NHS
Sheffield
Clinical Commissioning Group

Accountability Report
Financial Statements

Accountability Report
Corporate Governance Report
The Directors' Report

1.1. NHS Sheffield CCG Governing Body – Composition and Profiles

The CCG Governing Body is responsible for NHS clinical commissioning decisions across Sheffield and for the long term success of the CCG. Membership of the Governing Body is set out in the CCG's Constitution. The CCG's Member Practices and then NHS England approved changes to the Membership of Governing Body during 2016/17 which came into effect from November 2016. These changes were the inclusion of 3 new non clinical executive director posts: Director of Delivery – Care Outside of Hospital, Director of Strategy and Integration and the Director of Commissioning and Performance. At the same time 2 non clinical executive director posts were disestablished: Chief Operating Officer and Chief of Business Planning & Partnerships.

At 30 September 2016 all 4 Elected GP Members' terms of office were due to expire. The CCG's Constitution sets out a process for election, but the Constitution also allows that where there are the same number or fewer candidates who have applied and are suitable for appointment then the appointment will be automatic. The CCG had four applications. Dr Terry Hudsen and Dr Annie Majoka were appointed with effect from 1 January 2017 for a term of 3 years, replacing Dr Anil Gill and Dr Ted Turner, neither of whom chose to stand for re-election. Dr Nikki Bates and Dr Marion Sloan had their terms of appointment extended for the same 3 year period until 31 December 2019.

Appointment processes were held for the two Lay member posts as their terms of office came to an end during 2016/17. Both Professor Mark Gamsu and Ms Amanda Forrest were re-appointed for 3 year terms following a competitive interview process. Professor Devaka Fernando, Secondary Care Doctor resigned from his post as Secondary Care Doctor on 31 January 2017 and we are currently in the process of recruiting to this vacancy.

Governing Body Members (i.e. voting Members) with effect from 1 November 2016 were:

- CCG Chair
- Accountable Officer
- Director of Finance
- Medical Director
- Chief Nurse
- 4 elected GP Members
- 4 Locality appointed GP Members (one of which is currently the Chair)
- 4 Lay members (one of which is the Vice Chair)
- Secondary Care Doctor
- Director of Delivery – Care Outside of Hospital
- Director of Strategy and Integration
- Director of Commissioning and Performance

1.2. Member profiles

Members of our Governing Body during 2016/17 were as follows. If no dates are shown, this means the Member was in post all year:

Dr Tim Moorhead - Chair (Locality Nominated GP (West Locality)

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

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

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

Maddy Ruff - Accountable Officer

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

Maddy is passionate about delivering high quality healthcare services to improve the health of everyone in the city. She is committed to achieving organisational success and drives improvement through her own passion and energy, engaging and inspiring others. She is dedicated to developing staff, both within the CCG and across health and social care, to allow them to provide the best possible care for patients.

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

Julia Newton - Director of Finance

Julia Newton was appointed as Director of Finance at NHS Sheffield CCG in July 2012. A Chartered Accountant, Julia has held a number of senior finance posts since joining the NHS in 1992. Julia oversees all aspects of financial planning, accounting and financial & corporate governance. During 2016/17 she also provided the lead finance role for all CCGs across South Yorkshire and Bassetlaw in the formulation of the five year Sustainability and Transformation plan and is the finance lead on the Working Together Joint Committee of CCGs

Dr Zak McMurray - Medical Director

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

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

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

Penny Brooks - Chief Nurse
(from 1 September 2016)

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

Dr Marion Sloan - Elected GP Member

Dr Marion Sloan is senior partner within a large inner city practice offering person centred care. Marion has been involved with the PCT and now CCG over the past 10 years. Starting with development of training for GP teams in long acting reversible contraception, making sure the right incentives were in place, bringing chlamydia screening to national coverage levels, innovating gynecology clinics in primary care and latterly developing a primary care option for pipelle biopsies as recommended by the updated NICE guidelines for menorrhagia. Marion worked with Central consortium offering a consultant led gastroenterology service in primary care that was safe, innovative, popular with patients and evaluated well financially. This was successful in bringing services previously only available in secondary care, into the community.

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

Dr Nikki Bates - Elected GP Member

Dr Nikki Bates has been a GP for 26 years. She is Senior Partner at Porter Brook Medical Centre. Nikki was elected by Sheffield GPs as one of their representatives to the CCG Governing Body in 2014.

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

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

Dr Terry Hudsen - Elected GP Member (from 1 January 2017)

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

Dr Hudsen has a keen interest and expertise in the use of information technology in improving people's health and health promotion, having produced mobile applications for patients and clinical computer systems for doctors. He is passionate about preventative health by encouraging healthier lifestyles to prevent the burden of disease, reduce health inequality and improve people lives.

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

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

Dr Ngozi Anumba - Locality Nominated GP (Hallam and South Locality)

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

Dr Amir Afzal - Locality Nominated GP (Central Locality)

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

Dr Leigh Sorsbie - Locality Nominated GP (North Locality)

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

She is passionate about ensuring high-quality evidenced-based clinical care is available for everyone within the city, regardless of postcode or background. Her work in Firth Park has enabled her to experience the challenges faced by communities in ethnically diverse areas of high deprivation, she is committed to working within the CCG to reduce health inequalities and address the factors which perpetuate them.

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

John Boyington CBE - Lay Member

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

Amanda Forrest - Lay Member

Amanda has worked in the voluntary and public service for over 30 years - predominantly working on issues around patient and public engagement, working in partnership, and service innovation. Until the end of July 2014 Amanda was Chief Executive of Sheffield Cubed - an organisation which enables voluntary sector organisations to work collaboratively. Amanda is Chair of the Quality Assurance Committee and Vice Chair of the Audit and Integrated Governance Committee, she is also a member of the Remuneration Committee and the Primary Care Commissioning Committee. She has a major role in patient and public involvement, supporting meaningful and effective engagement with the public and patients from a well thought through approach at all levels.

Mark Gamsu - Lay Member

Professor Mark Gamsu believes that if people's health and wellbeing is to improve, and inequalities are to be addressed, then it is essential to do this in collaboration with members of the public. In his career he has worked for a range of community organisations as well as local government and the civil service. He established 'Altogether Better', an award winning national health champions programme that continues to flourish. He chairs the Public Engagement, Experience and Equalities Group (PEEEG) which supports the CCG improve the way it consults, collaborates and engages with people in Sheffield. He is particularly interested in the way the CCG can help general practice and the voluntary sector work together better in the more disadvantaged parts of the city.

Phil Taylor - Lay Member

Phil was appointed as a lay member in March 2016 with responsibility for audit, governance and strategy. He is a Chartered Accountant and has worked in the NHS as a finance director and deputy chief executive for 10 years as well as gaining director level experience within the Department of Health. Phil joined the NHS in 1991 as Finance Director of the Northern General Hospital. He has been chair of the Healthcare Financial Management

Association and Senior Independent Trustee of the NHS Confederation. Phil believes that excellent governance is crucial for the quality of health and wellbeing services in Sheffield and is committed to improving value for money. He has a mentoring qualification and is currently the chair of the Sheffield Hospitals Charity. As well as the Audit and Integrated Governance Committee Chair, Phil is also the Conflicts of Interest Guardian.

Nicki Doherty Interim Director of Delivery - Care Outside of Hospital (From 1 November 2016)

Nicki is responsible for the Transformation and Delivery Directorate, her areas of responsibility include: Primary Care; Active Support and Recovery; Active Aging, Long Term Conditions and End of Life Care; Communications and Engagement; Equality and Diversity and Emergency Preparedness Planning and Resilience. Nicki worked with partners across Sheffield to produce the Sheffield Place Based plan.

Nicki has worked for the CCG since February 2015, prior to this she developed a broad range of operational and corporate experience in the acute hospital sector. She is passionate about the NHS and designing services that work for both people who need them as well as people who deliver them.

Peter Moore - Director of Strategy and Integration (from 1 November 2015)

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

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

Matt Powls - Interim Director of Commissioning and Performance (From 1 November 2016)

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

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

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

Tim Furness Chief of Business Planning & Partnerships (to 1 September 2016) Tim Furness was appointed to his Director role in the CCG in September 2012. He joined the NHS in 1990 and has held various senior management roles in commissioning and planning.

Idris Griffiths, Substantively Director of Delivery – Care Outside of Hospital and previously Chief Operating Officer (Currently seconded to NHS Bassetlaw CCG wef 1 October 2016) Idris has been an Executive Director at the CCG since it was established in 2013 and has worked in the NHS for over 25 years. Prior to working in commissioning Idris held a number of senior roles in community services and acute hospitals. Idris has an MBA and holds Chartered Institute of Personnel and Development Post Graduate Diploma.

Dr Anil Gill, Elected GP Member (to 23 September 2016)
Dr Anil Gill has been a GP since 1999 and has worked in Sheffield since 2005. He is the Senior Partner at Selborne Road Medical Centre. He was elected by his GP colleagues across Sheffield to join the CCG from its inception in 1 April 2013. His particular interests included acute care and his early work with the CCG involved developing IT connectivity between primary and secondary care enabling improved record sharing and patient care.

Dr Ted Turner, Elected GP Member (to 30 September 2016)
Ted graduated in 1988 and has been a GP at Shiregreen Medical Centre in Sheffield since 1995. Ted's interests include dermatology and skin surgery, cardiovascular medicine and care of the elderly. Ted was a member of the Remuneration Committee and the Sheffield Health and Wellbeing Board. His role included Governing Body lead for patient and public involvement.

Professor Devaka Fernando, Secondary Care Doctor (to 31 January 2017) Professor Devaka Fernando is a consultant endocrinologist. He trained in clinical endocrinology, clinical epidemiology and. medical management. His posts have included service director, head of service and Associate Medical Director at Sherwood Forest Hospitals NHS Foundation Trust.

Kevin Clifford, Chief Nurse (to 31 August 2016)
Kevin Clifford was appointed to the Chief Nurse post in September 2012. He joined Sheffield PCT in March 2010 as Chief Operating Officer for Provider Services and from September 2012 was Chief Nurse at the CCG until his retirement on 31 August

2016. Kevin, a registered nurse since 1983, previously worked at Sheffield Teaching Hospitals NHS Foundation Trust where he was Nurse Director for Emergency Care and Director of Clinical Operations. Kevin's role included Vice Chair of the Quality Assurance Committee.

1.3. Committee(s), including Audit Committee

The Governing Body has four directly reporting committees: The Primary Care Commissioning Committee, Audit and Integrated Governance Committee, Quality and Assurance Committee and Remuneration Committee. The Governance Sub- committee reports to the Audit and Integrated Governance Committee. Highlights from each of the committees are detailed in the Governance Statement at page 8

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

- Phil Taylor, Lay Member (Chair and Conflicts of Interest Guardian)
- John Boyington CBE, Lay Member
- Amanda Forrest, Lay Member (Deputy Chair)
- Dr Ngozi Anumba, CCG GP
- Dr Leigh Sorsbie, CCG GP

The Committee includes the following regular attendees:
- Director of Finance
- External Audit representative
- Internal Audit representative
- Counter Fraud representative
- Financial Accountant
- Corporate Services Risk and Governance Manager

1.4. Register of Interests of Governing Body Members

The CCG maintains a number of Registers of Interests. An extract of the Register giving the position for Governing Body Members at 31 March 2017 can be found at Appendix 1 on page 28 of this Accountability Report. Details of all of the CCG's Registers of Interests can be found at http://www.sheffieldccg.nhs.uk/about-us/declarations-of-interest.htm

At the start of each meeting of the Governing Body and formal committee / sub- committee meetings, members are required to declare any conflicts of interests in the items for consideration on the agenda and these are formally recorded. The CCG has set out how it will formally manage any declared conflicts of interest within its Standards of Business Conduct and Conflicts of Interest Policy.

1.5. Statement of Disclosure to Auditors

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

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

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

1.6. Information on personal data related incidents

The CCG has had no Serious Untoward Incidents relating to information on personal data in 2015/16 where these have been formally reported to the information commissioner's office.

1.7. Our Member Practices

The following is a list of all of NHS Sheffield CCG's 81 GP member practices listed by localities.

Central Locality (23)
Abbey Lane Surgery
Baslow Rd, Shoreham St & York Rd Surgeries
Carrfield Medical Centre
Clover City Practice
Clover Group Practice
Darnall Health Centre (Mehrotra)
Dovercourt Group Practice
Duke Medical Centre
East Bank Medical Centre
Gleadless Medical Centre
Handsworth Medical Centre
Heeley Green Surgery
Highgate Surgery
Manor Park Medical Centre
Norfolk Park Health Centre
Park Health Centre
Sharrow Lane Medical Centre
The Mathews Practice
The Medical Centre, Tinsley
The Sloan Practice
Veritas Health Centre
White House Surgery
Woodseats Medical Centre

Hallam and South Locality (22)
Birley Health Centre
Carterknowle Surgery
Charnock Primary Care Centre
Crystal Peaks Medical Centre
Falkland House Surgery
Greystones Medical Centre
Hackenthorpe Medical Centre
Jaunty Springs Health Centre
Manchester Road Surgery
Meadowgreen Health Centre
Mosborough Health Centre
Nethergreen Surgery
Owlthorpe Surgery
Richmond Medical Centre
Rustlings Road Medical Centre
Selbourne Road Medical Centre

North Locality (22)
Barnsley Road Surgery
Burchanan Road Surgery
Chapelgreen Practice
Burngreave Surgery
Crookes Valley Medical Centre
Dunninc Road Surgery
Ecclesfield Group Practice
Elm Lane Surgery
Foxhill Medical Centre
Grenoside Surgery
Mill Road Surgery
Norwood Medical Centre
Page Hall Medical Centre
Pitsmoor Surgery
Sheffield Medical Centre
Shiregreen Medical Centre
Southey Green Medical Centre
The Flowers Health Centre
The Health Care Surgery
Upperthorpe MedicalCentre
Upwell Street Surgery
Wincobank Medical Centre

West Locality (14)
Broomhill Surgery
Deepcar Medical Centre
Devonshire Green Medical Centre
Dykes Hall Medical Centre
Far Lane Medical Centre
Harold Street Medical Centre
Oughtibridge Surgery
Stannington Medical Centre
The Crookes Practice
Tramways Medical Centre (Milner)
Tramways Medical Centre (O'Connell)
University Health Service Health Centre
Valley Medical Centre
Walkley House Medical Centre

1.8 . Modern Slavery Act

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

1.9. Statement of Accountable Officer's Responsibilities

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

The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable 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 and include:

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

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

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

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; 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 auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aare 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.

Signed: Date:

Maddy Ruff
Maddy Ruff Accountable Officer

Annual Governance Statement

1. INTRODUCTION

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

The Clinical Commissioning Group's (CCG) 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 2016, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006

2. SCOPE OF RESONSIBILITY

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

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

3. GOVERNANCE ARRANGEMENTS AND EFFECTIVENESS

3.1. The Clinical Commissioning Group Governance Framework

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.

3.2. NHS Sheffield Constitution

NHS Sheffield CCG is a member organisation comprising 81 member practices and has a responsibility to ensure that robust corporate, clinical and financial governance arrangements are embedded within the organisation in accordance with best practice. The geographical area covered by NHS Sheffield CCG is the City of Sheffield, each GP practice falls within one of four localities. Our Constitution has been approved by Member practices and NHS England and reflects how the organisation operates. It sets out the CCG's powers and functions, describes our mission, values and aims and how these are delivered through the governance framework.

The Constitution includes the following information:

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

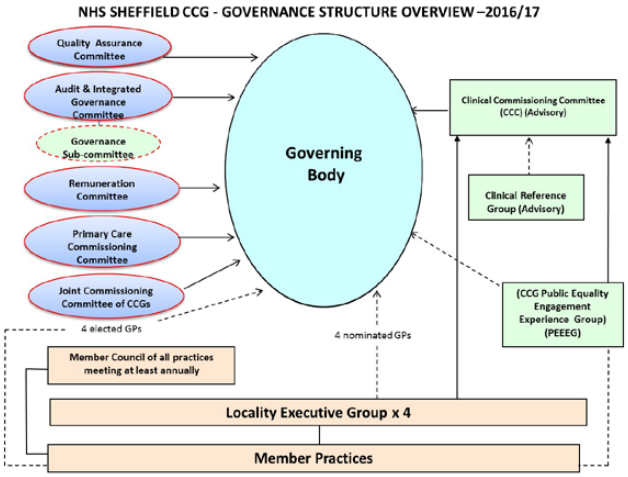
The Constitution was reviewed and updated twice during 2016/17, the second update following a full review of governance arrangements within the CCG. The following key changes were proposed and agreed by our Membership and NHS England:

- Updated roles of Lay Members
- Committees of the Governing Body – updated to include reference to Auditor Panel
- Terms of Reference are no longer appended to our Constitution but will continue to be referenced within the document. This will enable them to be updated and amended quickly and effectively to reflect current circumstances. Terms of Reference of our high level committees are now available on the CCG's webpage http://www.sheffieldccg.nhs.uk/our-information/documents-and-policies.htm
- The Conflicts of Interest Protocol remains referenced in the Constitution but no longer appended to ensure that the document may be updated and amended to reflect changes following the issue of any future statutory guidance. The document has been replaced by the Standards of Business Conduct and Conflicts of Interest Policy and is published on the CCG's website. http://www.sheffieldccg.nhs.uk/our-information/documents-and-policies.htm
- Changes to reflect revised management structure
- Reference to the Commissioner's Working Together Joint Committee
- Specific reference to the role of the Conflicts of Interest Guardian
- Changes to membership of the Primary Care Commissioning Committee
- Changes to the appointment process to clarify and strengthen the arrangements for Locality GPs.
- Changes to the Membership and quorum of the Governing Body
- Changes to make clear distinction between CCG and Governing Body

The Constitution, particularly through the Scheme of Reservation and Delegation, makes clear the respective responsibilities of the Members' Council (membership body), the Governing Body and its Committees. With the exception of changes to the Constitution, all powers and responsibilities have been delegated to the Governing Body.
The Constitution for NHS Sheffield CCG is available on the organisation's website www.sheffieldccg.nhs.uk

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

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



NHS Sheffield CCG Governance Structure

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

The CCG's governance arrangements, agreed by the Member practices and set out in the CCG's Constitution, gives the Governing Body the power to lead and manage the CCG on the Members' behalf.

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

The Governing Body is collectively responsible for the long term success of the CCG and from November 2016 comprises:

- CCG Chair
- Accountable Officer
- Director of Finance
- Medical Director
- Chief Nurse
- 4 elected GP Members
- 4 Locality appointed GP Members (one of which is the Chair)
- 4 Lay members (one of which is the Vice Chair)
- Secondary Care Doctor
- Director of Delivery – Care Outside of Hospital
- Director of Strategy and Integration
- Director of Commissioning and Performance

3.3.1. Responsibility

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

- Joint working through Partnerships Boards with the Local Authority and local NHS Foundation Trusts
- Joint working through partnership arrangements with neighbouring CCGs and Core City CCGs
- A joint arrangement with the Clinical Commissioning Groups from South Yorkshire and Bassetlaw, Hardwick and North Derbyshire for the CCG Collaborative Commissioning Network
- Joint working with NHS England at both national and local area team levels

The Governing Body is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. During 2016/17 it has maintained sound risk management and internal control systems as described in the Risk Management and Internal Control Framework sections.

3.3.2. Key Performance Highlights

A range of governance and strategic reports have been considered by the Governing Body including assurances on quality, finance and performance. Meetings are held in public and agendas, papers and minutes are published on the CCG website. All Governing Body agendas include the requirement for declarations of interest. The Governing Body receives information in a timely manner in a form and of a quality appropriate to enable it to discharge its duties.

The delivery of financial sustainability in the context of the CCG's Quality, Innovation, Prevention and Productivity (QIPP) challenge, enables the CCG Governing Body to continue to examine any risks to delivery of the significant financial challenge the CCG is facing.

The Governing Body continued to conduct the majority of its business in public, meeting seven times in public in 2016/17.

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

The Governing Body reviewed its governance arrangements in September 2016 which resulted in changes to the CCG's Constitution.

3.3.3. Risk Framework

The Governing Body is committed to providing resources and support systems necessary to support the Risk Management Framework. The Governing Body Assurance Framework

(GBAF) and Corporate Risk Register are reviewed by the Governing Body throughout the year. A development session on the GBAF was held for all Governing Body members in January 2017.

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

a. Audit and Integrated Governance Committee
b. Remuneration Committee
c. Primary Care Commissioning Committee
d. Quality Assurance Committee

Each committee has formal Terms of Reference and provides summary reports to the Governing Body. The Terms of Reference for each of these committees were reviewed following removal from the Constitution, ensuring they remained fit-for- purpose and offered stringent governance assurance. Terms of Reference of each of the Committees and Governance Sub-committee are available on the CCG Website.

Governing Body Member	Role	Attendance Actual	Possible
Dr Amir Afzal	CCG GP Locality representative	5	7
Ngozi Anumba	CCG GP Locality representative	6	7
Dr Nikki Bates	CCG GP Elected City-wide Representative	7	7
John Boyington	Lay Member	5	7
Penny Brooks (from 2.8.16)	Chief Nurse	2	3
Kevin Clifford (to 31.8.16)	Chief Nurse	4	4
Nicki Doherty (from 1.1.17)	Interim Director of Delivery – Care Outside of Hospital	1	1
Devaka Fernando (to 31.1.17)	Secondary Care Doctor	4	6
Amanda Forrest	Lay Member	6	7
Tim Furness (to 1.9.16)	Chief of Business Planning and Partnerships	3	4
Mark Gamsu	Lay Member	7	7
Dr Anil Gill (to 23.9.16)	CCG GP Elected City-wide Representative	2	4
Idris Griffiths (on secondment to NHS Bassetlaw CCG from 1.10.16)	Chief Operating Officer	4	4
Dr Terry Hudsen (from 1.1.17)	CCG GP Elected City-wide Representative	1	1
Dr Annie Majoka (from 1.1.17)	CCG GP Elected City-wide Representative	1	1
Dr Zak McMurray	Medical Director	6	7
Peter Moore (from 9.11.15)	Director of Strategy and Integration	1	2
Dr Tim Moorhead	CCG GP Locality representative CCG Chair	6	7
Julia Newton	Director of Finance	7	7
Matt Powls (from 1.11.16)	Interim Director of Commissioning and Performance	2	2
Maddy Ruff	Accountable Officer	6	7
Dr Marion Sloan	CCG GP Elected City-wide Representative	6	7
Leigh Sorsbie	CCG GP Governing Body Member	3	7
Phil Taylor	Lay Member	7	7
Dr Ted Turner (to 30.9.16)	CCG GP Elected City-wide Representative	4	4

Audit and Integrated Governance Committee

Responsibility
This Committee is chaired by the Lay Member with responsibility for financial strategy and governance. The Chair of this committee is also the Conflicts of Interest Guardian. The AIGC has delegated responsibility for critically reviewing the CCG's financial reporting and internal control principles and for maintaining an appropriate relationship with internal and external audit and the CCG's Counter Fraud Service. A key responsibility of the Committee is to review the financial statements before submission to the Governing Body with recommendation for approval.

The Committee also has delegated authority to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the CCG's activities.

The AIGC is underpinned by the functions of the Governance Sub-committee and ongoing dialogue with internal and external auditors. It has met on four occasions during the year, considering relevant issues in line with its Annual Work Plan.

During 2016/17, the AIGC undertook its annual assessment using the checklist provided by its external auditors who were able to provide a report as how Sheffield AIGC self assessed compared with other CCG audit committees. The results of the self- assessment have been used to determine future actions e.g. additional training for committee members.

Key Performance Highlights
Key areas of the committee's work in 2016/17 included:

- Appointment of a new Chair from 1April 2016 who is a qualified accountant with extensive experience of NHS finance, including chairing Finance and Audit Committees.
- Approval of the annual programme of work to be undertaken
- Receiving and reviewing updates from external audit
- Review of Internal Audit and Counter Fraud Services; in year monitoring and delivery against plans
- Review of policies against NHS Protect Standards for Bribery and Corruption against the Bribery Act 2010
- Ongoing review of various aspects of internal control, including updates on key quality and performance issues from the Quality Assurance Committee
- Review of the Governing Body Assurance Framework with particular focus on ongoing identified gaps in control and/or assurance.
- Review of attendance at Governing Body and its committees
- Annual review of the CCG's Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies
- Establishing the Audit Panel to allow the successful appointment of external auditors with effect from 2017/18 financial year.
- Receiving and noting revised guidance on conflicts of interest including the appointment of the Chair of Audit and Integrated Governance Committee as the Conflict of Interest Guardian
- Reviewing the draft and final accounts, including the annual and quality reports and the CCG's Annual Governance Statement, prior to recommending approval by the CCG Governing Body
- Receipt and review of auditor's "ISA260" year end report

Quality Assurance Committee

Responsibility
This Committee is chaired by a Lay Member with a lead role in Patient and Public Engagement. The Committee has responsibility for seeking assurance that all providers with whom the CCG places service contracts are delivering high quality and safe care, and that a culture of continuous quality improvement is embedded within organisations and services. The committee meets quarterly and has provided exception reporting to Governing Body on quality concerns and good practice. During the year it has streamlined reporting and focused on specific clinical issues or service areas.

Key Performance Highlights
During 2016/17 the committee has continued to develop and deliver its responsibilities. Specifically, the committee has:

- Secured increased clinical representation, via a second GP Quality Lead.
- Systematically reviewed provider's performance in relation all areas of quality including performance against national reviews and priorities.
- Reviewed feedback relating to providers from the Care Quality Commission and other regulatory bodies and taken action with providers where appropriate.
- Monitored patient safety issues, including Serious Incident, Never Events, targets and plans to reduce hospital and community acquired infection.
- Monitored performance of providers relating to Clinical Quality and Innovation Schemes (CQUIN).
- Approved strategies for Commissioning for Quality and Patient Experience, and monitored delivery of the action plans.
- Monitored patient feedback from both provider and public websites.
- Reviewed and approved clinical policies and procedures.
- Received reviews from Internal Audit relating to the internal functions of the CCG's Quality Assurance systems.
- Provided Feedback to Governing Body on a Quarterly basis.

Remuneration Committee

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

Key Performance Highlights
During 2016/17 key areas considered by the Committee included:

- Review of Remuneration Committee Terms of Reference
- CCG Senior Officers' On Call Arrangements
- Redundancy Business Cases
- Managing the Lay Members recruitment process
- Managing the Governing Body Elected GP Representative process
- Review of the remuneration of all Governing Body Members

Primary Care Commissioning Committee

Responsibility
The CCG formally took over delegated co commissioning responsibility for primary care medical services with effect from 1 April 2017 and hence 2016/17 was the first full year of operation of the committee. It strengthened its governance processes. This was recognised in an Internal Audit review which highlighted only a few minor changes for consideration.

Key Performance Highlights
During 2016/17 key areas considered by the Committee included:

- Approval of a number of Locally Commissioned Services to support the CCG's wider Out of Hospital Strategy
- Conclusion of the Special Cases approach as part of PMS funding transitional arrangements
- Approval of the Estates and Electronic Transformation Fund (ETTF) bid to NHS England
- Approval of the Sheffield CCG GP Forward View (GPFV) submission to NHS England
- Supported the smooth transition of patients to alternative practices as a result of a practice closure
- Supported the development of a Primary Care Business Intelligence function
- Sponsored the CCG's approach to establishing a practice visiting programme

Committee Membership and Attendance

The table below sets out details of membership and attendance at each of the CCG's committees. All meetings of all committees were quorate throughout the year except for the Primary Care Commissioning Committee meeting on 29 June 2016 which was not quorate. However, decisions made at this meeting were subsequently ratified by core members following the meeting.

Committee	Membership	Role	Attendance Actual	Attendance Possible
Audit & Integrated Governance (Meets quarterly)	Phil Taylor	Lay Member and Chair	4	4
	John Boyington	Lay Member	2	4
	Amanda Forrest	Lay Member and Vice Chair	2	4
	Ngozi Anumba	CCG GP Governing Body Member	4	4
	Leigh Sorsbie	CCG GP Governing Body Member	3	4
Quality Assurance (Meets Quarterly)	Amanda Forrest	Lay Member and Chair	4	4
	Amir Afzal (to 8.3.17)	CCG GP Lead for Quality	3	3
	Penny Brooks (from 1.9.16)	Chief Nurse and Vice Chair	2	3
	Kevin Clifford (to 30.8.16)	Chief Nurse and Vice Chair	2	2
	Devaka Fernando (to 31.1.17)	Secondary Care Doctor	3	3
	Mark Gamsu (from 25.11.16)	Lay Member	2	2
	Jane Harriman (to 1.2.17)	Deputy Chief Nurse	2	3
	Terry Hudsen (from 9.3.17)	CCG GP Lead for Quality	0	1
	Zak McMurray	Medical Director	4	4
	Mandy Philbin (from 2.2.17)	Deputy Chief Nurse	0	1
	Marion Sloan (from 25.8.16)	CCG GP	2	2
Primary Care Commissioning (Meets at least six times per year)	John Boyington	Lay Member and Chair	9	9
	Penny Brooks (from 1.9.16)	Chief Nurse	5	5
	Kevin Clifford (to 30.8.16)	Chief Nurse	3	4
	Nicki Doherty (from 2.2.17)	Director – Care Outside of Hospital	1	1
	Amanda Forrest (from 2.2.17)	Lay Member	1	1
	Mark Gamsu	Lay Member and Vice Chair	9	9
	Julia Newton	Director of Finance	7	9
	Maddy Ruff	Accountable Officer	6	9
Remuneration Committee (Meets quarterly)	John Boyington	Lay Member and Chair	3	3
	Amanda Forrest	Lay Member and Vice Chair	2	3
	Amir Afzal	CCG GP Governing Body Member	3	3
	Nikki Bates	CCG GP Governing Body Member	2	3
	Mark Gamsu	Lay Member	1	3
	Annie Majoka (from 15.3.17)	CCG GP Governing Body Member	0	1
	Ted Turner (to 30.9.16)	CCG GP Governing Body Member	1	2

Governance Sub-committee

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

It receives reports on high level risks, reviews the risk register and scrutinises any new organisational risks and their associated risk scores. The Sub-committee receives reports from a number of sub groups including information governance, freedom of information and health and safety. Reports to the Sub-committee include quarterly updates in relation to workforce planning, finance, and legal claims and litigation and compliments and complaints. The Sub-committee also receives reports with regard to the review and implementation of CCG policies for which it has delegated responsibility including corporate and HR policies.

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

Key Performance Highlights
During 2016/17 key areas considered by the Sub-committee included:

- Governing Body Assurance Framework (GBAF) reviewed at each meeting.
- Principal risks reviewed and challenged and in particular identified gaps in controls and/or assurances were challenged by its members.
- Operational risk register reviewed at each meeting and the scores of all new risks scrutinised.
- Incident reporting reviewed at each meeting, providing assurance that actions were taken following reported incidents in order to minimise the likelihood of future re-occurrence.
- Assurance received with regard to Information Governance systems and processes, including IG toolkit and Freedom of Information requests
- Positive assurance received in support of health and safety initiatives, premises inspections and fire risk assessments.
- On-going review of the policy management system for the review and updating of all corporate, human resources, clinical and financial policies
- Reviewed the Sub-committee Terms of Reference

Joint Committee
To enable Sheffield CCG to collaboratively commission with partners the Governing Body at its meeting on 6 October 2016 resolved to become a member of a new Working Together Joint Committee of CCGs (JCCC). The JCCC consulted with the public on proposals to change the way Hyper Acute Stroke Services and Children's Surgery & Anaesthesia are provided across South and Mid Yorkshire, Bassetlaw and North Derbyshire between 3 October 2016 and 14 February 2017. The Committee currently has delegated authority to only make decisions on these two service areas. It held its first formal meeting in public on 18 April 2017 and currently intends to consider the business cases for the two service areas in June 2017.

The CCG has also become a partner in the Sustainability & Transformation Plan (STP) across South Yorkshire & Bassetlaw; published in November 2016. This plan builds on strong partnerships already in place across South Yorkshire and Bassetlaw to review services better commissioned "at scale". An STP Collaborative Partnership Board has been established which is currently a collaborative non-decision-making forum where commissioner and provider partners across South Yorkshire and Bassetlaw meet to discuss STP progress. Assurance is provided via Chief Officer representation and receipt of minutes and recommendations to Governing Body. New governance arrangements for the STP will be established during 2017/18.

4. UK CORPORATE GOVERNANCE CODE

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

From 1st April 2016 and up to the date of signing this statement, the CCG has complied with the provisions set out in the NHS Clinical Commissioning Group's Code of Governance and applied the principles of the Code.

Principle of Leadership
NHS Sheffield CCG is headed by an effective unitary Governing Body comprised of Clinical Leads, Executive Directors and Lay Members each with clear understanding of individual and collective responsibilities. There is a clear division of responsibilities with no one individual having unfettered powers of decision.

The Chair is responsible for leadership of the Governing Body and ensuring its effectiveness on all aspects of its role and in particular a clear process for decision making. Our four Lay Members are valued for their impartial focus and expertise, their role is to oversee key elements of governance including audit, remuneration, and engagement, and conflicts of interest. We rely on their constructive challenge as well as their assistance in the development of strategy. All committees are chaired by a Lay Member.

The Governing Body sets the Clinical Commissioning Group's strategic aims and, with a revenue resource limit of £748.1m for CCG programme spend, £75.0m for primary care co commissioning and £12.7m for running costs for 2016/17, ensures that the necessary financial and human resources are in place for the organisation to meet its objectives.

Principle of Effectiveness
The Governing Body and its committees draw their membership from a broad pool of NHS staff, clinicians and lay members, providing the appropriate balance of skills, experience, independence and knowledge of the organisation to enable them to discharge their respective duties and responsibilities effectively. There is a formal process of reviews where time commitment of members is appraised.

A comprehensive organisational development programme is in place, primarily targeting the needs of Governing Body members, but also those of the CCG's Clinical Directors, enabling them to regularly update and refresh their skills and knowledge and support the CCG's programme for succession planning.

To enable the Governing Body to discharge its duties, information is received in a timely manner well in advance of meetings, with a choice of formats (hard or electronic). All papers presented at Governing Body and Committee meetings follow a recommended format including a standard front sheet, with three important functions:

- quickly draws members' attention to the key issues and recommendations.
- clearly states how the main body of the paper provides assurance that identified risks are being controlled
- provides evidence of the CCG's compliance with the requirements of the Equality Act 2010 and its duty to secure public involvement in the planning of commissioning arrangements.

The Governing Body reviews its own performance and that of its committees annually, with findings and recommendations being formally reported in its public facing meetings. Executive directors and lay members are subject to formal assessment and appraisal processes.

Principle of Accountability
The Governing Body undertakes a balanced and understandable assessment of the organisation's position and prospects via a number of routes including:

- papers presented to each Governing Body meeting, (e.g. Finance, Quality and Outcomes reports)
- development and publication of an Annual Plan
- development and publication of an Annual Report
- Annual Public Meeting
- meetings of the Members' Council.

The Audit and Integrated Governance Committee (AIGC) is chaired by an independent Lay Member with relevant financial experience. The AIGC is responsible for reviewing the CCG's internal control and risk management systems.
Principle of Remuneration

Principle of Remuneration
The Remuneration Committee oversees the appointment of all Governing Body Members and has delegated authority to determine their remuneration and conditions of service, taking into account any national directions or guidance on these matters. The Committee has the delegated authority to review the performance of the Accountable Officer and other senior CCG employees and determine any financial awards as appropriate.

Principle of Relations with Stakeholders
All Governing Body members actively engage in some form of dialogue with our stakeholders, be they constituent practices, Clinical Director meetings with practices, partner organisations or our citizens.

We seek to cultivate a mutual understanding of objectives and undertake this by sharing information in a variety of ways including:

- Publishing an Annual Report
- Annual Public Meeting
- Cross organisation Board Meetings
- Members' Council Meetings
- General Public Meetings
- Public facing web site
- Our "Involve Me" engagement network

5. DISCHARGE OF STATUTORY FUNCTIONS

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

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

Quarterly assurance reviews with NHS England continue, which also cover the discharge of statutory functions with positive outcomes in 2016-17.

In July 2016, the Accountable Officer commenced an assessment and review of the organisational and leadership structures and operating model for delivery set against the organisational strategic direction, ambitions and aims. This was undertaken using feedback from partners, Governing Body diagnostics and a better understanding of the range of portfolios to support the operating model.

The review indicated the requirement for strengthening clarity on the remit, autonomy and responsibility of roles and a structure of portfolios that supports the operating model required to deliver. As such an appropriate consultation was undertaken and a revised leadership structure was implemented. In support of these changes, a full review of the CCG's Constitution was undertaken in the autumn of 2016 this was followed by NHS England approval in November 2016.

6. RISK MANAGEMENT ARRANGEMENTS AND EFFECTIVENESS

A system of internal control is the set of processes and procedures in place within 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, the impact should they be realised, and to manage them efficiently, effectively and economically.

We have effective controls in place to enable risk to be assessed and managed. The Risk Management Strategy sets out the aims of the CCG to ensure that staff, patients, visitors, reputation, and finances associated with the CCG are protected through the process of risk identification, assessment, control and elimination/reduction. The strategy also sets out accountability arrangements in terms of risk management, including roles and responsibilities. The Director of Finance is designated as the lead officer for implementing the system of internal control, including the Risk Management Strategy.

The objective of the CCG's Risk Management Strategy is to create a framework to achieve a culture that encourages staff to:

- identify and control risks which may adversely affect the operational ability of the CCG
- compare risks using the 5 x 5 grading system (see table on page 16)
- eliminate or transfer risks or reduce them to an acceptable and cost effective level wherever possible, otherwise ensure the organisation openly accepts the remaining risks
- provide the Governing Body with assurance that risk is being effectively managed through appropriate risk management escalation mechanisms for the purposes of decision making

Risks are identified from a number of sources, including the Governing Body, Executive Directors, staff, Governing Body Assurance Framework (GBAF), internal and external audit reports and risk assessments. Monitoring, evaluation and control have been further developed throughout the year and all identified risks are included on the Corporate Risk Register or GBAF and more recently the introduction of Team Risk Logs. The Governance Sub-committee receives a report on all new risks and progress on addressing the high level risks at every meeting.

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

- Identify and prioritise risks to the achievement of the organisation's policies, aims and objectives;

- Evaluation the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The evaluation of risks to achieving the organisation's five high level objectives are set out in the GBAF which is regularly reviewed and scrutinised by the Governance Sub-committee, A AIGC and ultimately the Governing Body.

The GBAF forms part of the CCG's key assurance process and its purpose is to provide the Governing Body with 'reasonable' assurance that internal systems are functioning effectively. It is a high level document that is used to inform and give assurance to the Governing Body that the potential risks to achieving key objectives are recognised and that controls are in place or being developed to manage these potential risks.

The CCG's Risk Management Strategy and Action Plan, together with its policies and procedures, have been in place throughout 2016/17, and are reviewed annually. Responsibility for approval of the CCG's risk management arrangements is delegated to the AIGC. Preparation and review of the GBAF and operational Risk Register with recommendations for action to AIGC and Governing Body is delegated to the Governance Sub-committee.

There are a range of controls in place within the CCG which include risk prevention ie ensuring the risk does not occur and includes for example the Scheme of Delegation and Reservation and financial authorisation and authorisation levels. In addition, the CCG produces a range of detection controls ie performance monitoring and quality reports to Governing Body. The CCG also has a statutory and mandatory training regime which is a significant aspect of internal control. Finally, the CCG has in place directive controls which include a suite of policies and standard operating procedures which are monitored by the Governance Sub-committee at each of its meetings, such controls reduce the likelihood of a risk occurring.

The CCG reviews its compliance with the Public Sector Equality Duty annually and publishes details about the progress we have made towards meeting the requirements on our website. We also publish data on the make-up of our workforce, those affected by our policies and procedures, as well as our objectives for improvements in equality across all areas of our work. More information can be found on our website
www.sheffieldccg.nhs.uk/our-information/Public-Sector-

Equality-Duty
Incident reporting and serious incident reporting is openly encouraged from all staff and there is a process in place for the reporting, management, investigation and learning from incidents. We have a Senior Information Risk Owner (SIRO) to support our arrangements for managing and controlling risks relating to information/data security.

Attendance at risk management training, which includes the importance of incident reporting, is mandatory for all staff.

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

- Assurance that identified risks are being controlled
- Evidence of the CCG's compliance with the requirements of the Equality Act 2010
- How the report supports involving patients, carers and the public. The CCG values the involvement of public stakeholders in its local and collective decisions, and we utilise various engagement approaches to ensure an inclusive approach to involving the diversity of our citizens. To this effect, we have considered a number of key elements for involving public stakeholders set out in:
- The White Paper, 'Equity and Excellence: Liberating the NHS'
- Health and Social Care Act 2012
- The NHS Constitution

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

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

6.1. Capacity to Handle Risk

The CCG has sought to ensure that risk assessment and management is embedded throughout the organisation, with risks being identified from a number of sources, including the Governing Body, senior management, staff and reports from internal audit. Monitoring, evaluation and control systems have been reviewed and improved throughout the year and includes deputy directors taking an active role in reviewing corporate risks to ensure consistency in reporting across the organisation. All identified operational risks are included on our operational Risk Register and all strategic risks on the GBAF. The Corporate Services Risk and Governance Manager is responsible for overseeing the risk management process within the CCG.

The Governance sub-committee has delegated authority to routinely receive a report of all new risks and progress on addressing high level risks and any identified gaps in assurance and control at each meeting. There is a system in place to ensure lead directors, with their managers, from each directorate take responsibility for regularly reviewing and updating both the GBAF and the Risk Register.

The AIGC has responsibility for oversight of the CCG's risk management arrangements and receives update reports at each of its quarterly meetings. The Governing Body considers specific risk issues and receives minutes from its committees. The Governing Body also routinely receives information on Serious Untoward Incidents (SUIs) including lessons identified and learned.

A meeting of senior risk owners was held on 3 March 2016 to discuss the content of the GBAF in relation to the organisation's 5 year strategic ambitions and to ensure that risks remained relevant for the financial year ahead. This was followed by a 'Confirm and Challenge' session attended by Directors who reviewed and challenged the scores of all principle risks highlighted on the refreshed GB Assurance Framework. The Governing Body was provided with details of the refreshed GBAF at its meeting in May 2016 which included details of the changes to be taken forward for 2016/17. The Governing Body has received further update reports throughout the year.

Overall responsibility of the CCG's systems of internal control and preparation of the Annual Governance Statement is delegated to the Accountable Officer. The Director of Finance has delegated responsibility for ensuring that the CCG has in place a system for checking and reporting breaches of financial policies, together with a proper procedure for checking the adequacy and effectiveness of the control environment.

6.2. Risk Assessment

The CCG has adopted a local and systematic method of identifying, analysing, assessing, treating, monitoring and communicating risk. This process included the context in which risk had been managed. Front cover sheets of reports to the CCG's Governing Body and Committees and sub-committees make the link to any associated risks to the achievement of the organisation's objectives.

Risk management is embedded within the organisation through delivery of the Risk Management Strategy and also through assessments of specific risks including information governance, equality impact assessments, incident reporting and business continuity. We have a clear process for reporting, managing, investigating and learning from incidents captured via Datix our incident reporting system and as set out in our Incident Reporting Policy. Risk identification, assessment and monitoring is a continuous process in ensuring that we work within the legal and regulatory framework, identifying and assessing possible risks facing the organisation and how we respond to these.

The process of risk management covers the following 5 steps to risk assessment:

- Identify
- Assess
- Evaluate
- Record
- Review

Risks are scored using the standard 5 x 5 risk matrix together with controls identified in order to address or mitigate the risks. Gaps in control and/or assurance are noted and action plans to close gaps summarized and updated. The matrix incorporates both consequence and likelihood as detailed below:

	LIKELIHOOD				
RISK MATRIX	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
1 Negligible	1	2	3	4	5
2 Minor	2	4	6	8	10
3 Moderate	3	6	9	12	15
4 Major	4	8	12	16	20
5 Extreme	5	10	15	20	25

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

In accordance with the CCG's Risk Management Strategy, senior managers have initial responsibility for identifying and managing operational risks within their areas of responsibility and all staff are required to report potential risks to their line manager. When a risk has been confirmed it is added to the operational Risk Register and rated using the standard NHS 5 x 5 scoring system. During 2016/17 this has been via web based reporting software. The system ensures risks are reviewed by the risk owner, senior manager and senior risk owner during the 13 week review cycle. Teams are encouraged to review their risks at monthly team meetings.

Every new risk identified is reviewed by the Governance Sub-committee who will confirm any actions required in order to reduce the level of risk, together with the risk rating. A protocol in support of the Risk Register has been established, which sets out the requirements and the reporting arrangements, and is regularly updated and circulated to risk owners.

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

The CCG uses three risk scores:

- Initial Risk Score: This is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risks and is used as a benchmark against which the effect of risk management will be measured.
- Current Risk Score: This is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans to mitigate the risks are developed and implemented.
- Target (Appetite) Risk Score: This is the score that is expected after the action plan has been fully implemented and which the CCG deems to be an acceptable level of risk.

An Annual Risk Management Report was presented to the Governance Sub- committee in August 2016 and AIGC in September 2016 providing assurance of the continued progress throughout the year with regard to risk management. The report identified that Directors and senior managers who develop business plans were attuned to the importance of risk management and played a pivotal role in identifying risk to the achievement of objectives at both team and organisational level.

6.3. Governing Body Assurance Framework (GBAF)

The GBAF identifies our five strategic objectives (the first four taken from our Prospectus and the fifth from the authorisation process), the principal risks to delivery of these and any gaps in assurance and control. The five objectives are:

- To improve patient experience and access to care
- To improve the quality and equality of healthcare in NHS Sheffield CCG
- To work with Sheffield City Council to continue to reduce health inequalities in NHS Sheffield CCG
- To ensure there is a sustainable, affordable healthcare system in Sheffield
- Organisational development to ensure the CCG meets organisational health and capability requirements set out in the 6 domains (Annex C NHS England CCG Assurance Framework)

In addition to the organisation's objectives eight further goals were identified, each of the goals is linked to the 5 key objectives. The Goals identified include:

1 Deliver timely and high quality care in hospital for all patients and their families
2 Become a person-centred city: promoting independence for our citizens and supporting them to take control of their health and health care.
3 Tailor services to support a reduction in health inequalities across the Sheffield population.
4 Integration of physical and mental health, ensuring parity of esteem for people with mental health needs.
5 Supporting people living with and beyond life threatening or long term conditions
6 Give every child and young person the best start in life
7 Prevent the early onset of premature disease and avoidable deaths
8 We will work in collaboration with partners for sustainable care models by playing an active role in regional sustainability and be recognised as a system leader for public sector reform.

The GBAF is designed to meet the requirements of the Annual Governance Statement, providing a structure and process to enable the organisation to focus on the high level strategic and reputational risks with the potential to compromise the achievement of its strategic objectives. The framework is a dynamic tool that maps out key controls and highlights any gaps in controls and assurances to mitigate the risks, and provides a mechanism to assure the Governing Body of the effectiveness of these controls. It is part of the wider governance and assurance framework to ensure the CCG's performance across the full range of its commissioning activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for patients. Crucially, the GBAF provides the Governing Body with confidence that systems and processes in place are operating in a way that is safe and effective.

Management of the GBAF is the responsibility of the Corporate Services Risk and Governance Manager and is formally reviewed by each Risk Lead (Executive Directors) quarterly. This is to ensure the controls and assurances remain valid and any identified gaps are mitigated by timely implementation and are clearly defined. During the year, two additional worksheets have been added to the GBAF framework which include:

- Identification of gaps in control/assurance and details of action plans in order to close the gaps/assurances, together with a target date for closure of the gap;

- Details of action plans identified in order to mitigate the level of risk which are RAG rated.

At the end of the monitoring period there remained 16 risks identified on the GBAF – the level of risk is set out below. No new risks were added during the year and no risks closed during this period. This is compared, in the table below, to the position reviewed in the previous quarters.

Review period	Low	Medium	High	Very High (Serious)	Critical
Up to and including 20 March 2017	0	2	1	13	0
Up to and including 15 November 2016	0	6	2	8	0
Up to and including 26 October 2016	0	6	5	5	0
Up to and including 30 August 2016	0	5	6	5	0

At 31 March 2017, the Governing Body Assurance Framework identified the following outstanding gaps in control.

Risk	Principal Risk	Identified Gap in Control
2.3	That the CCG fails to achieve Parity of Esteem for its citizens who experience mental health conditions, so reinforcing their health inequality and life expectancy	1. As an organisation, we do not yet have a coherent response to Parity Of Esteem through the work that is being delivered on Health Inequality overall. 2. Insufficient corporate equality activity to highlight this agenda, alongside other inequality agendas and work. 3. We need a higher degree of scrutiny of Equality Impact Assessments for all CCG activity. 4. Ongoing engagement within this CCG with existing partners to embed MH into structure and context of our organisational delivery plans.
5.2	Unable to secure timely and effective commissioning support to enable us to adequately respond and secure delivery to existing and new emerging requirements. Quality of externally purchased commissioning support (IT and data management) falls below required levels.	Limited contractual mechanisms available via the LPF contract to drive performance improvement.

The above gaps in control have robust action plans and have been built into the 2017/18 Framework

6.4. Operational Risk Register

Current Risks
At 31 March 2017 there were 23 risks identified and added to the Operational Risk Register. Of these, 13 risks were classified as high and 2 risks identified as Very High (serious);

- Inability to meet NHS Constitution pledge on A&E waits, flow through Sheffield Teaching Hospitals NHS FT and impact on elective waiting times.

- Impact of outstanding Joint Packages of Care: There are approximately 50 patients who have become eligible for a joint package of care. Some of whom had their care solely funded by the LA and others solely funded by the CCG.

The funding responsibilities are still being agreed. This could lead to an increase in costs overall, including the backdating of any payments to the Local Authority.

4 risks were rated moderate and 4 low level.

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

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

The Risk Report to Governance Sub-committee now includes details of those risks which have remained static in score for two or more cycles.

7. OTHER SOURCES OF ASSURANCE

7.1. Internal Control Framework

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

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

Our control framework is articulated through our Constitution, Standing Orders, Scheme of Reservation and Delegation and Detailed Financial Policies. The risk assessment component of our internal control framework is contained in our Risk Management Strategy.

The GBAF provides an overview of the controls and assurances in place to ensure that the CCG's principal objectives are achieved and that risks identified are managed. The template for Governing Body papers further adds to our control mechanisms.

7.2. Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

Our Internal Auditors have carried out our annual internal audit of conflicts of interest and the findings of the audit were:

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

Each of the 5 agreed actions identified by internal audit have now been completed.

7.3. Data Quality

All reports received by Governing Body provide information on how they link to the Governing Body Assurance Framework. The Governing Body receives a monthly Performance and Quality Report which contains a significant range of data which officers' ensure is the most up to date available and from reliable sources such as contract data sets, nationally published data etc. The Governing Body, as part of its monthly discussions on all reports, seeks reassurance on the accuracy and timeliness of the data and has found it acceptable.

7.4. Information Governance

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

Sheffield 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 a named Senior Information Risk Owner (SIRO), Caldicott Guardian and Information Governance Lead and access to information governance subject matter expertise from our external providers. The CCG has an Information Governance Group that reports to the Governance Sub-committee and addresses information governance matters for the CCG.

We have ensured all staff undertake annual information governance training and have implemented an information governance framework, to ensure that staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents.

The level of compliance demonstrated by completion of the 2016/17 Information Governance (IG) Toolkit is 70% with all standards at a score of at least two, which is deemed by NHS Digital to be satisfactory. Our IG Toolkit was also reviewed by our Internal Auditors, and this audit resulted in an outcome of significant assurance. The areas covered include:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance

There were no Serious Untoward Incidents relating to data security breaches in 2016/17.

The CCG operates effectively with pseudonymised data for secondary uses. In common with all Yorkshire and Humber CCGs our Data Services for Commissioners Regional Officers DSCRO services are contracted from North East Commissioning Support (NECS).

As a result of the NHS England led Lead Provider Framework (LPF) procurement exercise, in common with the majority of Yorkshire and Humber CCGs, Sheffield CCG contracted its IT Services from eMBED/Kier Healthcare with effect from April

2016. This contract includes the provision of specialist Information Governance support.

7.5. Business Critical Models

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

7.6. Third party assurances

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.

The CCG received and reviewed the following SARs after the submission of the draft accounts:

- North East Commissioning Services (NECS) relating to Data Management and Integration. Assurance is received through the contract which we hold with NECS and through the oversight of the flow of data by an Information Sharing Contract which we hold with NHS Digital and an Information Sharing Agreement.
- From NHS Shared Business Services for the provision of Financial and Accounting Services
- From McKesson / IBM for the Electronic Staff Records Programme (ESR)
- From NHS England/Capita over GP Co-Commissioning Recharges
- From NHS Business Service Authority regarding Prescription Services.

In addition to the above Service Auditor Reports, the CCG takes additional assurance from its own internal control procedures. For example, for GP Co- commissioning expenditure is monitored against budgets on a monthly basis and is reported to the Primary Care Commissioning Committee. The CCG also holds contracts for third party support with eMBED Health Consortium. Assurance is received through the contract which we hold with eMBED in relation to minor services such as our Registration Authority. Certain support services are shared with local CCGs in South Yorkshire & Bassetlaw on a hosted basis. All partnership arrangements were overseen by NHS England at establishment, and are supported by Memorandums of Understanding. Each hosted service has established formal arrangements through their Memorandum of Understanding for review and assurance of the service. All CCGs in South Yorkshire and Bassetlaw contract with the same internal audit partner, 360 Assurance. Internal audit plans incorporate the assurances required for all partners in relation to hosted services.

The Director of Finance reviews all internal audit reports, considers the implications of any deficiencies in control which are highlight, and advises the Audit and Integrated Governance Committee accordingly. Reports are presented quarterly to the AIGC of all high and medium level risks.

8. CONTROL ISSUES

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

9. REVIEW OF ECONOMY, EFFICIENCY & EFFECTIVENESS OF THE USE OF RESOURCES

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

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit and Integrated Governance Committee and Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

There are procurement processes in place to which the CCG adheres. There is a Scheme of Reservation and Delegation which ensures that financial controls are in place across the organisation.

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

As detailed in Section 11 below, the CCG actively deters risk through the adoption of robust counter-fraud methodology. NHS England assess the CCG's Quality of Leadership within the CCG Improvement and Assessment Framework. NHS England have 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 for Quarter 2 2016/17 confirm that for NHS Sheffield CCG the Quality of Leadership is 'Good'.

The Director of Finance, who is a member of Governing Body, is responsible for providing financial advice and for supervising financial control and accounting systems. She presents a monthly finance report to Governing Body, encouraging open debate and understanding from its members. This report provides members with information on cumulative expenditure against the approved budgets, together with a forecast of the likely year end position, and any risks or actions required to manage the overall financial position. The CCG contained expenditure within allocated resources, both for Programme (including primary care Co-commissioning) and Running Costs and has ended the year with a surplus of £11.6million (£3.5m

planned surplus plus release of a 1% (£8.1m) reserve which all CCGs were required to hold throughout 2016/17 as uncommitted,

The Director of Commissioning and Performance, who is a member of Governing Body, is responsible for providing advice to the Governing Body on the progress of the CCG's Quality, Innovation, Productivity and Prevention (QIPP) programme. He presents a monthly QIPP report to Governing Body outlining the progress of the key programmes and projects, and the impact that these initiatives are having on the delivery of improved quality, efficiency and effectiveness.

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

10. DELEGATION OF FUNCTIONS

We have collaborative commissioning arrangements for 999 and 111 services across CCGs in the Yorkshire & Humber region. Assurance is provided via a Memorandum of Understanding and local representation at the Joint Strategic Commissioning Board. This Commissioning Board will become a Joint Committee of CCGs in due course. Limited delegation is in place to the Commissioning Board through a Memorandum of Understanding.

11. COUNTER FRAUD ARRANGEMENTS

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

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

All staff are required to attend mandatory Fraud Awareness sessions. Staff are notified of the quarterly Fraudulent Times Newsletter which is available on the CCGs intranet.

12. HEAD OF INTERNAL AUDIT OPINION

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

"In providing an opinion for the financial year, it is important to reflect on the environment in which the organisation has been required to function and the impact of an on-going need to meet quality challenges whilst reducing costs, along with responding to the sustainability and transformation agenda. This will undoubtedly impact on the operation of control, however, the system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure. 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 to date, I am providing a 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 organisation'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:

Area of Audit	Level of Assurance Given
Continuing Healthcare	Significant
Primary Care Co-commissioning	Significant
Information Sharing	Significant
QIPP Review	Limited
Budgetary Control and Key Financial Systems	Significant
Information Governance Toolkit	Significant
Conflicts of Interest	**Compliant:** • Governance • Declarations of Interest and Gifts and Hospitality • Identifying and managing non-compliance **Partially Compliant:** • Registers of interests, giftsand hospitality and procurement decisions • Decision making processes and contract monitoring
Patient and Public Engagement	To be confirmed
Payroll	Significant
Better Care Fund	To be confirmed

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

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

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

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

- The Governing Body: responsible for providing clear commitment and direction for risk management within the organisation and approving the CCG's risk management arrangements. It is responsible for determining the nature and extent of significant risks it is willing to take in achieving its strategic objectives. During 2016/17 it has maintained sound risk management and internal control systems as described in the risk management section of this statement.
- The Audit and Integrated Governance Committee: responsible for providing an independent overview of the arrangements for risk management within the CCG, with specific responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews all internal and external audits.
- The Quality Assurance Committee: has a responsibility for ensuring clinical risks are identified and reported on the risk register, escalating to the Assurance Framework where necessary. The Committee provides assurance to the Governing Body that appropriate clinical risk management arrangements are in place across the organisation. Its work programme addresses safeguarding, infection control, quality in contracts, incidents and medicines management.
- Primary Care Commissioning Committee: is a committee of the Governing Body. The Committee has been established to enable the Members to make collective decisions on the review, planning and procurement of primary care services in Sheffield under delegated authority from NHS England. In performing its role, the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG. Minutes of each meeting of the PCCC are forwarded to NHS England for information, including the minutes of any sub-committees to which responsibilities are delegated.
- Internal audit: reviews of systems of internal control and progress reports to Audit and Integrated Governance Committee have supported my review, especially with regard to the Assurance Framework and Conflicts of Interest Reviews.
- Executive Directors: Each director is responsible for ensuring that risks have been properly identified and assessed across all their work areas. They are responsible for reviewing risks entered onto the corporate risk register and that each risk owner is actively managing their risks and escalating as appropriate. Directors are responsible for the management of all high level risks facing delivery of the organisations objectives. Directors also play a crucial role in ensuring that risk related issues are adequately dealt with when policies are developed within their area of work.
- Director of Finance: is responsible for ensuring that the organisation complies with the Standing Orders to achieve financial balance and reporting of financial risk to the Governing Body.
- Senior Managers and Clinical Leads within the CCG who have responsibility for the development and maintenance of the internal control framework
- Performance information – Quarterly Quality and Performance reports to Governing Body
- External Auditors - Comments in their Annual Audit Letter and other reports My review was also informed by:
- Delivery and audit plans by External and Internal Auditors
- Results from the Staff Survey
- Results from the NHS England survey
- Annual Operational Plan
- Information Governance Toolkit Assessment
- Monthly delivery and performance reports
- Regular reviews of risk registers
- Regular reports to the Governing Body from each of the formal committees
- Quarterly Assurance reports to NHS England
- Results of the 360 Stakeholder Review
- NHS England Assurance review

14. CONCLUSION

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

Signed: Date:

Maddy Ruff

Maddy Ruff Accountable Officer

Remuneration and Staff Report

Remuneration Report

1. Remuneration Committee

Details of the membership of the Remuneration Committee can be found within the Annual Governance Statement (page 12). The Committee is responsible for advising about the appropriate remuneration and terms of service for the Accountable Officer, executive directors and other senior managers, as well as monitoring and evaluating their performance.

2. Senior Managers' Remuneration and Terms of Service

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

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

The Accountable Officer of the CCG has determined that this definition applies to all voting members of Governing Body as set out in the CCG's Constitution. NHS England approved changes to the CCG's Constitution which included changes to job titles for certain directors and also the number of voting members with effect from November 2016. While some directors may have used a locally agreed title before the approved changes to the Constitution, for the purposes of this Annual Report we have only used the titles set out in the Constitution. For the relevant directors remuneration information is provided from the date they became a voting member. Profiles of each Governing Body member can be found in the Members' Report section of this Annual Report.

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

Senior Managers' remuneration for 2016/17 was determined by the Remuneration Committee and took account of national guidance, the prevailing economic climate, local market conditions and the requirement to obtain best possible value for money. The costs of posts are met from the notified Clinical Commissioning Group running cost allowance.

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

- The Agenda for Change guidance from NHS Employers including the staffing body pay and employment conditions in relation to senior managers' remuneration to ensure parity as far as reasonably practicable. Staff engaged on Agenda for Change payscales received a 1% pay increase.
- The work and recommendations of the Senior Salaries Review Body.
- Recommendations made in 2012 by HM Treasury and HMRC regarding tax arrangements in relation to Governing Body members and senior officials.
- National guidance set out in "Clinical commissioning group governing body members: Role outlines, attributes and skills" (October 2012).
- NHS England guidance regarding the remuneration of clinical commissioning group Chief Officers (Accountable Officers) and Chief Finance Officers (Directors of Finance). This covers basic salary, recruitment and retention premia where deemed applicable and additional payments for additional duties.

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

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

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

The Remuneration Committee sets the framework within which the terms and conditions of the Very Senior Managers are developed and agreed. It also receives reports on performance against standards set in relation to local and national targets from the CCGs strategic and operational plans for the Accountable Officer and Director of Finance. The remuneration is set through a process that is based on a consistent framework and independent decision of performance measures against an individual's performance with due consideration to comparative salary data, the labour market, the financial circumstances of the organisation plus any national guidance. Performance related pay was paid to the Accountable Officer of 3% of basic salary (paid pro rata based on the start date of 1.9.2015) following assessment of individual performance in 2015/16 and a subsequent recommendation by the Remuneration Committee. The Director of Finance received a 5% consolidated increase to basic salary with effect from 1st April 2016 following a review of salary and assessment of individual performance in 2015/16 and a subsequent recommendation by the Remuneration Committee.

Very Senior Managers are on permanent contracts. Six months' notice is required by the organisation to terminate the contract and three months by the individual. Directors engaged under Agenda for Change have a three month notice period on either side to terminate the contract. All other Governing Body members are appointed for a period of up to three years, with a notice period of three months. Further information on can be found in the CCG's Standing Orders which are available on our website as part of our constitution:

http://www.sheffieldccg.nhs.uk/about-us/our-constitution.htm

There are four senior managers on the Governing Body whose salary exceeds £142,500 per annum when adjusted to

reflect a full time annualised equivalent post. Two of these posts are filled by GPs on a part time basis and they are providing expert leadership and clinical advice to the CCG, the level of remuneration reflects this specialist input. The other posts are for the Accountable Officer and a Director post which is paid for on an off-payroll basis due to the CCG at the time being unable to recruit substantively because of the specialist skills and knowledge required. The CCG followed NHS England's national approvals process for this temporary off payroll appointment. This arrangement will cease in May 2017 following a substantive appointment to the Director of Commissioning and Performance.

The table below provides, for each senior manager who has served on the Governing Body in 2016/17, further information on their service contract.

Name	Title	Contract Commencement	Contract expiration
Dr Tim Moorhead	Chair Locality Appointed GP	1st April 2013 1st November 2014*	31st October 2018 31st September 2017
Mrs Madeline Ruff	Accountable Officer	1st September 2015	Substantive post
Mr Kevin Clifford	Chief Nurse	1st April 2013	31st August 2016
Mrs Penny Brooks	Chief Nurse	1st September 2016	Substantive post
Mr Tim Furness	Chief of Business Planning & Partnerships	1st April 2013	1st September 2016
Mr Idris Griffiths *	Chief Operating Officer Director of Delivery – Care Outside of Hospital *on secondment to Bassetlaw CCG with effect from 1 October 2016 to 30 September 2017	1st April 2013 1st November 2016	30 October 2016 Substantive post
Miss Julia Newton	Director of Finance	1st April 2013	Substantive post
Ms Nicola Doherty (internal secondment)	Director of Delivery – Care Outside of Hospital (interim)	1st January 2017	30th September 2017
Mr Matthew Powls (interim)	Director of Commissioning & Performance (interim)	1st November 2016	19th May 2017
Mr Peter Moore (external secondment)	Director of Strategy and Integration	1st November 2015	25th October 2017
Dr Zak McMurray Dr	Medical Director	1st April 2013	Substantive post
Nikki Bates	GP Elected Member	1st January 2017*	31st December 2019
Dr Anil Gill	GP Elected Member	1st October 2013	23rd September 2016
Dr Marion Sloan	GP Elected Member	1st January 2017*	31st December 2019
Dr Ted Turner	GP Elected Member	1st October 2013	30th September 2016
Dr Amir Afzal	Locality Appointed GP	1st November 2014*	31st October 2017
Dr Ngozi Anumba	Locality Appointed GP	14th May 2015	13th May 2018
Dr Leigh Sorsbie	Locality Appointed GP	1st November 2014*	31st October 2017
Dr Qurat-ul-Ain (Annie) Majoka	GP Elected Member	1st January 2017	31st December 2019
Dr Terry Hudsen	GP Elected Member	1st January 2017	31st December 2019
Prof Devaka Fernando	Secondary Care Doctor	16th July 2015	31st January 2017
Mr John Boyington	Vice Chair & Lay Member	1st July 2013	31st March 2018
Ms Amanda Forrest	Lay Member (re-appointed in year for further 3 years)	1st July 2013	31st March 2020
Prof Mark Gamsu	Lay Member (re-appointed in year for further 3 years)	1st July 2013	30th June 2019
Mr Phillip Taylor	Lay Member	1st March 2016	28th February 2019

*Contract commencement relates to the commencement date of the current contract not necessarily the initial appointment date for GP members.

3. Salaries and Allowances (subject to audit)

The table at Appendix Bi details the salaries and allowance for all the senior managers of the CCG, as defined above. Prior year comparators are shown for 2015/16 within Appendix Bi.

4. Payments for Loss of Office (subject to audit)

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

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

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

6. Pension Benefits (subject to audit)

The table at Appendix Bii details their pension entitlements. It is important to note that the pension values for the clinical members of the Governing Body relate to their Non Practitioner employment only as provided by the Business Services Authority. Whilst this will include, from 1st April 2014, the work undertaken in their capacity as a senior manager of the CCG, it might also include other, non-practitioner work. These pension values will also include contributions made in previous employments in a non-practitioner role. Prior year comparators are shown within the main pensions table for 2015/16.

7. Fair Pay disclosure (subject to audit)

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

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

The remuneration of the highest paid member in NHS Sheffield Clinical Commissioning Group in the financial year 2016/17 was £165,400 (£163,800 in 2015/16). This was 4.75 (4.68 times in 2015/16) times the median remuneration of the workforce which was £34,800 (£35,009 in 2015/16). There has been no material change year-on year to the remuneration of the highest paid member of the CCG, or to the median remuneration of all CCG staff.

There has been a change in the composition of the workforce. The size of the total workforce headcount including temporary staff that worked during the 12 month period in 2016/17 rose from 298 employees in 2015/16 to 369 employees in 2016/17. The main reasons for this were an increase in the number of interim staff and an expansion of the medicines management team required to deliver a new central prescription ordering system.

There was a 1% pay increase for all staff on Agenda for Change terms and conditions in 2016/17.

In 2016/17 no employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration for CCG employees ranged from £6,600 to £165,400 where the salary is calculated on an annualised, full-time equivalent basis.

Staff Report

1. Senior Managers

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

Pay Band	No. of Employees
Senior Managers	11
Of which; Very Senior Managers (VSM)	2

2. Staff Numbers

The table below summarises the average number of people employed by Sheffield CCG in 2016/17, calculated on a whole time equivalent basis, together with the net employee benefits costs. 'Other' relates to staff on secondment and temporary staff

	Total	Permanently employed	Other
Average number of Employees	246	235	11
Net employee benefit costs In £'000s	13,248	11,886	1,362

The table at Appendix Biii shows employee benefit costs in more detail.

3. Staff Composition

The table below provides an analysis of the number of persons of each sex who were Governing Body members, Very Senior Managers or total employees of the CCG as at 31 March 2017.

	Female	Male
All Employees	233	58
Of which; Very Senior Managers (VSM)	2	0
Of which; Members of the Governing Body	12	13

4. Sickness absence data

The sickness absence rate for the organisation is 3.95%. Sickness absence is managed in accordance with agreed policies and procedures which include employee wellbeing services of Occupational Health, counselling and physiotherapy.

5. Staff policies applied during the financial year:

5.1. Equality Impact Assessment

Equality Impact Assessments (EIAs) have been carried out on all relevant policies and over the next year we will be monitoring the impact of the implementation of our workforce policies on our staff to ensure that we are proactively identifying and addressing any inequalities.
We recognise that in order to remove the barriers experienced by disabled people, we need to make reasonable adjustments for our disabled employees. We do this on a case by case basis and involve occupational health services, refer to the sickness absence management policy and liaise with health and safety specialist colleagues to arrange work station assessments as appropriate.

5.2. Training

CCG staff members have participated in mandatory equality and diversity training, with senior management team members and staff directly involved in commissioning work attending a bespoke training session which described the implications of the Public Sector Equality Duty for people commissioning health services; and other staff completing an e-learning course.

5.3 Equality of Opportunity

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

The commitments are as follows:

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

6. Expenditure on consultancy

Sheffield CCG spent £1.13m on consultancy services in 2016/17 but received income from other partner organisations such as Sheffield City Council, the 3 Sheffield Foundation Trusts and other local CCGs towards this totalling £506k, leaving the net spend by Sheffield CCG at £607k.

£524k of gross spend was in relation to developing both our Sheffield Placed Based Plan and the wider South Yorkshire and Bassetlaw Sustainability & Transformation Plan (STP). Sheffield CCG has played a leading role in this work and hence hosted certain areas of expenditure.

A further £76k expenditure was incurred on behalf of Better Care Fund with Sheffield City Council. Income of £47k was received to contribute to this.

7. Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, CCGs must publish information on their highly paid and/or senior off-payroll engagements. Highly paid is defined as off-payroll engagements for more than £220 per day and that last longer than six months. The CCG has determined that this applies to work undertaken by a named individual, whether or not the payment is made directly to them or via a company/GP practice.

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

The off payroll engagements as of 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	35
The number that have existed:	
• For less than one year at the time of reporting	9
• For between one and two years at the time of reporting	5
• For between two and three years at the time of reporting	8
• For between three and four years at the time of reporting	13
• For four or more years at the time of reporting	0

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

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017.	12
Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to income tax and national insurance obligations.	12
Number for whom assurance has been requested (new and existing engagements) Of which the number:	50
• For whom assurance has been received	50
• For whom assurance has not been received	0
• That have been terminated as a result of assurance not being received.	0

	Number
Number of off-payroll engagements of Governing Body members during the financial year.	3
Number of individuals on payroll and off-payroll of Governing Body members during the financial year (this figure includes both off-payroll and on-payroll engagements).	25

8. Exit Packages

The table below details the number and value of the exit packages agreed in 2016/17 (2015/16 £nil).

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departure s 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
Less than £10,000								
£10,000 £25,000								
£25,001 £50,000								
£50,001 £100,000								
£100,001 £150,000	2	222,908		24,859	2	247,767		
£150,001 £200,000								
>£200,000								
Totals	**2**	**222,908**	**0**	**24,859**	**2**	**247,767**		

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

Table 2: Analysis of Other Departures

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

The exit packages detailed in the tables above relate to a) a compulsory redundancy for a senior manager of the CCG who is not a Governing Body member and b) a compulsory redundancy and a contractual payment in lieu of notice for a Governing body member. The 'Salaries and Allowances' table within the Remuneration Report includes a reference regarding disclosure of the exit payments payable to the individual named within that report.

Signed:
Date:

Maddy Ruff Accountable Officer

Appendix A

REGISTER OF INTERESTS GOVERNING BODY 2016/17

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

Name	Current position(s) held i.e. Governing Body, Member practice, Employee or Other (specify)	Declared Interest (Name of the organisation and nature of business)	TYPE OF INTEREST: Financial Interests	TYPE OF INTEREST: Non-Financial Professional Interests	TYPE OF INTEREST: Non-Financial Personal Interests	TYPE OF INTEREST: Is the interest direct	DATE OF INTEREST: From	DATE OF INTEREST: To	
Dr Amir Afzal	CCG GP Locality representative	Senior Partner, Duke Medical Centre	✓				1/8/94		
		GP Appraiser		✓			1/1/00		
		Director, Central Care Sheffield Ltd (not trading)					1/2/10	1/2/14	Always declared Not really relevant Declaration if it becomes relevant No longer exists
		Director, Saihara Care Ltd (Care agency based in London)	✓				1/1/06		
		B-TAK Enterprise Ltd (Rental of furnished offices company run by brother)					1/1/10		Ad hoc meeting
		Chair of Medical Education meeting, Astra-Zeneca		✓			1/7/94		
		Various pharmaceutical companies provide lunch to weekly practice nurses / GP meetings at practice					1/1/11		
		GP out of hours ad hoc shifts, Care UK	✓						
Dr Ngozi Anumba	CCG GP Locality representative	GP Partner, Woodhouse Health Centre	✓						
		Director, Woodhouse Healthcare Services Ltd (community pharmacy)	✓						
		Trustee, City Hearts (unpaid)		✓					
Dr Nikki Bates	CCG GP Elected City-wide Representative	GP Partner, Porter Brook Medical Centre	✓				1990		
		Practice is provider of Occupational Health Services for students at Sheffield Hallam University	✓				1990		
		GP Appraiser					2010		
		Minority stakeholder in Rivelin Healthcare Ltd	✓				2007		
		Partner Governor, Sheffield Children's NHS Foundation Trust					2013		
John Boyington CBE	Lay Member	Chairman (2 days per week paid), Bury GP Practices Ltd, a Company Limited by shares which is a provider of health services in Bury, Greater Manchester	✓				2015		Company situated 40 miles away and no established or planned links with CCG. Member would be excluded from any decisions where a conflict might occur
		Chairman (unpaid) of Masonic Care Ltd, a charitable Company providing residential care to 12 people with a learning disability in Thorne, South Yorkshire		✓			2014		Home situated in Thorne, Doncaster. Not personally involved in or able to influence any decisions about client placement.
		Trustee (unpaid), Croft House Settlement a registered charity providing premises and facilities for voluntary groups to meet in Sheffield city centre		✓			2000		This role predates appointment to CCG by many years and there are no evident links in related business.
		Trustee of the Masonic Charitable Foundation, a charity providing local, national and international support to Freemasons and to the community at large		✓			2016		MCF is a grant-making charity which neither commissions nor takes commissions from CCGs or other commissioners Nearest care home situated in York does take residents from Sheffield but I have no involvement or influence on admissions policy or practice
		• Member of the Charitable Support Executive Committee • Member of the Community Support sub- committee • Member of the Medical Research sub- committee							
		Director of the Royal Masonic Benevolent Institution Care Company, a subsidiary charity of The MCF providing care to 1,000 people in 17 homes across England and Wales. The position is non- remunerated. The nearest care home is situated in York	✓				2014		
Penny Brooks	Chief Nurse	Trustee (unpaid), Ashgate Hospice Care			✓				Out of area provider
		Director, PJ Brooks Consulting Ltd							
Nicki Doherty	Interim Director of Delivery – Care Outside of Hospital	Parent is Director of Planned and Unplanned Care at the Yorkshire Ambulance Service NHS Trust (YAS)				Indirect	1/1/17		Declare interest in meetings where topic relevant and not discuss CCG private issues directly.
Amanda Forrest	Lay Member	Partner Governor, STHFT	✓				21/4/15		
		Team Associate, University of Durham (2 year contract freelance)	✓				Sept 15	July 17	
		Team Associate, University of Sheffield (2 year contract freelance)	✓				Jan 16	Dec 17	
		Stage 2 Complaints Independent Investigator (Children Act) Sheffield City Council (freelance)					Oct 14	2018	
		Co-opted Trustee Sheffield Carers Centre			✓		14/2/17		
Mark Gamsu	Lay Member	Director, Local Democracy and Health Ltd (public health consultancy)	✓				2013		Declared
		Trustee - Chair, Sheffield Citizens Advice (organisation does receive contract funding from the CCG)		✓			2013		Declared
		Committee Member, Darnall Wellbeing (health project) (organisation does receive contract funding from the CCG)		✓			2013		Declared
		Trustee, Citizens Advice (national voluntary organisation)		✓			2013	31.3.17	Declared
		Professor Institute for Health Development, Leeds Beckett University (academic institution) (part time paid role)	✓				2016		Declared
		Chair, Chance to Dance (voluntary organisation)		✓			2012		Declared
		Co-ordinator of European Health Equity Programme, UK Health Forum (national voluntary organisation) (to 4.1.17)						4.1.17	
		Trustee, Voluntary Action Sheffield						4.1.17	
		Trustee, Sheffield Mental Health CAB (organisation does not receive contract funding from the CCG)						4.1.17	
		Trustee, Community Legal Advice Service South Yorkshire (organisation does not receive contract funding from the CCG)						4.1.17	
		Trustee, INVOLVE Yorkshire and Humber						4.1.17	
Dr Terry Hudsen	CCG GP Elected City-wide Representative	GP Principal, University of Sheffield Health Service	✓				May 14		
Dr Annie Majoka	CCG GP Elected City-wide Representative	GP Principal							
Dr Zak McMurray	Medical Director	Shareholder, Woodhouse Health Care Services Ltd – 10% holding (Woodhouse Pharmacy)	✓				06/14		Declare and abstain from discussion if needed.
		Trustee, Talbot Trusts		✓			10/12/12		Declare and abstain from discussion if needed.
		Spouse is Director of North East Derbyshire Healthcare					02/16		Declare and abstain from discussion if needed.
Peter Moore	Director of Strategy and Integration	Director of Strategy and Integration, Sheffield City Council (SCC) (50% SCC funded post)		✓			Oct 15	Sept 17	
Dr Tim Moorhead	CCG GP Locality representative CCG Chair	Senior Partner, Oughtibridge Surgery	✓						Declaration of Interest
		Minority shareholder, Rivelin Healthcare Ltd	✓						Declaration of Interest
		Member of Local Medical Committee		✓			12/16		Declaration of Interest
Julia Newton	Director of Finance	No Interests to Declare							
Matt Powls	Interim Director of Commissioning and Performance	Director, Pentland Healthcare Consulting (dissolved)					27/11/13	14/7/15	
Maddy Ruff	Accountable Officer	Spouse works for Royal Mail					2017		
Dr Marion Sloan	CCG GP Elected City-wide Representative	GP Principal, Sloan Medical Centre	✓				1978		
		Sessional GP, GP Collaborative	✓				1995		
		Clinical Assessor, STHFT						30.11.16	
		Lead GP, Gastroenterology Community Service						30.11.16	
Leigh Sorsbie	CCG GP Locality representative	GP Partner, Firth Park Surgery	✓				1/3/17		
		Partner Governor, SHSCFT					18/12/14	31/3/17	
Phil Taylor	Lay Member	Managing Director, Phil Taylor Associates Ltd (Management Consultancy)	✓				1/3/16		
		Chair and Trustee, Sheffield Hospitals Charity (NHS Charity)		✓			1/3/16		
		Chair and Trustee, Sheffield Hospitals Charity (independent charity)		✓			30/9/16		
		Chair and Director of Sheffield Hospitals Charity Trading Ltd (dormant organisation not in operation)		✓			30/9/16		
		Honorary Fellow of the Healthcare Financial Management Association (HFMA)		✓			1/3/17		
		Chair of the HFMA Non Executive Director and Lay Member Faculty (unpaid)		✓			1/3/17		

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

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

Name and Title	Salary (bands of £5k) £000	Expense Payments (taxable) (rounded to the nearest £100) £00	Performance pay and bonuses (bands of £5k) £000	Long term Performance pay and bonuses (bands of £5k) £000	All Pension Related Benefits (bands of £2.5k) £000	TOTAL (bands of £5k) £000
T Moorhead Chair of the Governing Body	95 - 100	0	0	0	17.5 - 20.0	115 - 120
M Ruff Accountable Officer	140 - 145	51	0-5	0	55.0 - 57.5	200 - 205
I Griffiths Chief Operating Officer (to 30 September 2016)	45 - 50	0	0	0	0	45 - 50
N Doherty Director of Delivery - Care Outside of Hospital (Interim) (from 1 January 2017)	15 - 20	0	0	0	25.0 - 27.5	40 - 45
K Clifford Chief Nurse (to 31 August 2016)	40 - 45	1	0	0	0	40 - 45
P Brooks Chief Nurse (0.6 wte from 1 September 2016)	30 - 35	0	0	0	0	30 - 35
*T Furness Chief of Business Planning & Partnerships (to 1 September 2016	40 - 45	0	0	0	7.5 - 10.0	50 - 55
J Newton Director of Finance	110 - 115	1	0	0	15.0 - 17.5	125 - 130
Z McMurray Medical Director	110 - 115	0	0	0	0	110 - 115
*P Moore Director of Strategy & Integration (voting rights from November 2016)	40 - 45	1	0	0	75 - 77.5	115 - 120
*M Powls Director of Commissioning & Performance (Interim) - (voting rights from November 2016)	70 - 75	0	0	0	0	70 - 75
N Bates GP Elected Member	10 - 15	0	0	0	2.5 - 5.0	15 - 20
A Gill GP Elected Member (to 23 September 2016)	5 - 10	0	0	0	0 - 2.5	5 - 10
T Hudsen GP Elected Member (from 1 January 2017)	0 - 5	0	0	0	0 - 2.5	0 - 5
A Majoka GP Elected Member (from 1 January 2017)	0 - 5	0	0	0	0 - 2.5	0 - 5
M Sloan GP Elected Member	10 - 15	0	0	0	0	10 - 15
T Turner GP Elected Member (to 30 September 2016)	5 - 10	0	0	0	0 - 2.5	5 - 10
A Afzal Locality appointed GP	10 - 15	0	0	0	0	10 - 15
N Anumba Locality appointed GP	10 - 15	0	0	0	2.5 - 5.0	15 - 20
L Sorsbie Locality appointed GP	10 - 15	0	0	0	17.5 - 20.0	30 - 35
D Fernando Secondary Care Doctor (to 31 January 2017)	10 - 15	0	0	0	0	10 - 15
J Boyington CBE Vice Chair and Lay Member	10 - 15	0	0	0	0	10 - 15
A Forrest Lay Member	10 - 15	0	0	0	0	10 - 15
M Gamsu Lay Member	10 - 15	0	0	0	0	10 - 15
P Taylor Lay Member	10 - 15	0	0	0	0	10 - 15

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

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

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

Executive Directors on Very Senior Manager contracts can be considered by the CCG's Remuneration Committee for a performance bonus. The Accountable Officer is on such a contract and the perfomanance bonus paid in 2016/17 relates to the 2015/16 financial year.

*The salary relating to M Powls is paid on an off-payroll basis via an Agency. To ensure the salary is comparable to the salaries of employees the value shown is exclusive of VAT, agency fees and employers national insurance costs. *The salary relating to P Moore is a joint post with Sheffield City Council and 50% of the stated salary is recharged to that organisation.

Remuneration Report: Senior Managers: Salaries and Allowances

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

Name and Title	Salary (bands of £5k) £000	Expense Payments (taxable) (rounded to the nearest £100) £00	Performance pay and bonuses (bands of £5k) £000	Long term Performance pay and bonuses (bands of £5k) £000	All Pension Related Benefits (bands of £2.5k) £000	TOTAL (bands of £5k) £000
T Moorhead Chair of the Governing Body	95 - 100	0	0	0	22.5 - 25.0	120 - 125
M Ruff (1 Sept 2015 to present) Accountable Officer I Griffiths	80 - 85	24	0	0	27.5 - 30.0	110 - 115
Accountable Officer (acting 1 April 2015 to 31 August 2015)	50 - 55	0	0	0		
Chief Operating Officer (1 September to present)	55 - 60	0	0	0	117.5- 120.0	230 - 235
K Clifford Chief Nurse	95 - 100	2	0	0	15.0 - 17.5	110 - 115
T Furness Chief of Business Planning and Partnerships	95 - 100	1	0	0	17.5 - 20.0	115 - 120
R Gillott (1 April 2015 to 31 August 2015) Chief Operating Officer (acting)	35 - 40	0	0	0	32.5 - 35.0	70 - 75
J Newton Director of Finance	105 - 110	1	0 - 5	0	27.5 - 30.0	135 - 140
Z McMurray Medical Director	110 - 115	0	0	0	0	110 - 115
N Bates GP Elected Member	10 - 15	0	0	0	0 - 2.5	10 - 15
*A Gill GP Elected Member	10 - 15	0	0	0	(80.0 - 77.5)	(70 - 65)
M Sloan GP Elected Member	10 - 15	0	0	0	0	10 - 15
T Turner GP Elected Member	10 - 15	0	0	0	0 - 2.5	10 - 15
A Afzal Locality appointed GP	10 - 15	0	0	0	0	10 - 15
N Anumba (14 May 2015 to present) Locality appointed GP	10 - 15	0	0	0	2.5 - 5.0	10 - 15
L Sorsbie Locality appointed GP	10 - 15	0	0	0	7.5 - 10.0	20 - 25
D Fernando (16 July 2015 to present) Secondary Care Doctor	10 - 15	0	0	0	0	10 - 15
J Boyington CBE Vice Chair and Lay Member	10 - 15	0	0	0	0	10 - 15
A Forrest Lay Member	10 - 15	1	0	0	0	10 - 15
M Gamsu Lay Member	10 - 15	0	0	0	0	10 - 15
Philip Taylor (1 March 2016 to present) Lay Member	0 - 5	0	0	0	0	0 - 5

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

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

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

*The reduction in the pension related benefits for Dr A Gill is due to the salary of the individual decreasing in the current financial year compared to the previous financial year The salary relates to Non Practitioner work outside of the Governing Body member role.

Executive Directors on Very Senior Manager contracts can be considered by the CCG's Remuneration Committee for a performance bonus. The Accountable Officer and the Director of Finance are on such contracts. The performance bonus paid in 2015/16 relates to the 2014/15 financial year and because the Accountable Officer was not in post in that year he was not eligible to receive a bonus.

Pension Benefits - 2016-17

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

Name and Title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2017 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2017 £'000	Cash Equivalent Transfer Value at 1 April 2016 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension £'000
T Moorhead, Chair of the Governing Body	0 - 2.5	2.5 - 5.0	20 - 25	60 - 65	404	354	49	0
M Ruff, Accountable Officer	2.5 - 5.0	7.5 - 10	45 - 50	135 - 140	880	794	86	0
I Griffiths, Chief Operating Officer (to 30 September 2016)	(0 - 2.5)	(2.5 - 5.0)	30 - 35	100 - 105	642	665	(12)	0
N Doherty, Director of Delivery - Care Outside of Hospital (Interim) (from 1 January 2017)	0 - 2.5	0 - 2.5	10 - 15	25 - 30	130	116	3	0
*K Clifford, Chief Nurse (to 31 August 2016)	(0 - 2.5)	(0 - 2.5)	40 - 45	130 - 135	0	895	(375)	0
* P Brooks, Chief Nurse (from 1 September 2016)	0	0	0	0	0	0	0	0
*T Furness, Chief of Business Planning & Partnerships (to 1 September 2016)	0 - 2.5	0 - 2.5	30 - 35	100 - 105	0	667	(281)	0
J Newton, Director of Finance	0 - 2.5	2.5 - 5.0	30 - 35	95 - 100	634	591	42	0
*Z McMurray, Medical Director	0	0	0	0	0	0	0	0
P Moore, Director of Strategy & Integration (voting rights from November 2016)	0 - 2.5	0	10 - 15	0	126	81	19	0
*M Powls, Director of Commissioning & Performance (Interim) - (voting rights from Nov 2016)	0	0	0	0	0	0	0	0
N Bates, GP Elected Member	0 - 2.5	0 - 2.5	5 - 10	20 - 25	153	136	17	0
A Gill, GP Elected Member (to 23 September 2016)	0 - 2.5	0 - 2.5	5 - 10	25 - 30	209	197	6	0
T Hudsen, GP Elected Member (from 1 January 2017)	0 - 2.5	0	0 - 5	5 - 10	41	39	1	0
A Majoka, GP Elected Member (from 1 January 2017)	0 - 2.5	0	0 - 5	5 - 10	34	33	0	0
*M Sloan, GP Elected Member	0	0	0	0	0	0	0	0
T Turner, GP Elected Member (to 30 September 2016)	0 - 2.5	0 - 2.5	10 - 15	30 - 35	205	192	6	0
*A Afzal, Locality appointed GP	0	0	0	0	0	0	0	0
N Anumba, Locality appointed GP	0 - 2.5	0	0 - 5	5 - 10	54	48	6	0
L Sorsbie, Locality appointed GP	0 - 2.5	(0 - 2.5)	10 - 15	25 - 30	203	180	23	0
*D Fernando, Secondary Care Doctor (to 31 January 2017)	0	0	0	0	0	0	0	0

Notes:
*P Brooks, Dr McMurray, M Powls, Dr Sloan, Dr Afzal and Dr Fernando do not make contributions to the NHS Pension Scheme and hence no information is available to the CCG.
*T Furness and K Clifford ceased making contributions during the year 2016/17 and drew down their pensions, the Cash Equivalent Transfer Value at 31 March 2017 is therefore nil.

It is important to note that the pension values for the GPs of the Governing Body relate to their Non Practitioner employment only as provided by the Business Services Authority. Whilst this will include, from 1st April 2013, the work undertaken in their capacity as a senior manager of the CCG it might also include other, non practitioner work. These pension values will also include contributions made in previous employments in a non practitioner role.
Lay Members do not receive pensionable remuneration and hence there are no entries in respect of pensions for Lay Members.

Cash Equivalent Transfer Values
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in the CETV reflects the increase in the CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of period. Where an employee commences in post part way through the year the real increase in CETV is adjusted to reflect the part year effect.

EMPLOYEE BENEFITS 2016/17

2016-17	Grand Total			Admin			Programme		
Employee Benefits	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Salaries and wages	11,009	9,696	1,313	7,422	6,685	737	3,587	3,587	575
Social security costs	1,054	1,031	24	724	723	1	331	331	22
Employer Contributions to NHS Pension scheme	1,306	1,280	26	870	870	0	436	436	26
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	223	223	0	223	223	0	0	0	0
Gross employee benefits expenditure	**13,592**	**12,231**	**1,362**	**9,239**	**8,500**	**739**	**4,354**	**3,730**	**623**
Less recoveries in respect of employee benefits	(344)	(344)	0	(300)	(300)	0	(44)	(44)	0
Total - Net admin employee benefits including capitalised costs	**13,248**	**11,886**	**1,362**	**8,939**	**8,200**	**739**	**4,309**	**3,686**	**623**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**13,248**	**11,886**	**1,362**	**8,939**	**8,200**	**739**	**4,309**	**3,686**	**623**

2015-16	Grand Total			Admin			Programme		
Employee Benefits	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Salaries and wages	8,122	7,250	872	5,821	5,500	321	2,301	1,750	551
Social security costs	655	637	18	503	498	5	152	139	13
Employer Contributions to NHS Pension scheme	979	963	16	721	716	5	258	247	11
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
Gross employee benefits expenditure	**9,756**	**8,850**	**906**	**7,045**	**6,714**	**331**	**2,711**	**2,136**	**575**
Less recoveries in respect of employee benefits	(365)	(365)	0	(275)	(275)	0	(90)	(90)	0
Total - Net admin employee benefits including capitalised costs	**9,391**	**8,485**	**906**	**6,770**	**6,439**	**331**	**2,621**	**2,046**	**575**

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS SHEFFIELD CCG

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

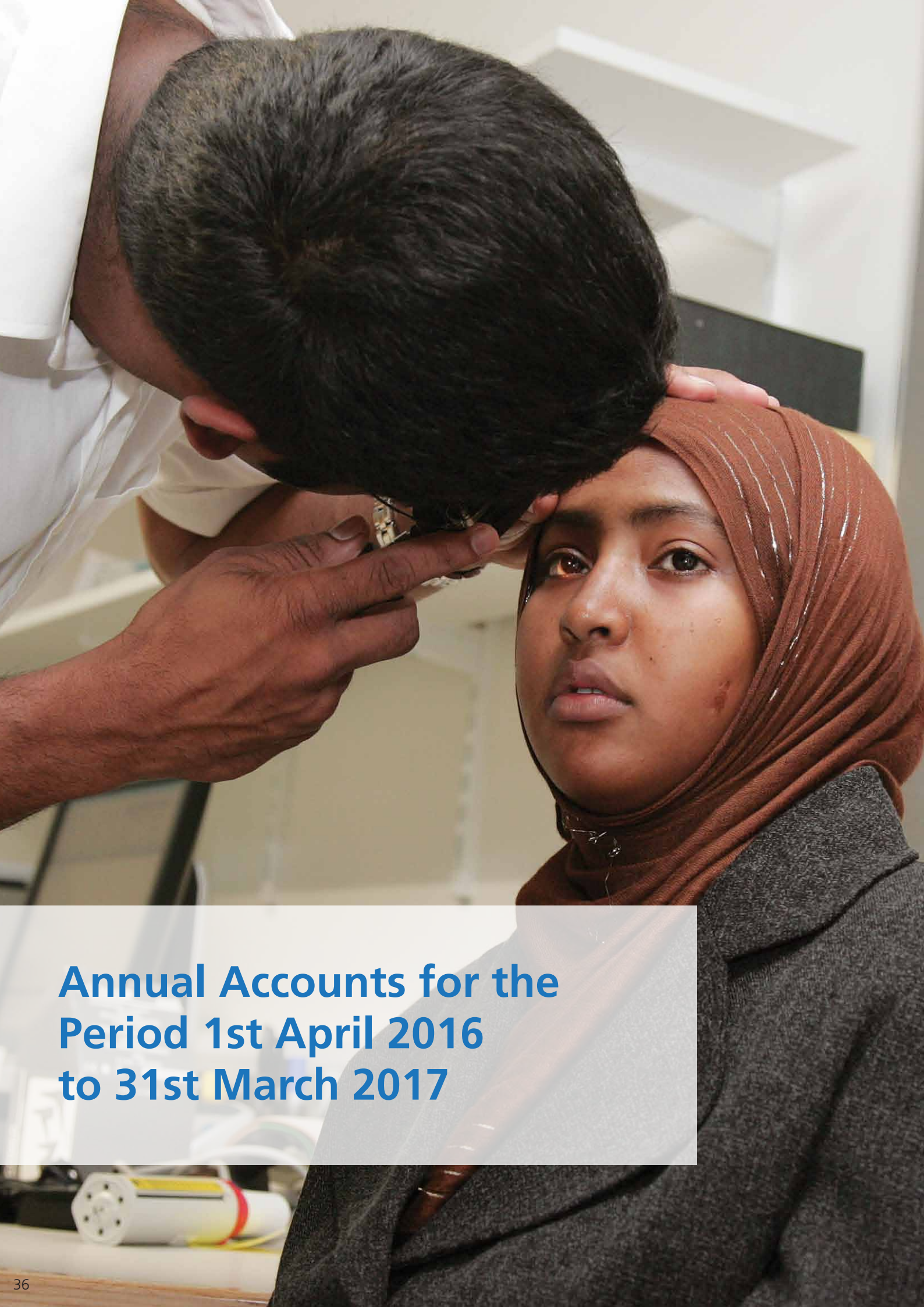
We have nothing to report in respect of the above responsibilities.

Certificate

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

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

25 May 2017



Annual Accounts for the Period 1st April 2016 to 31st March 2017

FOREWORD TO THE ACCOUNTS

NHS SHEFFIELD CLINICAL COMMISSIONING GROUP

The clinical commissioning group was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

These accounts for the year ended 31 March 2017 have been prepared by NHS Sheffield Clinical Commissioning Group under section 17 of schedule 1A of the National Health Service Act 2006 (as amended by the Health & Social Care Act 2012) in the form which the Secretary of State has, with the approval of the Treasury, directed.

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

CONTENTS

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	(2,421)	(961)
Other operating income	2	(3,499)	(7,317)
Total operating income		**(5,920)**	**(8,278)**
Staff costs	4	13,593	9,756
Purchase of goods and services	5	816,068	740,003
Depreciation and impairment charges	5	0	0
Provision expense	5	0	0
Other Operating Expenditure	5	408	967
Total operating expenditure		**830,069**	**750,726**
Net Operating Expenditure		**824,149**	**742,448**
Finance income			
Finance expense		0	0
Net expenditure for the year		**824,149**	**742,448**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**824,149**	**742,448**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2017		**824,149**	**742,448**

The notes on pages 5 to 25 form part of this statement

Statement of Financial Position as at 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Non-current assets:			
Property, plant and equipment	8	175	0
Intangible assets		0	0
Investment property		0	0
Trade and other receivables	9	0	0
Other financial assets		0	0
Total non-current assets		**175**	**0**
Current assets:			
Inventories		0	0
Trade and other receivables	9	7,632	10,254
Other financial assets		0	0
Other current assets		0	0
Cash and cash equivalents	10	141	60
Total current assets		**7,773**	**10,314**
Non-current assets held for sale		0	0
Total current assets		7,773	10,314
Total assets		**7,948**	**10,314**
Current liabilities			
Trade and other payables	11	(45,015)	(37,544)
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions	12	0	0
Total current liabilities		**(45,015)**	**(37,544)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(37,067)**	**(27,230)**
Non-current liabilities			
Trade and other payables	11	0	0
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions	12	0	0
Total non-current liabilities		0	0
Assets less Liabilities		**(37,067)**	**(27,230)**
Financed by Taxpayers' Equity			
General fund		(37,067)	(27,230)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(37,067)**	**(27,230)**

The notes on pages 5 to 25 form part of this statement
The financial statements on pages 1 to 4 were approved by the Governing Body on 25th May 2017 and signed on its behalf by:

Accountable Officer
Maddy Ruff

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

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

Changes in taxpayers' equity for 2015-16	General fund £'000	Revaluation reserve £'000	Other reserves £'000	TOTAL reserves £'000
Balance at 01 April 2015	(24,002)	0	0	(24,002)
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0
Adjusted NHS Clinical Commissioning Group balance at 31 March 2016	**(24,002)**	**0**	**0**	**(24,002)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating costs for the financial year	(742,448)		(742,448)	
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(742,448)**	**0**	**0**	**(742,448)**
Net funding	739,220	0	0	739,220
Balance at 31 March 2016	(27,230)	0	0	(27,230)

The notes on pages 5 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		(824,149)	(742,448)
Depreciation and amortisation	5	0	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	9	2,622	(3,544)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	7,444	6,711
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	12	0	0
Increase/(decrease) in provisions	12	0	0
Net Cash Inflow (Outflow) from Operating Activities		**(814,083)**	**(739,281)**
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(148)	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**(148)**	**0**
Net Cash Inflow (Outflow) before Financing		**(814,231)**	**(739,281)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		814,312	739,220
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**814,312**	**739,220**
Net Increase (Decrease) in Cash & Cash Equivalents	**10**	**81**	**(61)**
Cash & Cash Equivalents at the Beginning of the Financial Year		60	121
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**141**	**60**

The notes on pages 5 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

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

If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

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

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

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

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.4.1 Critical Judgements in Applying Accounting Policies

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

- Operating lease commitments - Sheffield CCG has in substance a property lease arrangement with NHS Property Services Ltd relating to the headquarters site. As it has been determined that Sheffield 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.

1.4.2 Key Sources of Estimation Uncertainty

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

- Basis of estimation of key accruals - The CCG has included certain accruals within the financial statements which are estimates. The basis of the estimation of key accruals have been approved by the Director of Finance and reported to the Audit & Integrated Governance Committee. The key areas requiring estimation were healthcare contracts and prescribing expenditure.

1.5 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

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

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

1.6.2 Retirement Benefit Costs

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

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

1.7 Other Expenses

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

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

1.8 Property, Plant & Equipment

1.8.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.8.2 Valuation

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

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

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

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

1.8.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible Assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.
  Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;

- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.9.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, Amortisation & Impairments

Assets held for sale are not depreciated.

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

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non- current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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

1.11 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.

1.11.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.11.2 The Clinical Commissioning Group as Lessor

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

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

1.12 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.

1.13 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.70% (previously: minus 1.55%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (previously: minus 1.%)
- Timing of cash flows (over 10 years): Minus 0.80% (previously: minus 0.80%)

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

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

1.14 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.

1.15 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.

1.16 Continuing healthcare risk pooling

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

1.17 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.17.1 Financial Assets at Fair Value Through Profit and Loss

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

1.17.2 Held to Maturity Assets

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

1.17.3 Available For Sale Financial Assets

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

1.17.4 Loans & Receivables

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

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

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

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

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

and the carrying amount of the asset is reduced through a provision for impairment of receivables.

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

1.18 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.

1.18.1 Financial Guarantee Contract Liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.18.2 Financial Liabilities at Fair Value Through Profit and Loss

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

1.18.3 Other Financial Liabilities

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

1.19 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.

1.20 Foreign Currencies

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

1.21 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).

1.22 Joint Operations

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

1.23 Research & Development

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

1.24 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 £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Tota £'000
Recoveries in respect of employee benefits	344	300	44	365
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	46	36	10	120
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	327	299	28	376
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	2,375	655	1,720	841
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	2,828	506	2,322	6,576
Total other operating revenue	**5,920**	**1,796**	**4,124**	**8,278**

Admin revenue is revenue received that is not directly attributable to the provision of healthcare services.
Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the clinical commissioning group and credited to the general fund.

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

For 2015/16, revenue shown under 'Other revenue' includes £2.9m income received from Sheffield Teaching Hospitals NHS Foundation Trust, in their role as lead provider for Musculo Skeletal (MSK) Services to cover expenditure incurred by NHS Sheffield Clinical Commissioning Group for MSK services from specific providers; and £2.7m income received from SCC, the main elements of which related to the following: recharge of care costs for care where SCC have funding responsibility (£1.2m); the recharge of prescribing costs for the services that SCC commission (£1.1m); and the SCC contribution to the Community Equipment Service which was administered by NHS Sheffield Clinical Commissioning Group up to June 2015, after which point responsibility transferred to SCC (£0.2m). Of the remaining £0.9m, £0.5m relates to pharmaceutical rebate schemes.

3 Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Tota £'000
From rendering of services	5,920	1,796	4,124	8,278
From sale of goods	0	0	0	0
Total	**5,920**	**1,796**	**4,124**	**8,278**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

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

2015-16	Other £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	8,122	7,250	872
Social security costs	655	637	18
Employer Contributions to NHS Pension scheme	979	963	16
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	**9,756**	**8,850**	**906**
Less recoveries in respect of employee benefits (note 4.1.2)	(365)	(365)	0
Total - Net admin employee benefits including capitalised costs	**9,391**	**8,485**	**906**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**9,391**	**8,485**	**906**

4.1.2 Recoveries in respect of employee benefits

Employee Benefits - Revenue	Total £'000	2016-17 Permanent Employees £'000	Other £'000	2015-16 Tota £'000
Salaries and wages	(275)	(275)	0	(301)
Social security costs	(31)	(31)	0	(25)
Employer contributions to the NHS Pension Scheme	(38)	(38)	0	(39)
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	**(344)**	**(344)**	**0**	**(365)**

4.2 Average number of people employed

	Total Number	2016-17 Permanent Employees Number	Other Number	2015-16 Tota Number
Total	**246**	**235**	**11**	**162**
Of the above:				
Number of whole time equivalent people engaged on capital projects	0	0	0	0

4.3 Staff sickness absence and ill health retirements

	2016-17 Number	2015-16 Number
Total Days Lost	2,228	760
Total Staff Years	240	147
Average working Days Lost	9	5
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	1	24,859	1	24,859
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	2	222,908	0	0	2	222,908
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**2**	**222,908**	**1**	**24,859**	**3**	**247,767**

	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	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**

	2016-17 Compulsory redundancies		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	1	24,859	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	**1**	**24,859**	**0**	**0**

As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above. Whilst the number of packages in Table 4.4 above totals 3, the number of individuals with exit package was 2 (one individual received a contractual payment in lieu of notice, in addition to a compulsory redundancy payment)

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

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure. Where entities has agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables. The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

Past and present employees are covered by the provisions of the 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 £1,300,444 were payable to the NHS Pensions Scheme (2015-16: £987,678) were payable to the NHS Pension Scheme 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 2012.

5. Operating expenses

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Employee benefits excluding governing body members	12,915	8,561	4,354	8,947
Executive governing body members	678	678	0	809
Total gross employee benefits	**13,593**	**9,239**	**4,354**	**9,756**
Other costs				
Services from other CCGs and NHS England	689	361	328	3,003
Services from foundation trusts	522,807	10	522,797	505,700
Services from other NHS trusts	24,389	49	24,340	23,365
Services from other WGA bodies	2	0	2	0
Purchase of healthcare from non-NHS bodies	81,348	0	81,348	94,915
Chair and Non Executive Members	296	296	0	307
Supplies and services – clinical	0	0	0	0
Supplies and services – general	1,990	1,163	827	1,892
Consultancy services (1)	1,126	526	600	327
Establishment	1,032	729	303	530
Transport	27	22	5	26
Premises	2,460	610	1,850	2,204
Impairments and reversals of receivables	0	0	0	123
Inventories written down and consumed	0	0	0	0
Depreciation	0	0	0	0
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	86	86	0	86
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	96,568	0	96,568	96,787
Pharmaceutical services	429	0	429	410
General ophthalmic services	291	0	291	255
GPMS/APMS and PCTMS	81,254	0	81,254	7,572
Other professional fees excl. audit	365	95	270	231
Grants to Other bodies	0	0	0	345
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	49	51	(2)	131
Education and training	177	141	36	131
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
Funding to group bodies	0	0	0	
CHC Risk Pool contributions	1,028	0	1,028	2,569
Other expenditure	63	63	0	61
Total other costs	816,476	4,202	812,274	740,970
Total operating expenses	**830,069**	**13,441**	**816,628**	**750,726**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.
(1) Sheffield CCG spent £1.126m on consultancy services in 2016/17 but received income from other partner organisations such as Sheffield City Council, the 3 Sheffield Foundation Trusts and other local CCGs towards this totalling £506k. In addition, we received £85k income from NHS England relating to the STP work, leaving the net spend by Sheffield CCG at £535k. £685k of gross spend was in relation to developing both our Sheffield Placed Based Plan and the wider South Yorkshire and Bassetlaw Sustainability & Transformation Plan (STP). Sheffield CCG has played a leading role in this work and hence hosted certain areas of expenditure. A further £76k expenditure was incurred on behalf of Better Care Fund with Sheffield City Council. Income of £47k was received to contribute to this. £338k of gross spend was incurred solely by the CCG to support service transformation including developing out of hospital care and mental health services.

6.1 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	14,714	206,139	13,168	107,909
Total Non-NHS Trade Invoices paid within target	14,511	205,339	13,011	107,233
Percentage of Non-NHS Trade invoices paid within target	**98.62%**	**99.61%**	**98.81%**	**99.37%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,179	563,685	3,447	574,025
Total NHS Trade Invoices Paid within target	4,171	563,636	3,418	573,952
Percentage of NHS Trade Invoices paid within target	**99.81%**	**99.99%**	**99.16%**	**99.99%**

The Better Payment Practice Code requires the clinical commissioning group to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

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	2,235	18	2,253	0	559	6	565
Contingent rents	0	0	0	0	0	0	0	0
Sub-lease payments	0	0	0	0	0	0	0	0
Total	**0**	**2,235**	**18**	**2,253**	**0**	**559**	**6**	**565**

Whilst NHS Sheffield Clinical Commissioning Group has an arrangement with NHS Property Services Limited which falls within the definition of operating leases, rental charges for future years have not yet been agreed. Consequently this note does not include future minimum lease payments for the arrangement. The financial value included in the Statement of Comprehensive Net Expenditure for 2016-17 is £890k (2015-16 £259k). This figure has increased due to increased space for Sheffield CCG's Headquarters as a result of bringing services in house and void space and subsidies in other buildings which have previously not been defined as Operating Leases.

Clinical Commissioning Groups are required to pay for void space in Primary and Community Care building that predecessor organisations had responsibility for or commissioned services within. On 1st April 2016, NHS Sheffield Clinical Commissioning Group assumed delegated responsibility for primary care co-commissioning, which has increased the amount paid on void space and subsidies. This arrangement with Community Health Partnerships Limited falls within the definition of operating leases but rental charges for future years have not yet been agreed. Consequently this note does not include future minimum lease payments for the arrangement. The financial value included in the Statement of Comprehensive Net Expenditure for 2016-17 is £1,231k (2015-16 £nil). This increase is due to assuming delegated responsibility for primary care co-commissioning and void space and subsidies which have previously not been defined as Operating Leases.

NHS Sheffield Clinical Commissioning Group had entered into a financial arrangement involving the use of Walk In Centre premises with One Medicare Limited. This arrangement ceased in year. Whilst this arrangement fell within the definition of an operating lease, there was no formal contract in place. The financial value included in the Statement of Comprehensive Net Expenditure for 2016-17 is £114k (2015-16 £300k).

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	62	62	0	-	9	9
Between one and five years	0	0	39	39	0	-	9	9
After five years	0	0	0	0	0	-	-	0
Total	**0**	**0**	**101**	**101**	**0**	**0**	**18**	**18**

8 Property, plant and equipment

2016-17	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2016	0	0	0	0	0	0	0	205	205
Addition of assets under construction and payments on account	0	0	0	0	0	0	0	09	0
Additions purchased	0	0	0	0	0	0	175	0	175
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**175**	**205**	**380**
Depreciation 01 April 2016	0	0	0	0	0	0	0	205	205
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**205**	**205**
Net Book Value at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**175**	**0**	**175**
Purchased	0	0	0	0	0	0	175	0	175
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**175**	**0**	**175**
Asset financing:									
Owned	0	0	0	0	0	0	175	0	175
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**175**	**0**	**175**

Revaluation Reserve Balance for Property, Plant & Equipment	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2016	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
Balance at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

8.1 Cost or valuation of fully depreciated assets

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

	2016-17 £'000	2015-16 £'000
Land	0	0
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	0	0
Furniture & fittings	205	205
Total	**205**	**205**

8.2 Economic lives

	Minimum Life (years)	Maximum
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	5	5
Furniture & fittings	0	0

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	966	0	2,214	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	3,405	0	3,354	0
NHS accrued income	386	0	1,271	0
Non-NHS and Other WGA receivables: Revenue	1,355	0	487	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	121	0	77	0
Non-NHS and Other WGA accrued income	1,256	0	2,930	0
Provision for the impairment of receivables	0	0	(123)	0
VAT	90	0	36	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	53	0	8	0
Total Trade & other receivables	**7,632**	**0**	**10,254**	**0**
Total current and non current	**7,632**		**10,254**	
Included above:				
Prepaid pensions contributions	0		0	

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

9.1 Receivables past their due date but not impaired

	2016-17 £'000	2015-16 £'000
By up to three months	586	1,643
By three to six months	31	871
By more than six months	1	0
Total	**618**	**2,514**

£3k of the amount above has subsequently been recovered post the statement of financial position date.
NHS Sheffield Clinical Commissioning Group did not hold any collateral against receivables outstanding as at 31 March 2017.

9.2 Provision for impairment of receivables

	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	(123)	0
Amounts written off during the year	0	0
Amounts recovered during the year	123	0
(Increase) decrease in receivables impaired	0	(123)
Transfer (to) from other public sector body	0	0
Balance at 31 March 2017	**0**	**(123)**

	2016-17 %	2015-16 %
Receivables are provided against at the following rates:		
NHS debt	0%	0%
Debt with a payment plan in place that is being adhered to	0%	0%
All other non-NHS debt between 1-90 days overdue	0%	10%
All other non-NHS debt between 91-120 days overdue	0%	50%
All other non-NHS debt over 121 days overdue	0%	50%

10 Cash and cash equivalents

	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	60	121
Net change in year	81	(61)
Balance at 31 March 2017	**141**	**60**
Made up of:		
Cash with the Government Banking Service	141	60
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**141**	**60**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	0	0
Balance at 31 March 2017	**141**	**60**
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
Interest payable	0	0	0	0
NHS payables: revenue	2,571	0	2,354	0
NHS payables: capital	0	0	0	0
NHS accruals	8,550	0	4,893	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	4,107	0	4,094	0
Non-NHS and Other WGA payables: Capital	27	0	0	0
Non-NHS and Other WGA accruals	28,512	0	25,658	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	149	0	118	0
VAT	0	0	0	0
Tax	118	0	119	0
Payments received on account	0	0	0	0
Other payables and accruals	981	0	308	0
Total Trade & Other Payables	**45,015**	**0**	**37,544**	**0**
Total current and non-current	**45,015**		**37,544**	

Non-NHS and Other WGA accruals includes £16.3m Prescribing accrual, £5.6m in relation to Primary Care, £4.9m Continuing Healthcare accruals and £1m in relation to Non-NHS contracts (31 March 2016: £16.1m Prescribing accrual and £6m relating to Continuing Healthcare and £1.3m Non-NHS contract accruals).

Other payables include £194k outstanding pension contributions at 31 March 2017 (31 March 2016: £187k).

12 Provisions

NHS Sheffield Clinical Commissioning Group had no provisions as at 31 March 2017 (as at 31 March 2016 nil).

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the NHS Sheffield Clinical Commissioning Group. The value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2017 is £668k (31 March 2016: £2,516k).

13 Commitments

13.1 Other financial commitments

The NHS Sheffield Clinical Commissioning Group has entered into a non-cancellable contract (which is not a lease, private finance initiative contract or other service concession arrangement) with eMBED Health Consortium to provide IT support and Business Intelligence services. The payments to which the clinical commissioning group are committed are as follows:-

	2016-17 £'000	2015-16 £'000
In not more than one year	1,253	1,424
In more than one year but not more than five years	2,414	3,666
In more than five years	0	0
Total	**3,667**	**5,090**

14 Financial instruments

14.1 Financial risk management

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

As NHS Sheffield Clinical Commissioning Group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Sheffield Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Sheffield Clinical Commissioning Group and internal auditors.

14.1.1 Currency risk

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

14.1.2 Interest rate risk

The NHS Sheffield Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

14.1.3 Credit risk

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

14.1.3 Liquidity risk

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

14.2 Financial assets

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Available for Sale 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,352	0	0
· Non-NHS	0	2,611	0	2,611
Cash at bank and in hand	0	141	0	141
Other financial assets	0	53	0	53
Total at 31 March 2017	**0**	**4,157**	**0**	**4,157**

	At 'fair value through profit and loss' 2015-16 £'000	Loans and Receivables 2015-16 £'000	Available for Sale 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0	0
Receivables:	0	0	0	0
· NHS	0	3,485	0	0
· Non-NHS	0	3,417	0	3,417
Cash at bank and in hand	0	60	0	60
Other financial assets	0	8	0	8
Total at 31 March 2017	**0**	**6,970**	**0**	**6,970**

14.3 Financial liabilities

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	11,122	11,122
· Non-NHS	0	33,626	33,626
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**44,748**	**44,748**

	At 'fair value through profit and loss' 2015-16 £'000	Other 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	7,247	7,247
· Non-NHS	0	30,060	30,060
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**37,307**	**37,307**

15 Operating segments

NHS Sheffield Clinical Commissioning Group considers that there is only one operating segment: Commissioning of Healthcare Services.

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	830,069	(5,920)	824,149	7,948	(45,015)	(37,067)

During the year NHS Sheffield Clinical Commissioning Group paid £393,677k, approx. 48% of total expenditure, (2015-16: £376,499k approx. 50%) to Sheffield Teaching Hospitals NHS Foundation Trust for the purchase of healthcare and other services provided.

During the year NHS Sheffield Clinical Commissioning Group paid £82,232k, approx. 10% of total expenditure (2015-16: £80,478k approx. 11%) to Sheffield Health and Social Care NHS Foundation Trust for the purchase of healthcare and other services provided.

16 Pooled budgets

Section 75 of the National Health Services Act 2006 allows partnership arrangements between NHS bodies, Local Authorities and other agencies in order to improve and co-ordinate services. Generally each partner makes a contribution to a pooled budget, with the aim of focussing services and activities for a client group. Funds contributed are those normally used for the services represented in the pooled budget and allow the organisations involved to act in a more cohesive way.

NHS Sheffield Clinical Commissioning Group and Sheffield City Council entered into a Section 75 agreement covering the Better Care Fund with effect from 1st April 2015. This pool is hosted by Sheffield City Council. The Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems. The Sheffield Better Care Fund pool was constructed around six themes focussed around the different areas of integration.

The following table summarises the contributions made by Sheffield City Council and the NHS Sheffield Clinical Commissioning Group into pooled budget

	2016/17 NHS Sheffield CCG £'000	2016/17 Sheffield City Council £'000	2016/17 Total £'000	2015/16 NHS Sheffield CCG £'000	2015/16 Sheffield City Council £'000	2015/16 Total £'000
The Better Care Fund	175,008	113,806	288,814	180,478	102,065	282,543
	175,008	**113,806**	**288,814**	**180,478**	**102,065**	**282,543**

The CCG net contribution to the Better Care Fund for 2016/17 shown above is included within the expenditure recorded in note 5 to these accounts (Services from foundation trusts £105,792k; Purchase of healthcare from non-NHS bodies £68,190k; GPMS/APMS and PCTMS £1,099k; Services from other CCGs and NHS England £45k) and within the revenue recorded in note 2 to these accounts (-£118k Other Revenue).

The memorandum account for the pooled budget is:

	2016-17 £'000	2015-16 £'000
The Better Care Fund	2016/17	2015/16
Income	£'000	£'000
NHS Sheffield Clinical Commissioning Group	175,008	180,478
Sheffield City Council	113,806	102,065
	288,814	**282,543**
Allocation of expenditure		
Theme 1 - People Keeping Well in their Local Community	(8,122)	(8,454)
Theme 2 - Active Support and Recovery	(52,161)	(53,358)
Theme 3 - Independent Living Solutions	(4,394)	(4,380)
Theme 4 - Ongoing Care	(162,315)	(154,438)
Theme 5 - Adult inpatient Medical Emergency Admissions	(59,230)	(59,385)
Theme 6 - Capital Grants	(2,592)	(2,528)
	(288,814)	**(282,543)**

17 Related party transactions

Details of related party transactions with individuals are as follows:

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

The values shown for related party transactions are for the full financial year including when the relevant individual has a part year interest in the organisation.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

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

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

Prior Year Comparator 2015-16

Name & Role of Individual	Related Parties for which transactions made & Role of Individual	Purpose of Payment/Receipt	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
A Afzal, Locality Appointed GP	Duke Medical Centre - Senior Partner	Practice Payments	83	0	17	0
N Anumba, Locality Appointed GP	Woodhouse Health Centre - GP Partner Woodhouse Healthcare Services Ltd - Director	Practice Payments Contract Payments	213 9	0 0	47 0	0 0
N Bates, GP Elected Member	Porterbrook Medical Centre - GP Partner Rivelin Healthcare Ltd - Minority Stakeholder	Practice Payments Contract Payments	182 63	(1) 0	57 5	0 0
M Gamsu, Lay Member	Darnall Wellbeing - Committee Member Voluntary Action Sheffield - Trustee Citizens Advice - Trustee	Rent of Building Contract Payments Contract Payments	0 32 238	0 0 0	50 1 0	0 0 0
A Gill, GP Elected Member	Selborne Road Medical Centre - GP Principal NHS Sheffield CCG - GP Elected Member	Practice Payments Overpayment of salary	16 0	0 0	11 0	0 (8)
Z McMurray, Medical Director	Woodhouse Healthcare Services Ltd - Shareholder	Contract Payments	9	0	0	0
T Moorhead, Chair of the Governing Body	Oughtibridge Surgery - Senior Partner Rivelin Healthcare Ltd - Minority Stakeholder	Practice Payments Contract Payments	298 63	0 0	20 5	0 0
M Sloan, GP Elected Member	Sloan Medical Centre - GP Principal	Practice Payments	127	0	34	0
L Sorsbie, Locality Appointed GP	Firth Park Surgery - GP Partner	Practice Payments	95	0	28	0
T Turner, GP Elected Member	Shiregreen Medical Centre - GP Partner & Principal	Practice Payments	85	0	24	0

18 Losses and special payments

18.1 Losses

	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 Number	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 Number
Administrative write-offs	0	0	2	123
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**	**2**	**123**

18.2 Special payments

	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 Number	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 Number
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	2	21	0	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**2**	**21**	**0**	**0**

19 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended). NHS Clinical Commissioning Group performance against those duties was as follows:

	2016-17 Target £'000	2016-17 Performance £'000	2015-16 Target £'000	2015-16 Performance £'000
Expenditure not to exceed income	841,694	830,069	758,216	750,726
Capital resource use does not exceed the amount specified in Directions	175	175	0	0
Revenue resource use does not exceed the amount specified in Directions	835,774	824,149	749,938	742,448
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	12,682	11,645	14,119	10,697