0	0	0	0	0	0	0	0
Other Senior Staff:								
V Peverelle, Chief of Corporate Affairs (to 02.10.16)	0-2.5	2.5-5	25-30	85-90	502	36	538	0
Richard Walker, Head of Governance & Assurance (from 01.09.16)	0-2.5	0	0-5	0	22	10	32	0
Jamie Wike, Head of Planning and Performance (from 01.09.16)	2.5-5	0	20-25	0	160	21	181	0

*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.
***Member has taken pension benefits in the last financial year.
****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.

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 for early retirement or 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]

A payment of £1,313 was made to the previous Chair of the Audit Committee on a consultancy basis between March and June 2016, during which period she operated as Acting Audit Committee Chair while a vacancy for the substantive post was filled.

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 2016/17 was £140,000 (2015/16: £135,000). This was 4.3 times (2015/16: 4.7) the median remuneration of the workforce, which was £32,023 (2015/16: £28,200).

In 2016/17, no employees received remuneration in excess of the highest-paid member (2015/16: nil). Remuneration ranged from £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.

Staff Report

Unless otherwise stated all the data below is for staff employed by Barnsley CCG on 31 March 2017.

Number of senior managers

The definition of senior managers has been agreed at Band 8A and above for the purposes of this disclosure.

	As at 31 March 2017	Average for 1 April to 31 March 2017
	Head count	Whole Time Equivalents
Governing Body*	15	5.92
Very Senior Manager (VSM)	1	-
Consultant	1	0.50
GP	1	0.43
Band 8D	3	1.83
Band 8C	5	5.83
Band 8B	8	4.13
Band 8A	31	18.74
Other staff	61	50.06
Total	126	87.44

*The one member of the Governing Body who was paid “off payroll” is included in the figure above.

Staff numbers and costs [SUBJECT TO AUDIT]

Employee benefits and staff numbers

Employee benefits	2016-17	Total		Admin		Programme	
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'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 (page 71) 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: a significant proportion of this increase relates to the part year impact of recruitment of 15 WTE clinical pharmacists.

Employee benefits 2015-16

	Total			Admin			Programme		
	Total £'000	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**
Employee Benefits									
Salaries and wages	4,084	3,419	665	2,355	2,268	87	1,729	1,151	578
Social security costs	299	299	0	201	201	0	98	98	0
Employer Contributions to NHS Pension scheme	414	414	0	275	275	0	139	139	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	216	216	0	216	216	0	0	0	0
Gross employee benefits expenditure	**5,013**	**4,348**	**665**	**3,047**	**2,960**	**87**	**1,966**	**1,388**	**578**
Less recoveries in respect of employee benefits	(623)	(623)	0	(269)	(269)	0	(354)	(354)	0
Total - Net admin employee benefits including capitalised costs	**4,390**	**3,725**	**665**	**2,778**	**2,691**	**87**	**1,612**	**1,034**	**578**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**4,390**	**3,725**	**665**	**2,778**	**2,691**	**87**	**1,612**	**1,034**	**578**

Staff composition

As at 31 March 2017 the composition of the CCG's workforce was as follows:

	Male	Female	Total
Governing Body*	10	5	15
Very Senior Manager (VSM)	1	0	1
Consultant	0	1	1
GP	0	1	1
Band 8D	0	3	3
Band 8C	1	4	5
Band 8B	3	5	8
Band 8A	12	19	31
Other staff	8	53	61
Total	35	91	126

*The one member of the Governing Body who was paid "off payroll" is included in the figure above. ** The definition of senior managers was agreed at Band 8A and above for the purposes of this data.

Sickness absence data

As disclosed at Note 4.3 to the accounts, during 2016/17 the average annual sick days per whole time equivalent member of staff was 4.6 (2015/16: 7.7).

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.

Expenditure on consultancy

Consultancy expenditure is the provision to management of objective advice and assistance relating to 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.

During 2016/17 the CCG spent £91K (2015/16: £190k) on consultancy services, the main schemes are detailed below :

Sustainability and Transformation Plans	£7K
QIPP plans	£84K

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 GPs are deemed to be 'Off payroll' engagements and are therefore subject to these disclosure requirements.

Table 1: Off payroll engagements longer than 6 months

Off payroll engagements as at 31 March 2017, for more than £220 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2017	1
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	1

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.

The arrangement that has existed at the time of reporting relates to the Practice Manager Member of the Governing Body who is paid through the payroll of her practice which ensures appropriate deductions are made in respect of tax, National Insurance and pension.

Table 2: New off-payroll engagements

There are no new off payroll engagements in 2016/17, for more than £220 per day and that last longer than six months (2015/16: 2).

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	0
Number of new engagements which include contractual clauses giving NHS Barnsley CCG the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received.	0

Table 3: Off payroll engagements / senior official engagements

Off payroll engagements of Governing Body members and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017 are as follows:

Number of off payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year (this figure includes both on payroll and off payroll engagements).	3

The Clinical Chair, Chief Officer (as Accountable Officer) and the 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 2016/17.

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 X (list 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, 25 May 2017

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 2017 have been prepared by NHS Barnsley Clinical Commissioning Group under section 17 of schedule 1A of the National Health Service Act 2006 (as amended by the Health and Social Act 2012) in the form which the Secretary of State has, with the approval of the Treasury, directed.

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

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The Primary Statements:

Notes to the Financial Statements

Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	2	(2,662)	(48)
Other operating income	2	(1,180)	(970)
Total operating income		**(3,842)**	**(1,018)**
Staff costs	4	5,316	5,013
Purchase of goods and services	5	402,693	400,487
Depreciation and impairment charges	5	49	136
Provision expense	5	0	0
Other Operating Expenditure	5	435	430
Total operating expenditure		**408,493**	**406,066**
Net Operating Expenditure		**404,651**	**405,048**
Total Net Expenditure for the year		**404,651**	**405,048**
Other Comprehensive Expenditure		0	0
Comprehensive Expenditure for the year ended 31 March 2017		**404,651**	**405,048**

Statement of Financial Position as at 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Non-current assets:			
Property, plant and equipment	8	13	62
Total non-current assets		13	62
Current assets:			
Trade and other receivables	9	2,742	3,301
Cash and cash equivalents	10	48	80
Total current assets		**2,790**	**3,381**
Total assets		**2,803**	**3,443**
Current liabilities			
Trade and other payables	11	(25,529)	(23,182)
Total current liabilities		**(25,529)**	**(23,182)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(22,726)**	**(19,739)**
Assets less Liabilities		**(22,726)**	**(19,739)**
Financed by Taxpayers' Equity			
General fund		(22,726)	(19,739)
Total taxpayers' equity:		**(22,726)**	**(19,739)**

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 25 May 2017 and signed on its behalf by:

Lesley Smith
Chief Officer/Accountable Officer
Date 25 May 2017

Statement of Changes In Taxpayers Equity for the year ended 31 March 2017

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17		
Balance at 1 April 2016	**(19,739)**	**(19,739)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17		
Net operating expenditure for the financial year	(404,651)	(404,651)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(424,390)**	**(424,390)**
Net funding	401,664	401,664
Balance at 31 March 2017	**(22,726)**	**(22,726)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16		
Balance at 1 April 2016	**(17,692)**	**(17,692)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16		
Net operating costs for the financial year	(405,048)	(405,048)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(422,740)**	**(422,740)**
Net funding	403,001	403,001
Balance at 31 March 2016	**(19,739)**	**(19,739)**

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

Statement of Cash Flows for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(404,651)	(405,048)
Depreciation and amortisation	5	49	136
(Increase)/decrease in trade & other receivables	9	559	(1,386)
Increase/(decrease) in trade & other payables	11	2,347	3,287
Net Cash Inflow (Outflow) from Operating Activities		**(401,696)**	**(403,011)**
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(401,696)**	**(403,011)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		401,664	403,001
Net Cash Inflow (Outflow) from Financing Activities		**401,664**	**403,001**
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(32)**	**(10)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**80**	**90**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**48**	**80**

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. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis

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

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

1.2 Accounting Convention

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

1.3 Pooled Budgets

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 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.

1.8 Property, Plant & Equipment

1.8.1 Recognition

Notes to the financial statements

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.

Notes to the financial statements

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).

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016-17, all of which are subject to consultation:

- 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)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2 Other Operating Revenue

	2016-17 Total	2016-17 Admin	2016-17 Programme	2015-16 Total
	£'000	£'000	£'000	£'000
Non-patient care services to other bodies	2,662	0	2,662	48
Recoveries in respect of employee benefits	366	283	83	623
Other revenue	814	7	807	347
Total other operating revenue	**3,842**	**290**	**3,552**	**1,018**

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

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

The 2015-16 figures include recovery costs incurred by the CCG on behalf of the Barnsley Healthcare Federation (Community Interest Company) The costs totalled £230,000 of pay costs and £170,000 or non pay costs which were recharged to the new organisation.
These recharges are recorded as revenue with Recoveries in respect of employees benefits and Other revenue respectively (note 4.1.1)

3 Revenue

	2016-17 Total	2016-17 Admin	2016-17 Programme	2015-16 Total
	£'000	£'000	£'000	£'000
From rendering of services	3,842	290	3,552	1,018
Total	**3,842**	**290**	**3,552**	**1,018**

4. Employee benefits and staff numbers

4.1 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
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 4.1.1)	(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**

2015-16	Total		
	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	4,084	3,419	665
Social security costs	299	299	0
Employer Contributions to NHS Pension scheme	414	414	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	216	216	0
Gross employee benefits expenditure	**5,013**	**4,348**	**665**
Less recoveries in respect of employee benefits (note 4.1.1)	(623)	(623)	0
Total - Net admin employee benefits including capitalised costs	**4,390**	**3,725**	**665**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**4,390**	**3,725**	**665**

4.1.1 Recoveries in respect of employee benefits

	2016-17			2015-16
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(357)	(357)	0	(587)
Social security costs	(5)	(5)	0	(15)
Employer contributions to the NHS Pension Scheme	(4)	(4)	0	(21)
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	**(366)**	**(366)**	**0**	**(623)**

4.2 Average number of people employed

	2016-17			2015-16
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**93**	**87**	**6**	**87**
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 Staff sickness absence and ill health retirements

	2016-17 Number	2015-16 Number
Total Days Lost	700	1,026
Total Staff Years	152	133
Average working Days Lost	4.6	7.7

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	0	0
	£'000	**£'000**
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	3	64,309	0	0	3	64,309
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	2	152,189	0	0	2	152,189
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**5**	**216,498**	**0**	**0**	**5**	**216,498**

	2016-17 Departures where special payments have been made		2015-16 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	2016-17 Other agreed departures		2015-16 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**0**	**0**	**0**

These tables identify that there has been no exit packages agreed in the financial year.

The disclosures are shown only due to figures being relevant to the 2015-16 year comparators

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.

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

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.

4.5 Pension costs

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

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

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

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at www.nhsbsa.nhs.uk/pensions.

For 2016-17, employers' contributions of £488,490 were payable to the NHS Pensions Scheme (2015-16: £436,756) at the rate of 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

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	4,692	2,354	2,338	4,420
Executive governing body members	624	624	0	593
Total gross employee benefits	**5,316**	**2,978**	**2,338**	**5,013**
Other costs				
Services from other CCGs and NHS England	211	187	24	2,400
Services from foundation trusts	253,870	0	253,870	244,037
Services from other NHS trusts	14,339	46	14,293	13,689
Services from other WGA bodies	1	0	1	0
Purchase of healthcare from non-NHS bodies	41,069	0	41,069	47,474
Chair and Non Executive Members	411	411	0	387
Supplies and services – clinical	34	0	34	651
Supplies and services – general	2,868	431	2,437	3,440
Consultancy services	91	84	7	189
Establishment	2,058	513	1,545	2,024
Transport	244	7	237	11
Premises	643	188	455	1,385
Impairments and reversals of receivables	0	0	0	19
Depreciation	49	22	27	136
Impairments and reversals of property, plant and equipment	0	0	0	0
Audit fees	67	67	0	68
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
Prescribing costs	49,113	0	49,113	48,405
Pharmaceutical services	524	0	524	581
General ophthalmic services	231	0	231	122
GPMS/APMS and PCTMS	36,145	0	36,145	33,436
Other professional fees excl. audit	60	46	14	54
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	24	24	0	24
Education and training	191	80	111	186
CHC Risk Pool contributions	934	0	934	2,335
Other expenditure	0	0	0	0
Total other costs	**403,177**	**2,106**	**401,071**	**401,053**
Total operating expenses	**408,493**	**5,084**	**403,409**	**406,066**

6. Better Payment Practice Code

Measure of compliance	2016-17 Number	2016-17 £'000	2015-16 Number	2015-16 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	13,169	78,836	8,801	55,935
Total Non-NHS Trade Invoices paid within target	13,089	78,699	8,725	55,633
Percentage of Non-NHS Trade invoices paid within target	**99.39%**	**99.83%**	**99.14%**	**99.46%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,556	270,236	2,392	264,809
Total NHS Trade Invoices Paid within target	2,551	270,196	2,381	264,419
Percentage of NHS Trade Invoices paid within target	**99.80%**	**99.99%**	**99.54%**	**99.85%**

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 2016-17 (2015-16: Nil)

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense

	2016-17				2015-16			
	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	500	2	**502**	0	756	2	**758**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**500**	**2**	**502**	**0**	**756**	**2**	**758**

The amount recognised above under Buildings has been paid to two organisations:
NHS Property Services Ltd £190K (2015-16: £131K)
Community Health Partnership Ltd £310K (2015-16: £625K)
Of the amount paid to NHS Property Services Ltd, £146K (2015-16: £105K) relates to the occupancy of Hilder House (CCG Headquarters) and £44K (2015-16: £26K) 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 £310K (2015-16: £625K) 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

	2016-17				2015-16			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:								
No later than one year	0	0	2	**2**	0	0	2	**2**
Between one and five years	0	0	0	**0**	0	0	2	**2**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**0**	**2**	**2**	**0**	**0**	**4**	**4**

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

2016-17	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 April 2016	642	237	879
Cost/Valuation at 31 March 2017	**642**	**237**	**879**
Depreciation 1 April 2016	580	237	817
Charged during the year	49	0	49
Depreciation at 31 March 2017	**629**	**237**	**866**
Net Book Value at 31 March 2017	**13**	**0**	**13**
Purchased	13	0	13
Total at 31 March 2017	**13**	**0**	**13**
Asset financing:			
Owned	13	0	13
Total at 31 March 2017	**13**	**0**	**13**

8.1 Cost or valuation of fully depreciated assets

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

	2016-17 £'000	2015-16 £'000
Information technology	530	0
Furniture & fittings	237	0
Total	**767**	**0**

8.2 Economic lives

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

9. Trade and other receivables	Current 2016-17 £'000	Non-current 2016-17 £'000	Current 2015-16 £'000	Non-current 2015-16 £'000
NHS receivables: Revenue	990	0	1,890	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	1,137	0	863	0
NHS accrued income	0	0	6	0
Non-NHS and Other WGA receivables: Revenue	565	0	457	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	29	0	49	0
Non-NHS and Other WGA accrued income	0	0	15	0
Provision for the impairment of receivables	(19)	0	(19)	0
VAT	37	0	2	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	3	0	38	0
Total Trade & other receivables	**2,742**	**0**	**3,301**	**0**
Total current and non current	**2,742**		**3,301**	
Included above:				
Prepaid pensions contributions	0		0	

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

9.1 Receivables past their due date but not impaired	2016-17 £'000	2015-16 £'000
By up to three months	46	445
By three to six months	0	0
By more than six months	0	40
Total	**46**	**485**

£44K of the amount above has subsequently been recovered post the statement of financial position date.

The CCG does not hold any collateral against receivables outstanding at 31 March 2017.

9.2 Provision for impairment of receivables	2016-17 £'000	2015-16 £'000
Balance at 1 April 2016	(19)	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	0	(19)
Transfer (to) from other public sector body	0	0
Balance at 31 March 2017	**(19)**	**(19)**

Impaired receivables represent a single receivable over six months old that is considered to be irrecoverable by the CCG.

10 Cash and cash equivalents

	2016-17 £'000	2015-16 £'000
Balance at 1 April 2016	80	90
Net change in year	(32)	(10)
Balance at 31 March 2017	**48**	**80**
Made up of:		
Cash with the Government Banking Service	48	80
Cash in hand	0	0
Cash and cash equivalents as in statement of financial position	**48**	**80**
Balance at 31 March 2017	**48**	**80**
Patients' money held by the clinical commissioning group, not included above	0	0

11. Trade and other payables	Current 2016-17 £'000	Non-current 2016-17 £'000	Current 2015-16 £'000	Non-current 2015-16 £'000
NHS payables: revenue	967	0	1,315	0
NHS accruals	2,999	0	2,103	0
Non-NHS and Other WGA payables: Revenue	4,127	0	7,629	0
Non-NHS and Other WGA accruals	16,556	0	11,557	0
Social security costs	66	0	53	0
VAT	0	0	0	0
Tax	62	0	69	0
Other payables and accruals	752	0	456	0
Total Trade & Other Payables	**25,529**	**0**	**23,182**	**0**
Total current and non-current	**25,529**		**23,182**	

There are no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2016: Nil).

Other payables include £366K outstanding pension contributions at 31 March 2017 (31 March 2016: £67K)

12. Provisions

The CCG had no provisions as at 31 March 2017 (31 March 2016: 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 2017 is £441K (31 March 2016: £3,956K)

13. Commitments

13.1 Capital commitments

The CCG has no contracted capital commitments not otherwise included in these financial statements as at 31 March 2017 (31 March 2016: 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 continued

14.2 Financial assets

	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**

	Loans and Receivables 2015-16 £'000	Total 2015-16 £'000
Receivables:		
· NHS	1,896	1,896
· Non-NHS	472	472
Cash at bank and in hand	80	80
Other financial assets	38	38
Total at 31 March 2016	**2,486**	**2,486**

14.3 Financial liabilities

	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**

	Other 2015-16 £'000	Total 2015-16 £'000
Payables:		
· NHS	3,418	3,418
· Non-NHS	19,642	19,642
Other financial liabilities	0	0
Total at 31 March 2016	**23,060**	**23,060**

15. Operating segments

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

	2016-17 £'000
Total Gross Expenditure (as per note 5)	408,493
Total Gross Income (as per note 2)	(3,842)
Total Net Expenditure for the year	**404,651**
Total Assets (as per Statement of Financial Position)	2,803
Total Liabilities (as per Statement of Financial Position)	(25,529)
Total Net Assets as at 31 March 2017	**(22,726)**

During the year the CCG spent £399,857,000 on the commissioning of Healthcare and other services (net programme expenditure). This represents 98.8% of the CCG's net expenditure.

51.2% of the CCG's net programme expenditure was expensed with the two main local providers £137,109,000 (34.3%) to Barnsley Hospital NHS Foundation Trust and £67,555,000 (16.9%) 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;

	2016-17 £'000	2015-16 £'000
Contribution to pooled commissioning budget:		
Opening balance as at 1 April	0	0
Barnsley Clinical Commissioning Group	6,245	5,841
Barnsley Metropolitan Borough Council	26,144	24,568
	32,389	**30,409**
Services Commissioned from the pooled budget:		
Barnsley Metropolitan Borough Council	26,574	21,604
South West Yorkshire Partnership NHS Foundation Trust	4,353	7,607
Barnsley Clinical Commissioning Group	1,462	1,198
Over/ (under) spend	3,190	2,131
Transfer / Use of Balances	(3,190)	(2,131)
Total Commissioned services	**32,389**	**30,409**
Closing balance as at 31 March	**0**	**0**

The £3,190,000 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 £567,000 in its financial statements for 2016-17 this relates to the budgets the CCG has a statutory obligation for. BMBC has recognised a charge of £3,757,000.

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 2016-17 and 2015-16 period.

A summary of the pooled budget is shown below;

	2016-17 £'000	2015-16 £'000
Contribution to pooled commissioning budget:		
Opening balance as at 1 April	0	0
Barnsley Clinical Commissioning Group	18,263	17,370
Barnsley Metropolitan Borough Council	2,331	1,028
	20,594	**18,398**
Services commissioned from the pooled budget:		
Barnsley Clinical Commissioning Group	8,323	7,869
Barnsley Metropolitan Borough Council	12,271	10,529
Total Commissioned services	**20,594**	**18,398**
Closing balance as at 31 March	**0**	**0**

The Better Care fund in 2015-16 included an element of funding relating to achievement of reducing non elective admissions. During 2015-16 the achievement was not achieved and therefore the element of the funding was removed from the fund and distributed between the CCG and BMBC as per the S75 risk sharing agreement. The value of the under achievement deducted was £1,976,000, and was apportioned equally. Under national guidance the risk share arranagment was removed from the BCF fund in 2016-17.

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	1,059	2	74	0
White Rose Medical Centre	Dr Ghani	Medical Director	Practice Payments	1,304	1	120	0
Dr Harban & Partners	Dr Harban	Governing Body Member	Practice Payments	1,017	2	81	0
Royston Group Practice	Dr Krishnasamy	Governing Body Member	Practice Payments	1,043	0	116	0
Dr Law & Partners	Dr Luscombe	Governing Body Member	Practice Payments	1,573	7	160	0
Kingswell Surgery	Dr King	Governing Body Member	Practice Payments	734	1	46	0
Dr Smith & Taylor	Dr Smith	Governing Body Member	Practice Payments	1,370	6	124	1
Grove Medical Practice	Dr Guntamukkala	Governing Body Member	Practice Payments	747	0	61	0
Kakoty Practice	M Hoyle	Governing Body Member	Practice Payments	902	0	60	0
Wombwell Chapelfields Medical Centre	Dr Adekunle	Governing Body Member	Practice Payments	1,506	0	119	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 2016-17. 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 2016-17. Dr Harban & Partners 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 2016-17. Royston Group Practice is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 17.1

Dr King, Governing Body Member for the CCG (until 15 July 2016). Kingswell Surgery 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 2016-17. 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, Governing Body Member is 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 2016-17. 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

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 is regarded as the parent department. For example
- 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 2016-17 the CCG recognised income with the Community Interest Company for the recharge of £10,273 of expenditure.
The CCG also made expenditure transactions totalling £4,017,284 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. (2015-16: 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		2016-17 Target £'000	2016-17 Performance £'000	Duty Achieved	2015-16 Target £'000	2015-16 Performance £'000	Duty Achieved
223H (1)	Expenditure not to exceed income	420,793	408,493	Yes	413,328	405,048	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	416,951	404,651	Yes	413,328	405,048	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	411,412	399,857	Yes	407,432	399,761	Yes
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	5,539	4,794	Yes	5,896	5,287	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)
NHS Act Section 223J (2) Revenue resource use on specified matters relates to programme resource.

20. Impact of IFRS

	2016-17 £'000	2015-16 £'000
Depreciation charges	0	0
Interest expense	0	0
Impairment charge: Annually Managed Expenditure	0	0
Impairment charge: Departmental Expenditure Limit	0	0
Other Expenditure	0	0
Revenue receivable from subleasing	0	0
Total IFRS Expenditure (IFRIC 12)	**0**	**0**
Revenue consequences of private finance initiative/LIFT schemes under UK GAAP/ESA95 (net of any sublease revenue)	0	0
Net IFRS Change (IFRIC 12)	**0**	**0**
Capital Consequences of IFRS: private finance initiative/LIFT and other service concession arrangements under IFRIC 12		
Capital expenditure	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 2016-17 Number	Total Value of Cases 2016-17 £'000	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £'000
Administrative write-offs	0	0	1	19
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**0**	**0**	**1**	**19**

The CCG had no cases in 2016-17.

21.2 Special payments

	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £'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 CCG

We have audited the financial statements of NHS Barnsley CCG for the year ended 31 March 2017 comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related Notes to the Accounts under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

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 of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on pages 34 to 35, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for the regularity of expenditure and income. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. 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. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

Scope of the audit of the financial statements

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

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

In addition, we are required to obtain evidence sufficient to give reasonable assurance that 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.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, 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. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2017 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

Opinion on regularity

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

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit 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 relevant to Clinical Commissioning Groups in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;
- 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; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in respect of the above responsibilities.

Certificate

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.

John Graham Prentice FCCA MBA
For, and on behalf of, KPMG LLP Statutory Auditor
Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA

25 May 2017