NHS
Rotherham
Clinical Commissioning Group

ANNUAL REPORT

2014|2015

NHS Rotherham CCG (03L)

Foreword

Welcome to our second annual report for the period 1 April 2014 to 31 March 2015. After being fully authorised, with no conditions under the Health and Social Care Act 2012, we have addressed the many challenges facing the NHS and made significant progress in improving the local health services for Rotherham people.

We are an innovative, forward-thinking organisation that are leading in many areas of clinical commissioning nationally. We do the basics well and are not afraid to think differently or take risks. We have made some notable achievements, which reached a pinnacle in June 2014 when we were delighted to become the first NHS clinical commissioning group in the country to achieve the investors in Excellence (IiE) Standard – a prestigious international mark of excellence awarded to organisations that demonstrate high standard of all-round business performance during a rigorous external assessment process.

Rotherham has been in the news this year for problems relating to Child Sexual Exploitation, which has resulted in changes within the local authority. Despite this period of turmoil we have continued to work closely with other healthcare commissioners, our providers and the local authority to ensure the people of Rotherham have continued to receive high quality care in what has been a difficult time for Rotherham.

We, along with our healthcare providers, have made it a top priority to ensure that victims have post abuse support services they need. In early 2014, we recognised a need to enhance health support services for victims and have invested in improving access throughout the last year. In addition, since the Alexis Jay report was published in August we have spent a lot of time increasing awareness of Child Sexual Exploitation (CSE), identifying potential victims of abuse and ensuring the appropriate support services they need are available when they need them.

We are delighted to announce that we have met our statutory financial obligations. This has been made possible through the commitment and hard work of our staff and health providers, an exceptional achievement particularly when set against the challenging economic climate we are currently facing.

The dedication our staff and GP members have to improving services gives us a strong foundation to build on. We have a strong clinical leadership at the heart of our organisation and within the locality membership model, which allows us to make the best possible decisions for healthcare services in the borough. We have a well-developed engagement process with all our GP members. Our GP leads work effectively alongside officers, with a significant level of trust from colleagues.

We would like to thank all of the individuals and organisations who have taken part in our consultation and engagement activities over the past year, and shared their experiences of using local services. Their contributions have helped to inform our commissioning decisions, ensuring your local NHS continues to provide quality and responsive services. In this report we to tell you about some of the consultations that have happened over the last year, what people told us in those consultations and what we have done with the comments you made.

We are still a new organisation but we believe we have good progress in what is our second year as a statutory body. How we have performed and stories from the year are detailed later in this report, however our main achievements for 2014/15 are highlighted below.

Achievements in 2014/15

Clinical leadership - We are run by our clinical executive, with well-developed locality and membership inputs and with strong links with clinicians in our provider organisations. Programme of clinically led primary and secondary care quality visits and joint clinical education sessions for primary and secondary care clinicians.

Quality and Efficiency programmes - Signed off the business case for the Emergency Care centre that will open in 2017, achieved the first year of the Community Transformation Programme and begun the implementation of a comprehensive Mental Health Transformation plan.

Sustaining community investment - Successful evaluation of our £5 million investments in additional services in the community including case management of 8,000 people at most risk of hospital admission. Substantially developed provision by the voluntary sector including national recognition of the award-winning Rotherham model for social prescribing.

Innovation - care co-ordination centre, multi-award winning medicines management projects improving dietetics and stoma care, virtual clinics for haematology and prostate specific antigen results. Developed top tips for primary and secondary care clinicians.

CCG and staff development - Clinical executive received 100% vote of confidence from membership, We were the first CCG in the country to receive Investors in Excellence, in the top six CCGs nationally in the Health Service Journal Awards. All our staff have twice yearly personal development reviews. One of the highest response rates to the national staff survey and with 98% positive feedback on; staff opportunities to show initiative, support from line managers and senior management commitment to patient care.

Moving forward we have developed a plan for the next two years and a five year strategic vision. Plans and services of all commissioners and health and social service providers in Rotherham are prioritised by needs identified in our Joint Strategic Needs Assessment and the six Rotherham Health and Wellbeing strategic outcomes.

All local health and social care organisations will address collectively Rotherham's efficiency challenges, being mindful of the overall sustainability of health and social services and the impact of organisations on each other. Our five year commissioning plan along those of NHS England, Rotherham Metropolitan Borough Council (RMBC) and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) will all be aligned to maximise the use of the Rotherham public sector pound.

From 1st April 2015, we will take on responsibility for the commissioning of primary care services (currently only GP services). We have worked hard over the closing months of this year to ensure we have robust governance arrangements in place to take on this

responsibility, which includes how we will approach dealing with conflicts of interest. This provides us with an exciting opportunity provide resilient, fit-for-purpose health services for local people, whilst maximising the Rotherham health pound.

We look forward, with anticipation, to another challenging but productive year for the NHS in Rotherham, focussing on what matters most to us – high quality healthcare for our patients.

Thank for your taking the time to read our annual report, which reviews of our second year.

Dr Julie Kitlowski, Chair

Chris Edwards, Accountable Officer

Strategic Report

This annual report and accounts have been prepared under a direction issued by the NHS Commissioning Board (NHS England) under the National Health Service Act 2006.

Throughout the year, we have demonstrated a clear commitment to being open and transparent by conducting our business in the public domain by holding our Governing Body monthly meetings in public.

About Us

We are the custodian of Rotherham's multi-million pound NHS budget, operating in 2014/15 with a resource allocation of £347 million from NHS England. We are a clinically-led group responsible for making sure that the people of Rotherham have the healthcare services they need at the right time. We identify, plan, buy and manage health services (commission), making sure they are of high quality and perform well.

The CCG is a membership organisation, the 36 practices in Rotherham are our members, and there are eight localities. Our main decision making body is the Governing Body. We access additional expert advice we may require through Rotherham's Public Health service and the Chair of Rotherham's Health and Wellbeing Board who are in attendance at our Governing Body public meetings.

Our mission is **'Working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities'.**

Our values are in everything we do, we believe in:

- Clinical leadership
- Putting people first, ensuring that patient and public views impact on the decisions we make
- Working in partnership
- Continuously improving quality of care whilst ensuring value for money
- Showing compassion, respect and dignity
- Listening and learning
- Taking responsibility and being accountable

We are one of three health commissioners contributing to Rotherham's overall Health and Wellbeing Strategy (H&WBS). We are responsible for commissioning community health services, mental health services and end of life care, hospital health services, health aspects of social and continuing care, GP prescribing and GP out of hours services for Rotherham. Public health services are commissioned by Rotherham Public Health (part of Rotherham Council) and primary care services (GPs, pharmacists, optometrists and dentists) are commissioned by the NHS England (South Yorkshire and Bassetlaw).

Our relationships

We work with individual practice patient user groups and have jointly developed with them our CCG patient network. We also work closely with Healthwatch, where they helped us with public consultation on our commissioning plan and the planning joint public events in year. We are also an active member of the Rotherham Health and Wellbeing Board and the Rotherham Local Strategic Partnership.

We are accountable to NHS England for delivery of agreed outcomes, aimed at improving the health of Rotherham people. In addition we work in partnership with NHS England in areas where both our responsibilities overlap, such as the interface between primary care commissioning (NHS England), hospital and community service commissioning (CCG) and specialist commissioning (NHS England).

Throughout the year we have worked Rotherham Council (RMBC) to ensure that we deliver our Commissioning Plan in line with the Rotherham Health and Wellbeing Strategy. We have also worked with the Council to ensure that Rotherham's health and social care system uses resources efficiently and delivers high quality, seamless services for Rotherham patients. The important new development of the Better Care Fund (BCF) has been a key joint project over the last year. The BCF is a Government initiative to create a single joint budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services. The fund does not in itself create any new money but bringing existing budgets under joint commissioning responsibility is expected to lead to better outcomes for patients.

We maintained strong relationships with other CCGs including meetings between Chairs and Chief Officers to share best practice and to jointly commission services where appropriate. Working with our local CCG partners, we have agreed a significant commissioner led programme of work to review and redesign a number of services across a wider geographic footprint. This programme, known as 'Working Together', is working to improve services and increase the effectiveness of every pound we spend on healthcare. This is a major commitment to partnership working that will help to deliver necessary changes set out in the Five Year Forward View by Simon Stevens.

Workforce – Our Employees

We recognise our staff as our biggest asset and work in partnership with them to develop our organisation. We were delighted with their response to the recent NHS annual staff survey, which shows we have developed from our first year. The response rate was 97% (up 4% from last year) compared to the national average for CCGs of 78%. This fantastic response allows us to understand our employees' perception and satisfaction levels, which again were favourable when compared with the national average.

We have a dedicated and adaptable workforce, with the capacity and capability to deliver our objectives. We are proud to be compliant with all mandatory and statutory training, scoring within the top CCGs in the country for completion.

We have a monthly 'all staff' meeting which all staff, managers, senior managers and directors attend to discuss issues and receive feedback particularly about transition arrangements.

We recognise that the importance of effective staff communication and involvement is especially crucial for the development of our organisation. The arrangements described above, along with our staff intranet, help to keep staff informed about developments, organisational policies. Our Human Resource function has been, and continues to be provided the NHS Yorkshire and Humber Commissioning Support, who help us to manage all relevant activity related to our workforce.

Equal Opportunities

We are committed to ensuring equal opportunities in employment and have appropriate policies in place to provide guidance, including in specific areas such as Maternity Leave and Retirement, and via our Equality Strategy and Single Equality Scheme which covers six equality strands

Gender Distribution Data

As at 31/03/2015	Female	Male
Governing Body	3	8
Very Senior Managers	1	2
Operational Executive (Directors equivalent)	4	3
All Employees	51	25

Positive About Disabled People

All job applicants who meet the minimum criteria for a post are shortlisted for interview in accordance with our commitment to the disability symbol.

Progress on our Performance Targets

We have worked hard, with our members, partners and providers, towards achieving all of our key targets. We measure our commissioning plan, encompassing our performance outcome indicators, based on improving health, reducing health inequalities and we have national targets that we must adhere to.

We have a quarterly performance assurance review against a set of six domains, undertaken by NHS England (South Yorkshire and Bassetlaw). These domains are:

Domain 1 – Are patients receiving clinically commissioned, high quality services?
Domain 2 – Are patients and the public actively engaged and involved?
Domain 3 – Are CCG plans delivering better outcomes for patients?
Domain 4 – Does the CCG have robust governance arrangements?
Domain 5 – Are CCGs working in partnership with others?
Domain 6 – Does the CCG have strong and robust leadership?

There have been a number of performance issues in 2014/15 including in areas that Rotherham has previously had strong performance.

Over performance on non-elective and elective admissions

There are challenging trajectories to keep hospital activity within affordable trajectories. Our successful Clinical Referrals initiatives kept hospital new appointments below trajectory but there were more elective admissions and substantially more emergency admissions in 14/15 than are affordable in the long term. The long-term plan to keep to affordable trajectories are the Community Transformation, Emergency Centre and Clinical Referrals initiatives. We will implement some clinical restrictions to services in early 2015/16 to keep activity at affordable levels until the longer term projects start to have traction.

A&E

Rotherham did not meet the 95% performance target with year-end performance around 93.5%. The Rotherham NHS Foundation Trust (TRFT) benchmarks around midway of Acute Trusts in England for this measure. Our long-term response to rising demand for Accident and Emergency Services is the Emergency Centre and Community Transformation projects. The Emergency Centre will open in Spring 2017 so there are a range of short and medium term initiatives to manage appropriate conditions outside hospital and to improve flow through the hospital. These initiatives are managed through the Rotherham System Resilience Group (SRG) which is attended by all partners.

C Difficile

Both Rotherham as a health community and TRFT will narrowly miss the national C Difficile outcome targets. After years of strong performance, Rotherham's position is now around the national average. A full root cause analysis is done on every case and learning from these reviews is implemented across the health community.

52 week waits

TRFT had a number of patients who waited more than 52 weeks for treatment in 2014/15. This was due to lack of oversight of list of 14,000 patients who were felt to be inactive. Review of the first 13,000 of these patients found seven patients who had waited more than 52 weeks. All the case records will be investigated, the patients seen and then there will be a look back exercise to understand how this came about and if there are any implications for other waits.

Yorkshire Ambulance Service (YAS)

YAS has not met the national targets for urgent ambulance waiting times at both a Yorkshire and Humber and Rotherham level. YAS performance for Rotherham patients is closely linked to activity carried out over a wider footprint for example diverts and delays to Trusts across Yorkshire and Humber. YAS performance is managed by Sheffield and Wakefield CCGs on Rotherham's behalf and all 23 CCGs have worked with the Good Governance Institute to improve overall performance. Overall performance management of this contract is by Sheffield and Wakefield CCGs who are

continuing to have discussions with YAS in the context of the Good Governance Institute review. YAS attend the SRG where local performance issues are discussed.

Commissioning plan performance

A review of performance against our commissioning plan for 2014/15 took place in July 2014, October 2015 and April 2015, and reported to Governing Body each time. The year-end position showed that 66% of the commissioning plan activity was on track or complete. Each of the ten commissioning areas are detailed within our commissioning plan.

Stories from the year

This year we have experienced a number of challenges, highlighted in the performance section, as well as successes. Some of the highlights of our year are described below:

Increase in activity

In 2014/15 both non elective and elective hospital activity have grown faster than is affordable. Our plans are to address this in the long term but it is likely that we will have to take some short term actions to keep costs under control in 2015/16 while our longer term plans deliver.

Safeguarding our vulnerable clients

We remain dedicated to making safeguarding vulnerable clients everyone's business they remain committed to proactively developing their safeguarding commissioning responsibilities. We are an active partner in preventing and protecting the public from abuse or neglect; in recognition of this safeguarding is one of our four priority areas in our Commissioning Plan.

We regard safeguarding as a primary responsibility of all agencies we commission, with comprehensive safeguarding standards expectations included within all in contracts. In order to safeguard effectively there is a need for more than just robust contract arrangements, there is a need to link to other initiatives such a performance monitoring, peer challenge and as part of a network of measures aimed at enabling all citizens to live lives that are free from violence, harassment, humiliation and degradation. Therefore, we work as a proactive partner fully committed to ensuring that lessons are learnt from inspections, reviews and reports both local and national.

These reviews include partner reports such as the recent Ofsted Inspection into the council and the Children Looked After and Safeguarding Review of the 'health economy' undertaken in February 2015 by the Care Quality Commission (CQC). Our Accountable Officer and Chief Nurse are partners on the Rotherham Improvement Board.

Identified within the Ofsted Inspection into Rotherham's safeguarding commitment was the need for a Multi-Agency Safeguarding Hub (MASH). All areas of the country had previously been tasked by central government to set up a MASH and a variety of models had been established. Unfortunately, the MASH in Rotherham was not functioning in a productive manner. Having an effective MASH was proving a practical

challenge for health providers namely TRFT, RDaSH and Care UK; due in part to a lack of clarity around the local model of service delivery being proposed.

The principles of a MASH are to act as the first point of contact, receiving safeguarding concerns or enquiries and collating information from different agencies to build up a holistic picture of the circumstances of a case. This is regarded as the most effective and efficient approach to safeguarding. In practice this requires a person in post who has the capacity, knowledge, skills and competence to share agency specific sensitive and complex information. The post holder need to be of sufficient seniority to challenge both health and other agencies practice and be able to articulate with authority their agencies roles and responsibility. Therefore, in January 2015 we seconded two senior posts - one clinical and one project lead - to undertake a comprehensive review for one year reporting on the most effective model of service delivery for Rotherham health economy to adapt.

2014 saw the production of a safeguarding self-assessment template for use in GP practices. The self-assessment was part of a package of safeguarding templates provided to independent practices to raise awareness and develop their safeguarding competencies. In addition to the self-assessment GP practices were offered the opportunity to work with the CCG, Rotherham Local safeguarding Children Board and Rotherham Safeguarding Adult Board in a 'Supportive Peer Challenge'. The self-assessment template incorporated the CQC Essential Standard Outcome 7 (Safeguarding) and Section 11 of The Children's Act - 83.33% practices completed the challenge.

The Care Act 2014 came into force on the 1st April 2015 and is the most significant reform of care in 60 years. The Act is to deliver the key elements following on from the Governments response to the Francis inquiry from the events at The Mid Staffordshire hospital. A core concept to the Act is a focus on wellbeing and for the purpose of Safeguarding it is for Making Safeguarding Personal – "no decision about me without me" and is focused on the individual, their families and carers working together with agencies for outcomes.

The Act now has a number of statutory roles that include:

- Safeguarding Adult boards – and must have the 3 key partners of Local Authorities, Police and Health
- Serious case reviews to be mandatory

The Act now also includes three new categories for abuse – Domestic Abuse, Self-neglect and Modern Slavery.

We have been and remain a key member of Rotherham Adults Safeguarding Board and are committed to working as multi-agency in order to safeguard the individuals of Rotherham.

The Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards are fundamental safeguards for Human Rights. The MCA is there to protect and empower those who lack the mental capacity to make decisions for them sells.

March 2014 saw the House of Lords Select Committee (HoLSC) complete their report following a 10 month post-legislative scrutiny of the Mental Capacity Act 2005. It

concluded that whilst the MCA was a “visionary piece of legislation”, the Act had “suffered from a lack of awareness and a lack of understanding”. These were highlighted significantly with the implementation across all sectors of health and social care. Following on from this we have with the financial support of NHS England asked providers TRFT and RDaSH to complete self-assessments on how well MCA/DoLS are embedded within their service.

Deprivation of Liberty Safeguards (DoLS) and Deprivation of Liberty (DoL)

The Supreme Court on the 19th March 2014 passed judgment on two cases: - “P v Cheshire West and Chester Council” and “P and Q v Surrey County Council”. This judgment was to determine if arrangements made for care of an individual lacking capacity to consent to those arrangements would constitute to be a deprivation of liberty.
It was clarified by the Supreme Court that there is a deprivation of liberties for the purpose of Article 5 of The Human Rights Act if the following apply:

- “The person is under continuous supervision and control and is not free to leave, and
- the person lacks capacity to consent to these arrangements” commonly known as ‘The Acid Test’.

Since the Supreme Court's judgments there has been a focus on applying the 'Acid Test' to individuals that are potentially subject to Deprivation of Liberty Safeguards (DoLS) such as those who are in hospital or 24 hour care such as residential or nursing home patients. This has resulted in a significant increase in referrals to The Court of Protection (CoP). However, the regional consensus is that individuals who are in their own home and meet the acid test should be considered for a Deprivation of Liberties (DoL). We are fully aware of their responsibilities for health’s commissioned individuals and are working towards ensuring that all individuals where appropriate remain lawful.

In February 2014, the Counter Terrorism and Security Act came into force. The Act is required due to the considerable threat of terrorism to the UK and it will ensure that the law enforcement and intelligence agencies have the power needed to keep the UK safe. The Prevent Agenda is part of the Act and it is been rolled out to health care professionals due to skills that they possess in relation to identifying vulnerable individuals who may be at risk of been radicalised. We are addressing this internally for all staff and have nearly completed the training workshop to all GP practices within Rotherham.

Child Sexual Exploitation (CSE)

The Alexis Jay report was published in August 2014; this was an Independent Inquiry into Child Sexual Exploitation in Rotherham 1997 - 2013. We, like all other partners, were shocked by the extent of the exploitation and is been working with partners to produce and manage a comprehensive local action plan.

This action plan includes Recommendation nine (Jay 2014) which specifically highlights the need for all services to recognise that once a child has been affected by CSE they are likely to require support and therapeutic intervention for an extended period of time. This may necessitate the commissioning of additional support for victims; as part of that multiagency response we are working with public health to estimate what those on-

going support and therapeutic needs may require in order to ensure that victim support and effective services are commissioned.

Our work to improve health services for victims of CSE includes:

Support for Victims – Increasing access to services

We have worked closely with RDaSH, to improve Child and Adolescent Mental Health Services (CAMHS), providing additional capacity for CSE cases and increasing opportunities for victims to access help. The capacity of our talking therapy services for children and adults has also increased, concentrating on supporting new and existing CSE victims.

We are committed to supporting the Multi-Agency Safeguarding Hub by providing a senior nurse and an experienced health support worker to work alongside our partners to ensure robust input for health into the Hub.

Also, we have provided money to the Women's Counselling service to allow them to increase their capacity to support victims. In addition to £20,000 funding this year, we have agreed to provide the same amount each year for the next three years to provide support to women who are victims of sexual and domestic abuse. These may be victims referred by the Sexual Abuse Referral Centre (SARC).

Training for frontline staff

People's first contact with health in Rotherham is normally their local GP, therefore a priority has been to train over 500 GP practice staff in recognising signs of sexual exploitation. Over 750 health and social care staff, including GPs, from Rotherham have also attended a CSE *"awareness and training for health staff on understanding victim behaviours"* conference, organised by the CCG, which including nationally recognised speakers in sexual exploitation. A pocket guide, providing advice to health and social care professionals on CSE was launched at the conference, with every attendee receiving their own copy.

Governing Body Assurance

We have also ensured that frontline staff in Rotherham services in the community and in the hospital have received appropriate training in CSE awareness, spotting the signs of CSE and safeguarding. Our Governing Body members are assured that TRFT, CCG, RDaSH and GP practices have undertaken 'Stop the Shift' CSE sessions with frontline staff to raise awareness of CSE. Additionally, TRFT has provided training to 36 senior managers from the CSE Specialist Nurse and Safeguarding team. At RDaSH, all staff have received level 1 awareness training after the Named Nurses developed a bulletin in relation to CSE.

The Governing Body have also considered the actions required from the Casey Report and the CQC inspection into Looked After Children and Safeguarding. Actions from these discussions are being progressed with the relevant provider to make sure our patients continue to get high quality health services in Rotherham.

Care Quality Commission (CQC) - Review of Services for Children Looked After and Safeguarding (CLAS)

In February 2015, the CQC visited Rotherham to undertake a CCG led review of services for Children Looked After and Safeguarding. A week-long visit included meetings with healthcare providers including; hospital services, sexual health services and mental health services.

Feedback was provided at a well-attended multi-agency, multi-disciplinary meeting hosted by the CCG on Friday 27th February. The feedback regarding safeguarding children leadership and drive to improve standards and develop services was positive. A number of areas for further consideration were suggested with the CQC inspectors providing information on areas nationally that additional support could be sought. For example Oxford has undertaken some work on providing health information to Care Leavers in the form of a health passport. This advice has been acted upon and Care Leavers in Rotherham will now have access to this resource. In addition RCCG in partnership with public health are in the process of commissioning bespoke CSE training for all Rotherham students as part health services commitment to the prevention of CSE. RDaSH are undertaking an appreciative inquiry on safeguarding cases in order to learn lessons and move practice forward based on the CQC inspectors suggestion that NHS Birmingham CCG had a template that supported practice.

The CQC will publish the report on their findings in Rotherham in due course and commissioners and providers within the health economy produce an action plan to ensure that all recommendations are considered and taken forward.

Innovative Emergency Centre gets Green Light

A ground-breaking first-of-its-kind Emergency Centre is set to provide Rotherham patients with responsive and high quality services, under one roof when they need emergency or urgent NHS care after plans were given the go ahead.

Staffed by highly skilled and trained nurses and doctors experienced in assessing and treating patients' needs, will provide the right care, first time in a new centre that will open 24 hours a day, 7 days a week. 365 days a year on the Rotherham hospital site.

This is a new innovative way of working, with the Emergency Centre bringing together the skills of primary care with the skills of A&E clinicians in a modern facility to give patients one place to go to if you have an emergency or urgent care need.

Shortlisted for CCG of the year in HSJ awards

The CCG were delighted to be shortlisted as a finalist for the 2014 CCG of the year in the HSJ Awards. Following an extensive assessment process we were pleased to be recognised by the judging panel for *"really impressive delivery of the basics; a track record of delivering innovation at scale and a commitment to building".*

Improving outcomes for people experiencing mental health crisis in Rotherham

The development of a Mental Health Crisis Care Concordat by the CCG and our public sector partners will mean that people in Rotherham who are in a crisis due to a mental health condition are set to get better, high quality care when they urgently need help.

The Concordat aims to ensure the urgent needs of vulnerable people in a mental health crisis are met. In committing to the Concordat, organisations across Rotherham promise that people, and those close to them, will get:

- access to support before crisis point
- urgent and emergency access to crisis care
- the right quality of treatment and care in a crisis
- help to recover and stay well, preventing a future crisis.

The Mental Health Crisis Concordat action plan for Rotherham can be viewed in full at www.crisiscareconcordat.org.uk/

Working Together for a Healthier Rotherham

We facilitated a conference and workshops on behalf of the Health and Wellbeing Board, which demonstrated how partnership work is contributing to the health agenda, sharing aspirations and challenges with the public, and encouraging additional involvement and feedback. The event was attended by 150 people from a wide range of organisations, including young and old people; staff and community organisations, and patient representatives.

The keynote presentation was from the nationally acclaimed health commentator, Roy Lilley, who based his talk on the nine things that 'keep him awake at night, and was described by a member of the audience as 'inspiring'; encouraging people to think very differently about the issues facing health services in the future. This was followed by a series of updates from our local health organisations, focusing on celebrations, challenges and how we can work together, and a 'question time' style panel. All questions from the day, together with responses are on our website, with presentations and an event summary. From the evaluations and informal feedback received, people enjoyed the event, rating it very highly, and felt they had learnt a lot about the work that is ongoing, and the challenges – this was the primary aim of the day.

Voluntary Sector and Social Prescribing

The NHS Five Year Forward View published in October 2014, quoted the Rotherham Social prescribing service as an 'emerging model for the future'. We have an excellent relationship with the Voluntary Sector. We recognised two years ago that 'doing the same' was not an option and wanted to find a different innovative way to commission services for people with long-term conditions who were at risk of hospital admissions.

There are over 1,600 voluntary and community groups in Rotherham all of whom were keen to work with us. Together we came up with the Rotherham model of social prescribing.

An annual investment of £547,000 into the third sector has funded the infrastructure and commissioned extra services across the sector. There are five voluntary sector

health advisers who link to all GP practices and are equal partners around the table when discussing the case management of patients with long term conditions.

They act as a link to all the Voluntary and Community Services and work with patients to find a service or activity that meets the patient's needs. In 2015 we will extend this model by additional investment in social prescribing for mental health patients.

The service has been independently evaluated and has so far achieved between a 20-25% reduction in A&E attendances, patient admissions and out-patient attendances.

The award winning social prescribing service is a Win/Win for everyone:

- The public sector benefits, as it addresses inappropriate admissions into hospital and reduces Social care.
- The GPs benefit as it gives them a third option other from referral to hospital or to prescribe medication.
- The voluntary and community sector benefits as it supports their sustainability
- And most importantly, The patients and carers benefit as it improves quality of life, reduces social isolation and moves the patient from dependence to independence

Events

Throughout the year, the CCG has held several key engagement and information events. Bi-monthly clinical Protected Learning Time sessions, CSE Stop the Shift, PPG Network group meetings are just some examples of our events that have been attended by over 5,000 people in 2014/15 ranging from public, patients, GPs and practice staff, health professionals, voluntary sector and health staff from across all Rotherham agencies.

Details of the different events held throughout the year can be viewed on our website.

Services we commission

We are responsible for commissioning health services to meet all the reasonable requirements of our local population, with the exception of; certain services commissioned directly by NHS England, health improvement services commissioned by Rotherham Council and health protection and promotion services provided by Public Health England.

Commissioning areas activity for 2014/15

Unscheduled Care

- All GP practices are engaged in the Case Management Programme with 8,000 case management plans in place. Plans receive input from GPs, social workers, social prescribing workers, community nursing and, if needed, other allied health professionals. In 2014/15, we invested in additional GP support for all patients over 75 and work to improve care for patients in nursing and residential homes

- In February, the Emergency Care Intensive Support Team (ECIST) undertook a review of urgent and emergency care in Rotherham working in partnership with TRFT and the CCG. A full action plan was developed and work has taken place to implement the recommendations. A number of “perfect weeks” have been held to maximise A&E performance.

- We have agreed policies and processes to work in partnership with RMBC to deliver personal health budgets through the service commissioned from the Commissioning Support Unit. We have 40 patients currently in receipt of a personal health budget.

- The CCG and TRFT approved the final business case for the creation of an Emergency Centre on the hospital site. This will see primary and secondary care doctors and senior nurses working together in a new £12 million purpose built facility, co-located with mental health crisis teams, social care and services key to integration.

- Invested to deliver 7 day services across acute and community services.

Clinical Referrals

- Principle achievements of our approach to referrals management include the haematology virtual clinic, introducing a single point of access into musculoskeletal services, gynaecology fast track appointments and substantially reducing follow ups including transferring suture removal and Prostate Specific Antigen (PSA) monitoring to primary care through a secondary to primary care Locally Enhanced Service.

Mental Health

- We carried out a fundamental reviews of Adults and Older Peoples and CAMHS services and prioritised transformation plans for both areas
- We delivered a new acute Alcohol Liaison service which is providing services to frequent users of hospital services, 50% of these people were previously unknown to other alcohol services
- Rotherham benchmarks highly in terms of the identified diagnosis of dementia the 10th best in England.
- We improved dementia care by:
    - implementing the GP memory clinic referral pathway
    - GP Guidance on referral Memory Clinic produced. 95% of GPs surveyed reported the guidance to be either quite useful or very useful
    - investing additional funding to support the service over the winter period
- We have undertaken a review and public consultation on Learning Disability services
- We improved awareness of autism and learning disability across mental health and other health services, such as GPs and TRFT.

Maternity and Children’s

- We have worked closely with RMBC on the launch of the local offer for Special Educational Needs and Disabilities (SEND).

Transforming Community Services

- **A Better Quality Community Nursing Service**

We have delivered cost efficiencies within community health services, reinvesting the money saved into front-line staff. We have recruited seven new district nurses and seven clinical team leaders to support locality based community nursing. We have developed a better quality community nursing service, increasing capacity to deliver seven day working and realigning the service so it targets GP practice populations. The service now supports episodic care of housebound patients and the case management of people with long term conditions.

- **Enhancing the Care Co-ordination Centre (CCC)**

The Care Co-ordination Centre has three key functions:

  - Access point for GPs and other health professionals into alternative levels of care
  - Supported discharge planning for patients at risk of readmission
  - Single Point of Contact for NHS 111 patients who require community health services

The service has already had a significant impact on the number of GP admission. 11.5% of all referrals are diverted to alternative levels of care.

In 2014/15, we have extended the service to act as a supported discharge hub and provide proactive support to patients on the GP case management scheme. The service is now acting as a single point of access for community nursing referrals. Importantly the service now operates 24 hours per day seven days per week.

- **Development of The Oakwood Community Unit**

The Oakwood Community Unit is a 20 bedded nurse-led unit intended to meet the need for step-up care from the community and step-down care from the hospital. The Unit supports patients who are medically stable but unable to return home. 66% of all admissions are direct from A&E. The service has prevented 657 admissions since it started in September 2012. We evaluated the unit's first year of operation in October 2013. A further evaluation will be held in October 2014 this will establish the contribution the unit is making to reducing hospital admissions, nursing levels on the unit, arrangements for medical cover and the ability of the unit to accept step up as well as step down patients.

- **Reductions in Falls Related Admissions**

We have worked closely with TRFT to develop an integrated falls and bone health service that works across acute and community. We have made significant investment in our falls service at a time when other CCGs have decommissioned services. As a result, during the last year the number of falls related admissions for people over 55 years dropped by 19%. The number of fragility fracture admissions for people over 75 years also reduced by 16%. Finally the number of people with a fractured neck of femur reduced by 8%.

Better Care Fund

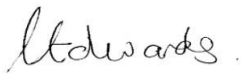
In 2014/15 we agreed the Rotherham Better Care Fund with Rotherham Council, which brings together 15 schemes that are particularly important for joint working into a single jointly owned budget of £23.3 million.

The plans have to achieve specific outcomes in seven areas:

1. Reducing years of life lost for (cancer, stroke, heart disease, respiratory disease, liver disease);
2. Improving quality of life for patients with 1 or more long term condition;
3. Reducing time In hospital through more integrated care in the community;
4. Increasing the amount of people living independently at home following discharge from hospital;
5. Reducing poor experience of inpatient care;
6. Reducing poor experience in primary care;
7. Eliminating avoidable death in hospital.

The fund will improve outcomes in the following areas:

- Delayed transfers of care;
- Emergency admissions;
- Effectiveness of re-ablement;
- Admissions to residential and nursing care;
- Patient and service user experience.



Chris Edwards
Accountable Officer
Date

We are a socially and environmentally responsible organisation. The Social Value Act 2012 requires the CCG to consider how to use its contracts to improve the economic, social and environmental well-being of our communities. During the year, we were committed to the NHS Carbon Reduction Scheme and there is an on-going focus to reduce our direct building related greenhouse gas emissions, business travel and waste going to landfill. In addition, we have ensured that all procurements have clauses requiring sustainability actions and all our core providers have sustainability plans in place. Our facilities management provider, NHS Property Services, have this year led on energy efficiency within the building that we are a tenant. They measure the reduction in our carbon footprint with our baseline for energy usage reported through the annual ERIC (Estates Return Information Collection) Return, that they produce. We are always looking for ways to reduce the use of natural resources, including water consumption. We are committed to recycling within the organisation, where staff are encouraged to separate their rubbish into recycling containers provided in the kitchen area.

NHS Property Services have provided us with utility and waste data up to quarter three. The last quarter for 2014/15 will be provided once final data is available. We occupy the top floor at Oak House in Bramley, Rotherham, therefore figures have been calculated based on our percentage of occupancy.

Water consumption has been calculated from costs on the basis of using a conversion factor of £2.55696 per cubic meter. This conversion figure is an average of ten water company charges for both Fresh Water supply and Sewerage processing from 2013 and 2014 that supply NHS Property Services' properties.

Where no details are available for electric consumption the consumption figures have been estimated using a conversion factor of 12.8 pence per unit. This conversion figure is based on an average taken from a representative sample of NHS Property Services' properties.

Where no details are available for gas consumption the consumption figures have been estimated using a conversion factor of 2.4978 pence per KWh. This conversion figure is based on an average taken from a representative sample of NHS Property Services' properties.

The weight of all waste categories has been estimated based on cost using an appropriate conversion factor.

The financial information included in this report is provided on the understanding that it is based on the information available at the time of the data's production.

Utility and Waste Consumption - Summary
Occupancy percentage = 20.56%

Electricity Usage (kWh)	151,370.94	Electricity Cost	£25,705.67
Carbon Emissions (kgCO2)	74,817.36 (Conv. Factor 0.494265)		
Gas usage (kWh)	93,557.05	Gas Cost	£3,291.21
Carbon Emissions (kgCO2)	17,305.53 (conv. Factor 0.184973)		
Water usage (units)	870.04 (estimate)	Water Cost	£2,224.66
Domestic Waste (Tn)	7.77 (estimate)	Domestic Waste Cost	£1,413.16
Recycling (Tn)	3.69 (estimate)	Recycling Cost	£447.22
Confidential Waste	2.08 (estimate)	Confidential Waste Cost	£512.88

Members' Report

Details of Directors - Who's Who

Governing Body

Throughout the year the Governing Body has met in public every month. Through these meetings the body has been responsible for making key strategic decisions, gaining assurance on how we use resources, agreeing priorities and overseeing the organisations budgetary spend.

Membership

The Governing Body is made up of four GPs, three executives, a nurse, a hospital consultant, a lay member overseeing patient engagement and a lay member overseeing governance, finance and audit. During the year, all meetings were fully quorate.

Name	Role
Dr Julie Kitlowski	Chair
John Barber (10th November 2014 – 31st March 2015)	Lay Member for Governance, Finance and Audit – Vice Chair
John Gommersall (1st April 2014 to 2nd September 2014)	Lay Member for Governance, Finance and Audit – Vice Chair
Chris Edwards	Chief officer (Accountable officer)
Dr Leonard Jacob	Chair of GP Members Committee
Dr Richard Cullen	Vice Chair of Strategic Clinical Executive
Dr Simon Mackeown	Vice Chair of GP Members Committee
Dr Robin Carlisle	Deputy Chief Officer and Senior Information Risk Officer (SIRO)
Sue Cassin	Chief Nurse and Caldicott Guardian
Keely Firth	Chief Finance Officer
Philip Moss	Lay Member for Patient and public Engagement
Dr Harry Ashurst	Secondary Care Doctor
Sarah Whittle (In attendance)	Assistant Chief Officer and Governing Body Secretary

Register of Interests of the Governing Body and Senior Officers

This register includes interests declared by the Governing Body and Senior Officers of our CCG. In accordance with our constitution, the Accountable Officer is informed of any conflict of interest that needs to be included in the register within not more than 28 days of the change in circumstance.

To be eligible to be a member of the Governing Body, all GPs are required to practice with the geographic boundary covered by Rotherham Council, therefore 'GP in a Rotherham practice' is not covered in any declaration on the register of interests.

Name	Position/Role	Interest Declared
Dr Julie Kitlowski	• Chair of the Governing Body and Strategic Clinical Executive	• GP practice holds an intermediate care contract.

Name	Position/Role	Interest Declared
	• Governing Body Chair of the Remuneration Committee	• Relative is a GP in Sheffield. • Relative is a doctor in Manchester.
John Barber	• Lay member • Member of the Audit Quality Assurance Committee (AQuA) • Member of the Remuneration Committee	• Interim management role, East Midlands Ambulance Trust. • Wickersley Parish Councillor. • Voluntary work with Closer Healthcare, Beverley.
John Gommersall	Lay Member	• Nil
Dr Harry Ashurst	Secondary Care Doctor	• Consultant Anaesthetist, Bradford.
Dr Robin Carlisle	Deputy Chief Officer	• Nil
Sue Cassin	Chief Nurse	• Nil
Dr Richard Cullen	• Vice-Chair of the Strategic Clinical Executive • GP lead on Governance & Finance of the Audit Quality Assurance Committee (AQuA) • GP lead on Governance and Finance on the Remuneration Committee	• Member of the Labour Party. • Family member, Constituency President of the Labour Party
Chris Edwards	Chief Officer	• Relative employed by Chesterfield Royal Hospital. • Patron, Rotherham Holiday Aid. • Relative works for the NHS supply chain
Keely Firth	Chief Finance Officer	• Relative is employed by NHS Barnsley CCG. • Treasurer Worsbrough Bridge Cricket Club (Volunteer). • Volunteer Trustee of Healthcare Financial Management Association (HFMA).
Dr Leonard Jacob	• Chair - GP Members Committee • GP lead member of the Audit Quality Assurance Committee (AQuA) • GP lead, member of the Remuneration Committee	• Employed by The Rotherham NHS Foundation Trust as a hospital practitioner • NHS Appraiser for South Yorkshire and Bassetlaw

Name	Position/Role	Interest Declared
Dr Simon Mackeown	Vice-Chair of GP Members Committee	• GP practice holds an intermediate care contract. • Relative is employed by Northern General Hospital Sheffield. • Hospital Practitioner employed by Rotherham Hospice.
Philip Moss	• Lay member • Member of the Audit and Quality Assurance Committee (AQuA) • Member of the Remuneration Committee	• Works for the Rotherham Citizens Advice Bureau. • Member of the Labour Party.

Pension Liabilities

We follow the NHS Pension Scheme which is open to all its employees. Details of how pension liabilities are treated within the CCG can be found in the Accounting Policies in the statement of accounts.

Committees of the Governing Body

Strategic Clinical Executive

The Strategic Clinical Executive (SCE) comprises nine Rotherham GPs and some senior NHS managers. It meets weekly to direct work on commissioning activities.

Register of Interest of the Strategic Clinical Executive

To be eligible to be a member of the SCE, all GPs are required to practice with the geographic boundary covered by Rotherham Council, therefore 'GP at a Rotherham practice' is not covered in any declaration on the register of interests.

Name	Position/Role	Interest Declared
Dr Julie Kitlowski	Chair of the Governing Body and Strategic Clinical Executive	• GP within a Rotherham practice. • GP practice holds an intermediate care contract. • Relative is a GP in Sheffield. • Relative is a Doctor in Manchester
Dr Richard Cullen	• Vice-Chair of the Strategic Clinical Executive • GP lead on Governance & Finance of the Audit	• GP within a Rotherham practice. • Member of the Labour Party. • Family member,

	Quality Assurance Committee (AQuA) • GP lead on Governance & Finance on the Remuneration Committee	Constituency President of the Labour Party
Dr Anand Barmade (1st September 2014 – 1st March 2015)	Strategic Clinical Executive	• GP in a Rotherham practice. • Family member a GP in Wakefield. • Director of Junster Limited. • Local Care Direct, Ad-hoc Out of Hours GP. • GP Advisor – Care Quality Commission (CQC). • Rotherham VTS trainer
Dr Phil Birks	Strategic Clinical Executive	• GP in a Rotherham practice. • Financial interest in local 100hr Pharmacy.
Dr Russell Brynes	Strategic Clinical Executive	• GP in a Rotherham practice. • Family member a GP.
Dr David Clitherow	Strategic Clinical Executive	• GP in a Rotherham practice. • Family member is a Radiology trainee Sheffield Teaching Hospital
Dr Avanthi Gunasekera	Strategic Clinical Executive	• GP in a Rotherham practice. • Family member a GP • Employee of Care UK – to work in the OOH sector as a GP and also works in A&E at TRFT • Private work – Does a clinic in Sheffield in relation to Botox and Dermal Fillers • Employed by Health Education England – Programme Director of the Rotherham VTS
Dr Jason Page	Strategic Clinical Executive	• GP partner in a Rotherham practice. • Family member a registrar in paediatrics STH.
Dr Ian Turner (1st April 2014 – 31st August 2014)	Strategic Clinical Executive	• GP in a Rotherham practice.

GP Members Committee

The GP Members Committee is a strong advisory group to the SCE and Governing Body and ensures that the member practices are linked into all of the wider commissioning decisions of the CCG.

It is representative of all of the GP Practices in Rotherham and is mandated by them. It makes sure that practices are linked into wider commissioning decisions. A full list of our 36 member practices is available in our constitution. The committee's key role is to provide a reference point for all commissioning developments, support the GPs on the SCE and to hold the SCE to account for its commissioning activities and agree the Annual Plan.

The Members Committee works through a locality structure having regular contact with executive GPs to ensure that the views of all Rotherham GPs are heard. Over the year, the Committee's aim was to facilitate the commissioning of good medical services and positively affect the health and wellbeing of the people of Rotherham, leading to improved quality and enhanced efficiency with cost effectiveness.

Register of Interest of GP Members Committee

To be eligible to be a member of the Members Committee, all GPs are required to practice with the geographic boundary covered by Rotherham Council, therefore 'GP at a Rotherham practice' is not covered in any declaration on the register of interests.

Name	Position/Role	Interest Declared
Dr Leonard Jacob	Chair	• Hospital Practitioner at The Rotherham NHS Foundation Trust • NHS England appraiser for South Yorkshire and Bassetlaw
Dr Simon Mackeown	Vice Chair	• Relative is employed at the Northern General Hospital, Sheffield • Hospital Practitioner employed by Rotherham Hospice • GP practice holds an intermediate care contract.
Dr Geoff Avery	Member	• Maltby Locality Representative • Part Owner in Blyth Road Late Night Pharmacy • The Stoddart Samaritan Fund member • Family member is a midwife • Family member is a doctor • Family member is a professor of general medicine
Dr Bipin Chandran	Member	• Director of CBE Development • Rother Valley Locality Chair
Dr Rob Evans	Member	• Nil
Dr Sophie Holden	Member	• Member of AQuA (Audit, Quality and Assurance Committee)
Dr Naresh Patel	Member	• Financial interest in two business premises

		that are leased on rental to pharmacy companies • No financial interest in those pharmacy businesses
Dr Srini Vasan	Member	• Wentworth South Locality representative • Wentworth South Locality directorship of LLP to be.

Audit and Quality Assurance Committee (AQuA)

AQuA provides the Governing Body with an independent and objective view of the group's financial systems, financial information and compliance with laws, regulations and directions governing the group, in so far as they relate to finance. It provides assurance on the quality of services commissioned and promotes a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience.

The purpose of the Committee is to gain assurance that:

- there is an effective and consistent process in commissioning for quality and safety across the CCG.
- high standards of care and treatment are delivered. This will include areas regarding patient safety, effectiveness of care and patient experience.
- an effective system of integrated governance, risk management and assurance across the Governing Body activities is established and maintained.
- risks to the achievement of Governing Body objectives are identified and assurances obtained that appropriate mitigating action is being taken.

The committee membership during 2014/15 was comprised of the two new lay members of the CCG and three GPs supported by representatives of both Internal and External Audit and senior CCG officers.

Name	Role
John Barber (10th November 2014 – 31st March 2015)	Lay Member for Governance, Finance and Audit – Vice Chair
John Gommersall (1st April 2014 to 2nd September 2014)	Lay Member for Governance, Finance and Audit – Vice Chair
Dr Leonard Jacob	Chair of GP Members Committee
Dr Richard Cullen	GP on Strategic Clinical Executive
Dr Jason Page	GP on Strategic Clinical Executive
Philip Moss	Lay Member for Patient and public Engagement

There are standing invitations to attend the committee to:

- The Chief Finance Officer
- The Chief Nurse
- The Assistant Chief Officer
- The CCG's Internal Auditors – provided by 360 Assurance
- The CCG's External Auditors – provided by KPMG
- The Counter Fraud Officer – provided by 360 Assurance

In addition, other officers from within the organisation have been invited to attend where it was felt that to do so would assist in the effective fulfilment of the committee's responsibilities. In accordance with the terms of reference the Chief Officer (Accountable Officer) also attended a meeting during 2014/15.

Staff Sickness Absence and Ill Health Retirements

	2014-15 Number
Total Days Lost	**408**
Total Staff Years	**56**
Average working Days Lost	**7.3**

The figures for staff sickness absence are in calendar years.

Employee Consultation

Throughout the year we have maintained good relationships with trade unions consulting with them where appropriate on policy and procedure decisions. We have held monthly staff meetings to generate discussions and ideas, where each team in the organisation is given the opportunity to organise table work to inform others about their area of work and to provide staff with the opportunity to ask questions and make suggestions.

Where staff have ideas and suggestions for improvement they are encouraged to share these with their line manager for further exploration and then an appropriate route for discussion and implementation is identified.

A staff suggestion box has been introduced, where ideas for improvement within the organisation are gathered, shared with the operational executive and then actioned appropriately. All outcome decisions from suggestions are communicated back to staff at the monthly all staff meeting. Feeding back to staff on how their ideas and suggestions have been actioned and is key to having good engagement with our staff.

Listening to our patients

Comments and Complaints

We aim to ensure that all complaints are used positively as a learning opportunity and will ensure that the patient or carer is not detrimentally treated as a result of lodging a complaint, whilst being fair and supportive to staff. We will ensure that we will work with the complainant on a customer and person centred, responsive and timely basis, in accordance with our values: Clinical Leadership; Putting People First; Ensuring that patient and public views impact on the decisions we make; Working in Partnership; Continuously Improving Quality of Care whilst ensuring value for money; Showing Compassion, Respect and Dignity; Listening and Learning; Taking Responsibility and Being Accountable, with a view to addressing and resolving the complaint at the earliest possible opportunity. We work with all providers of NHS Services to ensure that a similar customer focussed approach is taken to complaint handling.

During the year, we received 16 formal complaints. Of these, five related to Continuing Healthcare (CHC) i.e. lack of communication, dissatisfaction and CHC processes. Three related to retrospective continuing healthcare i.e. processes; two were prescribing/medication issues; two regarding mental adult health services; three were dissatisfaction, care and treatment, and diagnosis related to the Walk-in-Centre and one related to general administration.

Principles for Remedy

We adhere to the Parliamentary and Health Services Ombudsman's 'Principles of Good Complaint Handling and Principles for Remedy', when dealing with complaints. This is incorporated within our Complaints Policy.

Engaging with our community – A duty to Involve

As an organisation, we want to continuously improve and develop how we engage with our communities. We want people to see what we have done; how their feedback helped to shape local services and just how much we value all feedback and engagement.

In addition, since 2009, NHS organisations have had a duty to report to the public about on all engagement and consultation activities which have helped to shape the services bought (commissioned) on behalf of local people. This is the Duty to Report (Section 24A of the NHS Act 2006). This could be work we have carried out, or it could have been completed by partner organisations and used to inform the decisions we have made. To meet the criteria within the 'Duty to report', we need to include a lot of detail, such as the information that was sent out to people, the range of views expressed, and how the feedback has influenced decisions. We have included in this report an overview of our work. This report covers engagement activities between April 1st 2014 - 31st March 2015.

How to get involved

There are lots of ways for people to get involved in local health services and to share their views, (http://www.rotherhamccg.nhs.uk/your-say.htm) including:

- Patient Participation Groups (PPGs) - Each GP practice can set up as a group of patients who are interested in engaging with their work and other registered patients. The Patient Participation Group (PPG) Network links local PPGs and the CCG, and meets quarterly. Over the last year, the network has considered and influenced the following issues:
    - Emergency Care Centre
    - Friends and Family Test roll out to primary care
    - Mental Health
    - Public Health
    - Medicines waste
- Healthwatch Rotherham - an independent organisation representing the views of local people across health and care – www.healthwatchrotherham.org.uk

- Reader group - a number of people have offered to read drafts of papers and offer their views – this includes everything from the Commissioning Plan to public leaflets.
- Events - future events and the reports from those that have taken place are available on our website and on request
- NHS Choices or Patient Opinion – anyone can access these sites and leave feedback on health services they have experienced.

In year, we developed a new joint communications and engagement strategy for the next three years, demonstrating a strengthened approach towards communications and engagement within us.

We have established a Governing Body sub-committee for Engagement and Communications for 2015/16 that will ensure that we have the space and the expertise to plan, monitor and evaluate its communications and engagement activity. Importantly the structure includes in its membership representatives from the local authority, Healthwatch Rotherham and the Voluntary Sector, and will look to further extend this as the remit of the sub-committee develops.

Voluntary Action Rotherham (VAR) survey on community services – focus on social prescribing clients

Between July and December, social prescribing staff from Voluntary Action Rotherham spoke with 100 clients about community services, with the aim of informing and influencing the CCG's work in Transforming Community Services. VAR spoke to just over 100 people, slightly more women than men were interviewed, most of whom were aged between 70-90. Key points:

- Over 40 stated they did not know what a care plan was.
- Most people thought that a care plan included information about medication and emergency contacts
- The services most currently accessed were medication support and Telecare (including Rothercare)
- Most responses noted that people relied on support from GPs and from family – this could be noteworthy if GP practices are under pressure, and carers are not well supported themselves.
- The majority felt that they had enough information about their condition, and that they were confident in knowing where to get information. Patients also noted that they liked getting information face to face from a health professional, but that they could be overwhelmed and information could be hard to digest, so it was good to have something written to go back to.
- People were less interested in attending formal 'taught' self-management programmes, than in meeting up informally with people with similar experiences.
- If people felt their condition had worsened, most (77% would contact their GP); others would contact family or go to A&E; least preferred options were 111 and local pharmacies.
- The information is currently being shared, and consideration given as to ways of using the data to inform service development; for example, better promoting 111 and the services pharmacies offer.

Medicines Waste

From a number of informal conversations and early responses, it is clear that reducing waste – and medicines waste is a key part of this – is as important to patients, carers and the public as it is to us, with a number of organisations demonstrating enthusiasm to become involved in this work, this has included the Patient Participation Groups Network – December 2014 and Voluntary and community sector organisations through VAR – January 2015; with around 40 attendees in total, each representing other organisations. Key messages emerging from this work are:

- A significant number of patients are getting medication they don't need
- People don't always understand the system, and how the ordering of occasional items should work
- Patients are often reluctant to challenge the opinion or decision of medical staff, for example if they feel something is not working for them, they don't always mention it
- Pharmacies ordering for patients, without checking with the patient
- Patients no longer seeing the right-hand side of their prescription
- Rotherham hospital not returning medication to patients on discharge.
- Arms-length ordering may be convenient, but reduces the opportunities for staff to check that the medication is right, and is being taken correctly; possibly leading to unused meds and patients reaching crisis

Information from these sessions is being used to develop solutions to the issues and to inform a public campaign.

Disabled Children and Their Parents – experiences of health services

During 2014, parents of disabled children have raised a number of issues, telling us about their dissatisfaction with CAMHS, and with services and support for children with autism. We, with partners from the council and RDASH, have met informally with parents, at a time and place chosen by parents to discuss their concerns. In addition, feedback on social media has been encouraged and acted on.

Actions

- Specific quality issues have been passed to providers for action, for example letters and information provided
- Parents representatives have been invited to attend autism and ADHD strategy meetings, and to table specific issues for agendas and discussion (for example, post diagnosis support).
- Following this, parents have highlighted concerns with other health services; we have enabled the forum to further consult with families and young people, to better identify areas of concern and actions needed (Dec 2014 - March 2015.)
- The forum is leading on a grant funded and co-created health conference in March, in line with the principals of the SEND agenda and with the intention of developing actions together across all services that will address the issues raised.

The following comments represent some of the emergent findings:

- **Communication can make an experience worse**
    - .....uses terms hard to understand and can be difficult to understand

- We never felt included during our sons appointments, they didn't seem interested in our views and opinions. They didn't seem able to answer our questions.

- **The benefits of a clear diagnosis and path should not be under estimated**
  - We got our diagnosis for X 14/05/2014, I cried with relief, we now can help X, Thanks.

- **But some people do feel unsupported**
  - No follow up support following diagnosis.
  - More explanation on discharge on each condition.
  - Discharged a bit early, not sure what to look out for if she has problems
  - Given too much to read and think about all at one go. No time to accept information.
  - Needs more parent support when dealing with the fact your child is diagnosed with a disability.

- **When systems work well, and take the extra measures to put patients at the centre of services, it can make a real difference to people, especially where children and young people have several or complex health needs**
  - They need to realise that in complex cases with several needs, very often a multi-disciplinary agency approach is required in promoting the health and well-being of those who have been diagnosed as well as their carers.
  - We often need to see 2 different people on the same day, they ensure these appointments are one after another to avoid long waiting times. We find the department very child friendly and they find ways to accommodate his needs.

Learning Disability Assessment and Treatment Unit (ATU) and Community Investment Consultation – Report and outcomes summary April – July 2014

Why did we consult?

A review of the ATU service highlighted a number of quality and safety concerns. Where possible these were addressed immediately, however some issues could not be resolved. The low levels of bed use mean that Rotherham service cost more than other similar services, this brought into doubt the sustainability of the Rhymers Court service. Members of the Rotherham Learning Disability Partnership Board Health Sub-group and a group of self-advocates visited both Rhymer's Court and Sapphire Lodge, raising several concerns, which were dealt with by RDaSH. The visitors were also concerned about the style of the staff uniforms at Sapphire Lodge; leading to an immediate review of this by RDaSH. The ATU review report and the subsequent review of the health community service provision identified 3 options. During the development of the public consultation documentation, we decided to remove the option of continuing with the Rhymer's Court ATU service. This was because there were quality and safety concerns that could not be addressed in the Rhymers Court building. Also the high cost of the service gave no potential to invest into local community health services for people with learning disabilities.

What were the issues at Rhymers Court?

Beds at Rhymer's Court had reduced from 8 to 3; reductions were based on levels of use and also safety concerns. In addition, where the clinical presentation has indicated, people have been admitted to Swallownest Court. Despite the reductions, there have still been a number of vacant beds, with only one bed occupied during the consultation period. Increased investment into community services will also help to reduce the need for admissions in the future.

What happened during the consultation?

A document was developed to support a period of formal public consultation from 27th June to 31st July. It was launched at Rotherham's learning Disability Partnership Board on 27th June, and was supported by several events across the borough, an easy read version, and the publication on the CCG's website, with the opportunity to give feedback online, by post, on paper and at the events. The options consulted on were:

- three dedicated ATU beds for Rotherham on Sapphire Lodge in Doncaster and an enhanced Rotherham community LD service
- three ATU beds on Sapphire Lodge, an enhanced Rotherham community LD service plus 1 bed available at Swallownest Lodge with LD in-reach support as required

The public were also asked for their views and opinions about how to best use the investment into community services, and as to what aspects of the service they would prefer to see developed. One of the greatest challenges was explaining the ATU service, a number of people assumed it referred to all inpatient care, or all assessments. Therefore iterative changes were made during the consultation period, to better explain the service and issues.

What people told us

During the consultation events, all comments and responses were captured on flipcharts so that the audience could be assured that their views and opinions were heard and captured correctly. These were then summarised in a feedback documents after each event, and subsequently added to the CCG website page relating to the public consultation. The key themes raised throughout the events and the responses offered are summarised below:

- Ourselves and RDaSH will support people who have to travel further to visit family members
- The investment into Rotherham community LD health services will be recurrent, and the changes reviewed regularly, involving service users and carers
- Community support needs to be responsive and delivered by trained, consistent staff - the enhancements to the community teams should support this and provide more access and flexibility
- Carers stated that support should be available 24/7 – ourselves and RDaSH will look at carer support
- Carers who had visited Sapphire Lodge wanted assurance that their views and concerns had been heard and responded to – RDaSH have consulted on uniforms, have looked at making the unit more welcoming, and offered return visits.
- There would be no changes to the admission criteria for people needing an ATU admission

- The figure of three beds was based on previous years' admissions. If the three ATU beds were occupied, anyone else needing a bed would still be supported, no-one needing admitting has ever been turned away; this would not change.
- All staff will be supported to seek suitable alternative employment options, some of which may be in the new posts developed as part of the community services developments
- The introduction of an Acute Liaison role for Learning Disabilities was welcomed

Responses were mainly in favour of the proposed changes, information was also targeted at the BME community but no feedback received. In addition, a response was received from RMBC, highlighting the ongoing need to work together to provide integrated health and care services for people with a learning disability

What the CCG will do

We have has now implemented the changes, the Unit has moved to Sapphire Lodge in Doncaster and a bed will be provided for people with a learning disability at Swallownest Court. Money is also being put into community services so that people don't need to use the unit as much. Ourselves and RDaSH are still working on three issues:-

- Transport support to carers of people who are being cared for at Sapphire Lodge
- Changes to people's jobs and making sure that health and social care work well together; keeping services integrated.
- The cost of the unit and community services
- Uniforms at Sapphire Lodge – carers and people with learning disabilities have been a key part in selecting a new uniform for staff to be launched in 2015
- People have also been part of return visits to Sapphire Lodge, reporting positively back.

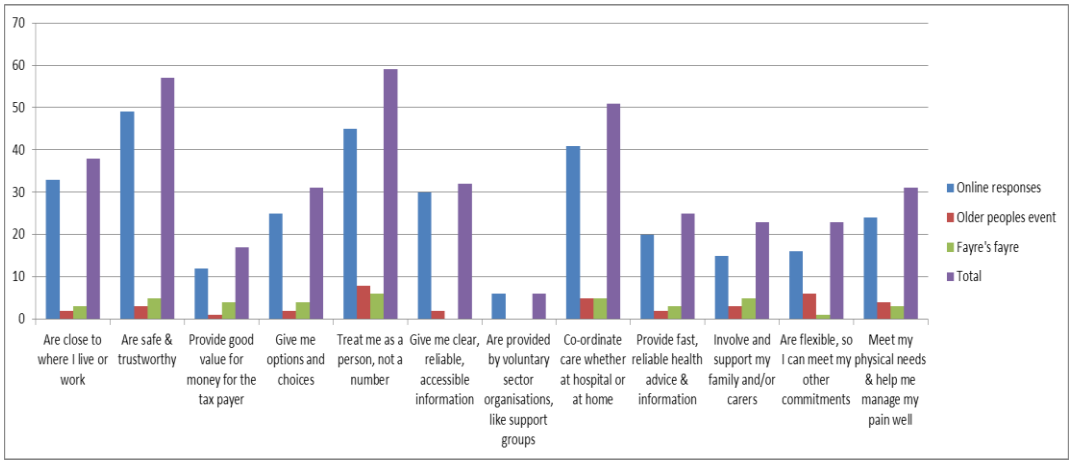
"If anything I found the ATU in Doncaster to be more homely, fresher in appearance, and more tailored to the needs of the individuals needing the service. As a parent who visited Rhymers court for over a year and someone who strongly believed that we needed to keep a facility in Rotherham for Rotherham people I left feeling rather assured that actually if the need arose for my daughter she would receive just as good care, if not better at Sapphire Lodge."

The outcomes have been reported to the Learning Disability Partnership Board (Oct 2014). We will continue to involve carers and service users in the developments and in the reviews due in March 2015, and then again in January 2016.

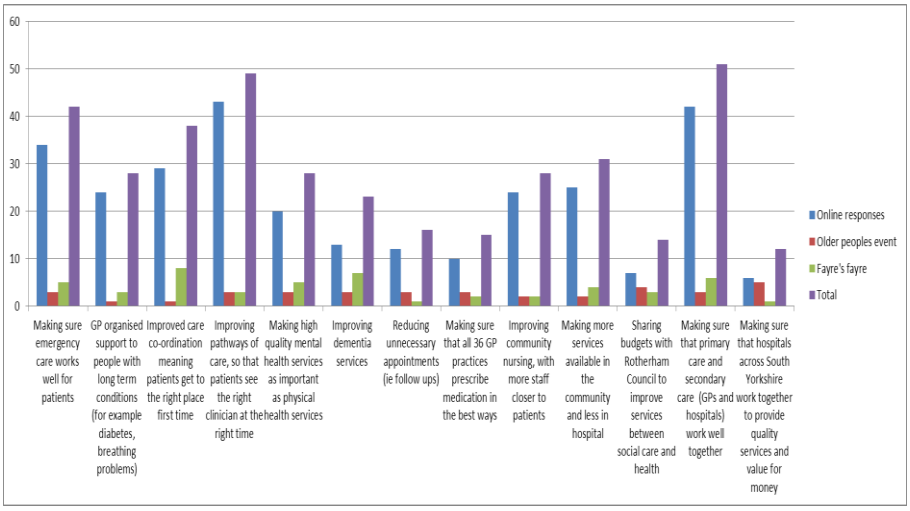
Priorities Survey

During September and October, we asked patients and the public their views on some general principles and on the existing commissioning priorities. Several mechanisms were used to collect data to ensure the exercise was open to all. These included an electronic survey, a paper version; the questions taken as a poster to community events; opportunity to simply add comments about what people thought about health services, or to be important to them and their health. This resulted in over 200 contacts.

Principles



Commissioning Priorities



Summary and actions

The main elements from both questions and the comments were that people want to be treated as individuals, that they want the service to work around them. People are not concerned about our designations, different hospitals, primary and secondary care etc; these are all part of the system and should work together with the patient at the heart. This has been shared internally, and has been used to inform all sections of the annual plan refresh.

For more information on engagement work and consultations we have undertaken in 2014/15, visit http://www.rotherhamccg.nhs.uk/your-say.htm

Equality and Diversity

Equality Act 2010 - The Equality Act has two broad aspects:

1. The Public Sector Equality Duty (PSED) places an obligation on public bodies including ourselves to proactively improve equality for people with one or more protected characteristics. It aims to help public authorities avoid discriminatory practices and integrate equality into core business. It is made up of a general

duty and specific duties. The general duty is the main part of the legislation with the specific duties supporting public bodies to demonstrate performance and compliance.

The General Duty

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity
- Foster good relations

Specific Duties

- **Equality objectives.** The Act requires public bodies like ourselves to prepare and publish one or more specific and measurable equality objectives which they believe will support them to achieve the aims of the general duty.

- **Publication of information.** Annually we must publish information which describes the key inequalities experienced by people with protected characteristic(s) and which demonstrates the impact of its policies and practices on people with protected characteristics.

We have established an Equality Steering Group which is chaired by the Assistant Chief Officer and which reports to the Governing Body. We have been using the national refreshed Equality Delivery System (EDS2), a system designed to support our organisation in our commissioning role and our providers of services to deliver better outcomes for their local population and better working environments for staff which are personal, fair and diverse.

Our Governing Body has approved our equality objectives that have been developed and supported by underpinning actions that are linked to the four EDS goals.

- Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within Provider contracts.

- Ensure appropriate and accessible targeted communication with local communities to ensure commissioners are aware of issues/barriers that influence commissioning decisions.

- Develop consistency of equality approaches across the CCG in respect of equality leadership, staff empowerment and access to development opportunities.

- Demonstrate leadership in advancing the equality agenda internally and with partners and providers to ensure inequalities are addressed within a partnership approach to ensure equity of access and outcomes for patients.

We have gathered information to show the key inequalities experienced by local people which is published on our website http://www.rotherhamccg.nhs.uk/psed.htm

We are, along with all public bodies, required to meet the requirements of the 2010 Equality Act and are committed to making sure that equality and diversity is a priority

when planning and commissioning local healthcare services. To enable us to do this most effectively our engagement strategy highlights the most appropriate ways to work with local communities and relevant groups, dependent on the focus required, to best understand their needs and how to utilise this intelligence to either require improvements in existing services from the relevant provider or to scope and remediate unmet need.

To ensure that our staff members do not experience discrimination, harassment and victimisation we have adopted a range of policies.

On which equality impact assessments have been carried out 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 inadvertent inequalities that may emerge.

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

Disabled Employees

We recognise that in order to remove the barriers experienced by disabled people, we need to make reasonable adjustments for any of our employees who declare a disability. We do this on a case by case basis and involve occupational health services as appropriate.

Looking after Personal Information

We have a clear Information Governance Strategy and Policy, and have a Senior Information Risk Owner (Robin Carlisle, Deputy Chief Officer) and Caldicott Guardian (Sue Cassin, Chief Nurse) at Governing Body level.

We have undertaken various initiatives to ensure good information governance within the organisation and in our work with our partners, including:

- All of the organisation's Information Governance policies have been reviewed, updated and approved
- A new Information Asset Risk Management Plan and Confidentiality Audit Procedure have been agreed and implemented
- The Information Asset Register has been thoroughly updated
- All key information assets have been risk assessed and the results have been reported to the Senior Information Risk Owner (SIRO)
- A confidentiality audit has been carried out across the CCG
- The Incident Reporting Policy has been updated to reflect the mandated procedures for managing Information Governance incidents.

The Information Governance Toolkit is a compulsory web-based self-assessment tool for NHS Trusts which is governed by Connecting for Health. The toolkit covers:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance

In 2014/15 our Information Governance Toolkit submission received an overall score of satisfactory.

Information Governance Serious Incidents

We reported no Serious Incidents (SIs) relating to Information Governance in 2014/15.

Emergency Preparedness, Resilience and Response

I certify that the CCG has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013 and meet the CCG requirements to act as a Category 2 responder. The clinical commissioning group works in partnership with NHS England to regularly review and make improvements to local major incident plans.

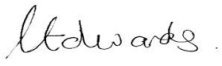
Fraud

We are committed to deterring and detecting all instances of fraud, bribery and corruption and to ensuring that losses are reduced to an absolute minimum therefore freeing up public resources for better patient care. Employees received fraud awareness training, provided by 360 Assurance, at one of our monthly all staff meeting. The Counter Fraud Officer from 360 Assurance had a standing invite to our Audit and Quality Assurance Committee throughout the year. All employees and members adhere to our fraud, bribery and corruption policy and response plan. (available on our website).

Health and Safety

A health and safety inspection is undertaken on an annual basis by the Commissioning Support Unit, based on the Health and Safety at work Act 1974 and The Management of Health and Safety at Work Regulations 1999. The assessment of our premises, located within a NHS Property Services managed building, focuses on physical issues that may require attention. An inspection was undertaken within year and an appropriate action plan put in place where necessary.

All employees and members adhere to our health and safety policy (available on our website) and have received mandatory training in this area. The training includes every member of staff receiving a “Health and Safety at Work” booklet covering the normal risks faced by staff in office premises.



Chris Edwards, Accountable Officer
Date

Finance Review

NHS Rotherham CCG was tasked with accomplishing a range of "business rules" which were all achieved successfully in 2014/15 – the details are below:

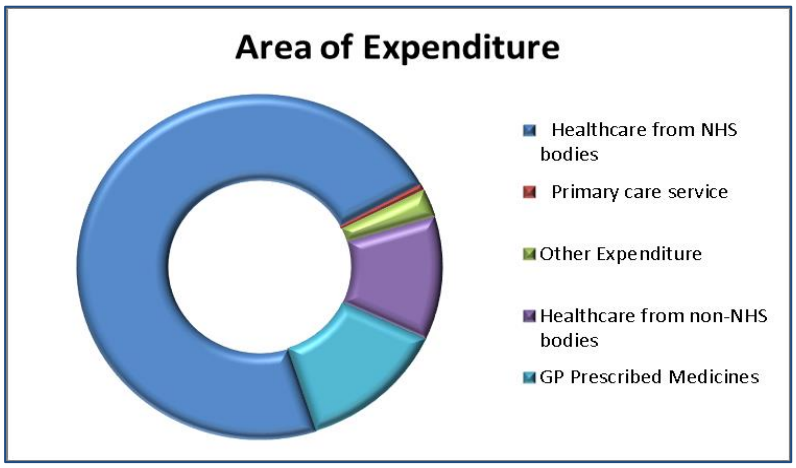
- A surplus of at least 1% of our allocation - £3.5m;
- 2.5% of our allocation invested non recurrently - £8.9m;
- Remain within a running cost allocation of £25 per head of population - £6.2m

The CCG also has an administrative duty to pay at least 95% of non-NHS trade creditors within 30 days. This was achieved during 2014/15 and more detail is shown within the Summary Financial Statements.

Revenue Expenditure

The allocation was spent on the following main headings:

- Healthcare from NHS bodies - £248m
- Healthcare from non-NHS bodies - £40m
- Primary care services - £2m
- GP Prescribed Medicines - £45m
- Other expenditure - £9m



During the year we have been able to invest in a number of high priority areas including:

- Maintaining waiting times for operations and diagnostic tests.
- 7 day working in key services across both Acute care and in the Community
- A Care Co-ordination Centre to ensure patients get the right services first time through investment in Initiatives to redirect patients to alternative levels of care.
- Hospice at Home services provided by the Rotherham Hospice.
- The award-winning initiative with the voluntary sector around social prescribing (referring people with long term conditions to community activities ensuring a better quality of life).
- The Initial works for the new Emergency Centre on the Rotherham Hospital site due to open in 2017.

Audit

The external auditor for the CCG is KPMG who audit the financial statements and gives its opinion including:

- Whether the statements give a true and fair view of the financial position of RCCG and its expenditure and income for the year;
- Whether accounts have been prepared properly in accordance with relevant legislation and applicable accounting standards;
- The regularity of RCCG's expenditure and income.

KPMG also has responsibility to satisfy itself that RCCG has proper arrangements in place to secure economy, efficiency and effectiveness in its use of resources.

Each director has stated that as far as he/she is aware, there is no relevant audit information of which the CCG's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director in order to make himself/herself aware of any relevant audit information and to establish that the CCG's auditors are aware of that. The audit fee in relation to the statutory audit for 2014/15 was £91,000.

Future Challenges

The future financial position is likely to be increasingly challenging. Growth allocations of 1.7% in 2015/16 along with the return of funds lodged with NHS England in prior years will enable us to invest in the planned programme of transformational initiatives for next year however, any growth beyond 2015/16 is likely to be limited.

Consequently, our Annual Plan includes a robust programme of efficiency challenges and demand management initiatives that ensure financial balance is maintained in the medium-term. During the period of economic decline, the CCG has managed reducing levels of growth funding with increased need for health and social care services and this will become a greater challenge in future years.

The Commissioning Plan sets out a number of key quality, innovation, productivity and prevention programmes:

- Clinical referrals management
- Unscheduled Care/System Resilience
- Prescribing
- Mental Health
- Community Transformation
- Better Care

GP commissioning has continued to develop well in 2014/15 with stronger clinical engagement across the whole Rotherham NHS system helping to manage demand for secondary care services more effectively.

GPs have continued the excellent work in the management of prescribing ensuring that drugs usage is cost effective and clinically appropriate.

2015/16 will see the CCG take on the commissioning of Primary Care GPs which offers a significant opportunity to prepare Rotherham for the five year forward view set out by the Chief Executive of NHS England.

Keely Firth

Chief Finance Officer

Remuneration Report

Remuneration Committee

The committee is a sub-committee of the Governing Body and advises on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the organisation and on determinations about allowances under any pension scheme that the organisation may establish as an alternative to the NHS pension scheme.

For the purpose of this report senior managers are defined as:
'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. This means those who influence the decisions of the organisation as a whole rather than the decisions of individual directorates or departments.'

The salaries and relevant pension details of the most senior managers, and the Lay Members of the Governing Body, who had control over the major activities of the CCG in 2014/15 can be found in the Summary Financial Statement. There were no early termination issues for senior officers to report in the year.

The committee members consist of:

- John Gomersall – Chair Lay Member for Governance, Finance and Audit (1st April 2014 – 2nd September 2014)
- John Barber - Chair Lay Member for Governance, Finance and Audit (10th November 2014 – 31st March 2015)
- Philip Moss - Lay for Public and Patient Engagement
- Dr Richard Cullen – GP Lead for Finance and Governance
- Dr Leonard Jacob – GP – Members Committee

The Committee had the opportunity to request specific advice from others including the Chief Officer and Chief Finance Officer.

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 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. The executive directors, GP Chair, GP elected members, and lay members' remuneration for 2014/15 was determined by the Remuneration Committee and took account of national guidance where this had been issued.

Executive Officers (Directors) are on permanent contracts. The only contractual liability on the CCG's termination of an Executive's contract is six months' notice. Details of the terms of office of other Governing Body members can be found in the CCG's Standing Orders which form part of the CCG's Constitution - available on our website.

Off- payroll engagements

Off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months are as follows:

	Number
The number that have existed:	
• For less than one year at the time of reporting	1
• For between one and two years at the time of reporting	
• For between two and three years at the time of reporting	2
• For between three and four years at the time of reporting	
• For four or more years at the time of reporting	
Total number of existing engagements as of 31 March 2015	**3**

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

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	3
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	1
Number for whom assurance has been requested	1
Of which, the number:	
• For whom assurance has been received	1
• For whom assurance has not been received	
• That have been terminated as a result of assurance not being received	

	Number
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed " Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year (this figure includes both off-payroll and on-payroll engagements)	3

The Clinical Chair, Chief Officer (as Accountable Officer) and the Chief Finance Officer are the three members of the Governing Body deemed to have significant financial responsibility for the purposes of the table above. The Clinical Chair, the Chief Officer

and Chief Finance Officer were all paid through the payroll, and all have been in post for the full year 1 April 2014 to 31 March 2015.

Pay Multiples

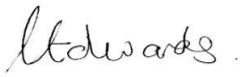
Reporting Bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisations workforce.

The banded remuneration of the highest paid director in NHS Rotherham Clinical Commissioning Group in the financial year 2014/15 was £122,100. This was 3.2 times the median remuneration of the workforce, which was £37,921.

In 2014/15, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £16,811 to £122,100.

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

GPs on the Governing Body are treated as non-executives for the purpose of the pay multiple ratio and so their remuneration has not been grossed up on an annualised basis.



Chris Edwards, Accountable Officer
Date

Directors Remuneration	2014-15							2013-14***						
Name and title	Salary & Fees (bands of £5k) £000	Taxable Benefits* (Rounded to nearest £00) £000	Annual Performance Related Bonuses (bands of £5k) £000	Long Term Performance Related Bonuses (bands of £5k) £000	Sub Total (bands of £5k) £000	All Pension Related Benefits** (bands of £2.5k) £000	Total (bands of £5k) £000	Salary & Fees (bands of £5k) £000	Taxable Benefits* (Rounded to nearest £00) £000	Annual Performance Related Bonuses (bands of £5k) £000	Long Term Performance Related Bonuses (bands of £5k) £000	Sub Total (bands of £5k) £000	All Pension Related Benefits** (bands of £2.5k) £000	Total (bands of £5k) £000
C.Edwards Chief Operating Officer	120-125	4.7	0	0	125-130	20 - 22.5	145-150	115-120	4.7	0	0	120-125	132.5-135	255-260
R.Carlisle Deputy Chief Officer	100-105	5.9	0	0	105-110	2.5 - 5	105-110	100-105	5.9	0	0	105-110	2.5-5	110-115
K.Firth Chief Finance Officer	95-100	4.7	0	0	95-100	0	95-100	95-100	4.7	0	0	95-100	120-122.5	220-225
S.Cassin Chief Nurse	65-70	0	0	0	65-70	0 - 2.5	65-70	60-65	0	0	0	60-65	0	0
S.Whittle Assistant Chief Officer	65-70	0	0	0	65-70	10 - 10.5	75 - 80	65-70	0	0	0	65-70	0	60-65
D.Tooth (Apr'13 to Sep'13) Chair of Governing Body	0	0	0	0	0			20-25	0	0	0	20-25	0	20-25
J.Kitlowski (Sep'13 to present) Chair of Governing Body	60-65	0	0	0	60-65			40-45	0	0	0	40-45	0	40-45
R.Cullen Vice Chair of Strategic Cinical Executive	65-70	0	0	0	65-70			40-45	0	0	0	40-45	0	40-45
L. Jacob Chair of GP Members Committee	30-35	0	0	0	30-35			25-30	0	0	0	25-30	0	25-30
S. MacKeown Vice Chair of GP Members Committee	15-20	0	0	0	15-20			15-20	0	0	0	15-20	0	15-20
H. Ashurst Secondary Care Specialist Doctor	5-10	0	0	0	5-10			10-15	0	0	0	10-15	0	10-15
J.Gomersall (Apr'13 to 2nd Sept'14) Vice Chair of Governing Body and Lay Member	5-10	0	0	0	5-10			10-15	0	0	0	10-15	0	10-15
J.Barber (commenced 10th Nov'14) Vice Chair of Governing Body and Lay Member	5-10	0	0	0	5-10			0	0	0	0	0	0	0
S.Lockwood (Apr'13 to Oct'13) Lay Member	0	0	0	0	0			5-10	0	0	0	5-10	0	5-10
P.Moss (Dec'13 to present) Lay Member	10-15	0	0	0	10-15			0-5	0	0	0	0-5	0	0-5

*** Taxable benefits relate to Car Allowance, Clinical Excellence Awards and On Call Duty.**

**** All Pension Related Benefits. For defined benefit schemes, the amount included here is the annual increase in pension entitlement determined in accordance with the "HMRC" method shown below.**

Increase = ((20 x Pension as at 31.3.15) + Pension lump sum as at 31.3.15) - ((20 x Pension as at 31.3.14 adjusted by inflation) + Pension lump sum as at 31.3.14 adjusted by inflation)

***** Comparators have changed slightly due to new guidance which states that a negative movement in pension benefits be presented as zero.**

Salary and Pension Entitlements of Senior Managers*

Pension entitlements Name and title	2014-15 Real increase in pension at age 60 (bands of £2,500)	2014-15 Real increase in pension lump sum at aged 60 (bands of £2,500)	2014-15 Total accrued pension at age 60 at 31 March 2014 (bands of £5,000)	2014-15 Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)	2014-15 Cash Equivalent Transfer Value at 31 March 2013	2014-15 Cash Equivalent Transfer Value at 31 March 2014***	2014-15 Real increase in Cash Equivalent Transfer Value	2014-15 Employer's contribution to partnership pension	2013-14** Real increase in pension at age 60 (bands of £2,500)	2013-14** Real increase in pension lump sum at aged 60 (bands of £2,500)	2013-14** Total accrued pension at age 60 at 31 March 2014 (bands of £5,000)	2013-14** Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)	2013-14** Cash Equivalent Transfer Value at 31 March 2013	2013-14** Cash Equivalent Transfer Value at 31 March 2014***	2013-14** Real increase in Cash Equivalent Transfer Value	2013-14** Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£'00	£000	£000	£000	£000	£000	£000	£000	£'00
C.Edwards Chief Operating Officer	0 - 2.5	2.5 - 5.0	25-30	85 - 90	374	416	32	0	5-7.5	20-22.5	25-30	80-85	263	374	105	0
R.Carlisle Deputy Chief Officer	0 - 2.5	0 - 2.5	25-30	75 - 80	500	543	29	0	0-2.5	2.5-5	20-25	70-75	450	500	41	0
K.Firth Chief Finance Officer	0 - 2.5	0 - 2.5	30-35	100 - 105	540	576	21	0	5-7.5	17.5-20	30-35	95-100	411	540	120	0
S.Cassin Chief Nurse	0 - 2.5	0 - 2.5	15-20	55 - 60	356	392	18	0	0	0	15-20	50-55	472	356	0	0
S.Whittle Assistant Chief Officer	0 - 2.5	0 - 2.5	15-20	55-60	370	398	27	0	0-2.5	0-2.5	15-20	55-60	341	370	21	0

*** As Lay Members, GP's and the Secondary Care Specialist Doctor do not receive pensionable remuneration from the CCG, there are no entries in respect of pensions for those members.**

**** Comparators have changed slightly due to new guidance which states that a negative movement in pension benefits be presented as zero.**

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

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of period. The % uplift for inflation is 2.7%.

Statement of Accountable Officer's Responsibilities

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

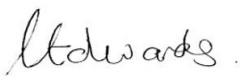
The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

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 *Manual for Accounts* 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 *Manual for Accounts* 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 in my Clinical Commissioning Group Accountable Officer Appointment Letter.



Chris Edwards
Accountable Officer
Date

- Annual Governance Statement – add in once at final version
- Auditor's opinion and report – Add in once received from auditor