investor in excellence

NHS
Rotherham
Clinical Commissioning Group

ROTHERHAM CLINICAL COMMISSIONING GROUP

ANNUAL GOVERNANCE STATEMENT 2014/15

May 2015

CONTENTS

NHS ROTHERHAM CLINICAL COMMISSIONING GROUP

ANNUAL GOVERNANCE STATEMENT 2014/15

Governance Statement by the Chief Officer, as the Accountable Officer of NHS Rotherham Clinical Commissioning Group.

1. INTRODUCTION

The Clinical Commissioning Group (CCG) was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the NHS Act 2006.

As at 1 April 2013, the clinical commissioning group was licensed without conditions.

2. SCOPE OF RESPONSIBILITY

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies and aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer appointment letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

3. COMPLIANCE WITH THE UK CORPORATE GOVERNANCE CODE

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

3.1 Effectiveness

The CCG is comprised of individuals with a range of skills, experience and knowledge. A formal process for appointments is in place and adhered to. They have been provided with a range of strategic information covering quality, finance, performance, strategy, policy and risk which is subject to annual evaluation via the Annual Governance Statement. In addition the organisation learns and improves its performance through continuous monitoring and review of the systems and processes in place for meeting its objectives and delivering appropriate outcomes. In June 2014 the CCG received the Investors in Excellence (IIE) standard. The accreditation is awarded to organisations who can demonstrate a high standard of all-round business performance through a rigorous external assessment process.

3.2 Accountability

There are clear accountability arrangements in place throughout the organisation. There are processes in place for effective management of 'conflicts of interest' and a robust process for risk management and internal control through regular reporting and interaction with internal and external audit. The Governing Body ensures that there are proper and independent assurances given on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes.

3.3 Remuneration

This is set by the 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 Group. It also advises on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme.

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

3.4 Relations with Shareholders

There are partnership arrangements with the local strategic partnership and also the local Health and Wellbeing Board. There are a range of other partnerships relevant to stakeholder groups including Patient Participation Groups (PPGs), the Local Safeguarding Boards, CCGCom for

collaborative arrangements and meetings with NHS England both to provide assurance and as a co-commissioner. Arrangements are in place to effectively share information between partners.

We achieve a dialogue with our shareholders based on the mutual understanding of our objectives by engaging our stakeholders in our strategic planning rounds and in specific clinical leadership events.

3.5 Annual Accounts

In terms of annual accounts, a clear process was identified which ensures that CCG accounts are effectively closed down and accounts produced in a timely manner. Accounts scrutiny and sign-off is planned via the Governing Body with the accounts first being reviewed in detail by the Audit and Quality Assurance Committee.

3.6 Discharge of statutory duties

Arrangements are in place to ensure effective discharge of statutory duties and this is documented through routine reporting arrangements.

3.7 Risk Management

A Board assurance framework and risk register have been maintained throughout the period and the 2014/15 risks reported three times at Governing Body.

4. THE CLINICAL COMMISSIONING GROUP GOVERNANCE FRAMEWORK

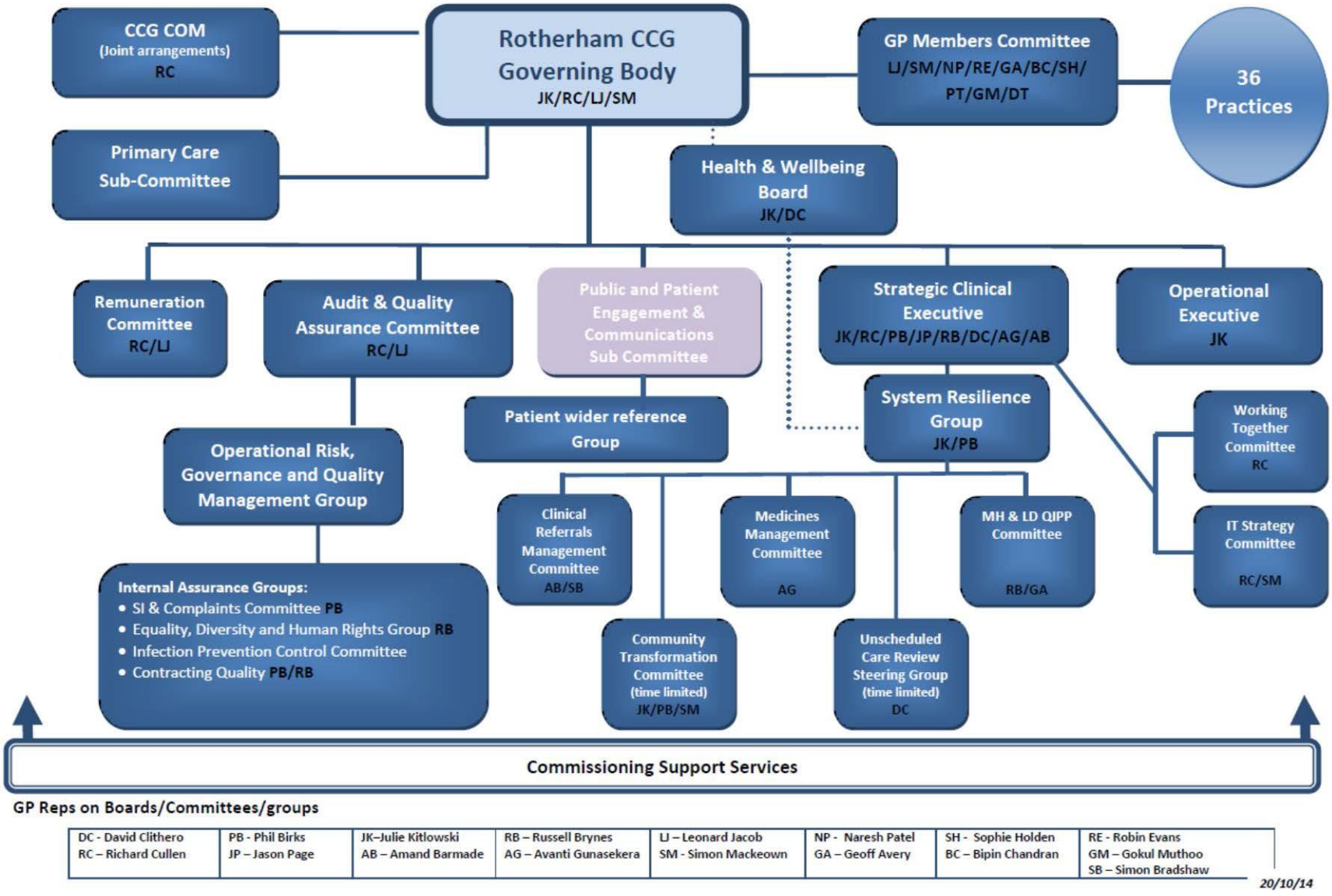
The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

4.1 Governance Structure

Our meeting governance structure is detailed below. There have been some recent additions to the structure as the CCG will be taking on delegated responsibility for Primary Care. The CCG also felt that it wanted to strengthen the public and patient engagement function of the CCG and have developed a sub-committee of the Governing Body

Organisational Chart 1: NHS Rotherham Clinical Commissioning Group Governance Structure, with GP representation



GP Reps on Boards/Committees/groups

DC - David Clithero RC – Richard Cullen	PB - Phil Birks JP – Jason Page	JK–Julie Kitlowski AB – Amand Barmade	RB – Russell Brynes AG – Avanti Gunasekera	LJ – Leonard Jacob SM - Simon Mackeown	NP - Naresh Patel GA – Geoff Avery	SH - Sophie Holden BC – Bipin Chandran	RE - Robin Evans GM – Gokul Muthoo SB – Simon Bradshaw

20/10/14

4.2 The CCG's constitution

The clinical commissioning group was licenced from 1 April 2013 without conditions, under provisions enacted in the Health & Social Care Act 2012, which amended the NHS Act 2006.

NHS Rotherham Clinical Commissioning Group is a membership organisation of 36 practices who are responsible for commissioning a range of health services on behalf of people in Rotherham.

The constitution sets out our arrangements to meet these responsibilities to ensure that decisions are made in an open and transparent way and that the interests of patients and the public are central. The constitution covers the responsibilities of individual member practices, the GP Members Committee (GPMC), the Governing Body and committees of the Governing Body.

It includes the CCG's duties to manage conflicts of interest and maintain a register of interests of its members and employees.

The constitution can only be varied in two circumstances.

- Where the CCG applies to NHS England and that application is granted;
- Where in the circumstances set out in legislation NHS England varies the CCG's constitution other than on application by the CCG.

The constitution will be reviewed on a regular basis at least every other year by the GP Members Committee and the Governing Body.

There are 2 opportunities per annum to submit changes to the constitution to NHS England for consideration, in June and November each year. However in 2014/15 NHS England changed the timescales to take in to account 'Primary Care delegation'. The CCG submitted amendments to NHS England for both general changes and Primary Care amendments in January.

Following the review of these changes, NHS England agreed and approved the proposed changes to the constitution.

4.3 The Governing Body

The Governing Body has been in place throughout the period 2014/15 and was quorate at each meeting.

The budget for which the Governing Body is responsible for includes the resources for community health services, maternity care, elective hospital services, urgent care, ambulance services, emergency and non-elective hospital services, older people's healthcare, children and young people's healthcare, rehabilitation services, healthcare for people with mental health and learning disabilities and continuing healthcare.

RCCG Member	Position	From - To	Possible attendance	Attended	%
J Kitlowski	GP – SCE member Chair	1st April 2014 – 31st March 2015	12	12	100
R Cullen	GP – SCE member	1st April 2014 – 31st March 2015	12	12	100
L Jacob	GP – GPMC	1st April 2014 – 31st March 2015	12	12	100
S MacKeown	GP - GPMC	1st April 2014 – 31st March 2015	12	11	92
*J Gomersall	Lay Member	1st April 2014 – 2nd Sept 2014	5	5	100
*J Barber	Lay Member	10th Nov 2014 - 31st March 2015	4	4	100
P Moss	Lay Member	1st April 2014 – 31st March 2015	12	12	100
H Ashurst	Secondary Care Doctor	1st April 2014 – 31st March 2015	12	11	92
C Edwards	Chief Officer	1st April 2014 – 31st March 2015	12	12	100
K Firth	Chief Finance Officer	1st April 2014 – 31st March 2015	12	11	92
R Carlisle	Deputy Chief Officer	1st April 2014 – 31st March 2015	12	11	92
S Cassin	Chief Nurse	1st April 2014 – 31st March 2015	12	11	92

RCCG Member	Position	From - To	Possible attendance	Attended	%
Participating Observers					
Public Health	Senior Public Health officials	1st April 2014 – 31st March 2015	12	10	83
K Wyatt/ J Doyle	Chair of the Health & Wellbeing Board (participating observer)	1st April 2014 – 4th Feb 2015	12	4	33
Officers in attendance					
S Whittle	Assistant Chief Officer (Board Secretary)	1st April 2014 – 31st March 2015	12	12	100
W Commons	Secretariat (minute taker)	1st April 2014 – 31st March 2015			

Vote of Confidence:

In accordance with the CCG's constitution, Rotherham CCG undertakes a vote of confidence from its member's each year. Two questions were asked:

1. Do you have confidence in the executive teams of the CCG?
   (100%) 36 out of 36 practices said 'Yes'.
2. Do you have confidence in the direction of travel?
   (94%) 34 out of 36 practices said 'Yes'.

The main functions of the Governing Body were to:

- lead the setting of vision and strategy.
- approve consultation arrangements for the commissioning plan and approve the 2015/19 commissioning plan.
- monitor performance against delivery of the annual commissioning plan.
- provide assurance of strategic risk.
- ensure the public sector equality duty is met.
- ensure active membership of Health and Wellbeing Board (HWBB).
- secure public involvement.
- promote the NHS constitution.
- delegate assurance of continuous improvement in quality to the Audit and Quality Assurance Committee (AQuA).
- promote improvement in the quality of primary care medical services.
- monitor the clinical quality of commissioned services.
- have regard to the need to reduce health inequalities.
- promote involvement of patients, their carers and representatives in decisions about their healthcare.
- act with a view to enable patients to make choices.
- promote innovation.
- promote research.
- promote education and training.
- promote integration of health services where this would improve quality or reduce inequalities.
- have responsibility for all financial duties.

The Rotherham CCG Governing Body considered a range of strategies, policies, quality/financial/performance assurance reports and risk/governance report throughout the year.

The Governing Body monitored performance on a monthly basis against the key performance indicators, which included the headline and support measures identified in the Operating Framework. For those indicators assessed as being below target, reasons for current performance were identified and included in the report along with any remedial actions to improve performance.

The Governing Body ensured that the organisation consistently followed the principles of good governance applicable to NHS organisations. This includes the oversight and development of systems and processes for financial control, organisational control, clinical governance and risk

management. The Governing Body assessed strategic and corporate risks against the CCG's objectives via the assurance framework.

4.4 CCG Governing Body performance including self-assessment

At a 'development day' for the Governing Body in March 2014, it was agreed that:

- we would change the layout of the room so that the public could observe more easily;
- nameplates would be used;
- the public would be asked for comments and feedback at the end of the meeting; and
- the 'big' items would be moved up the agenda.

All the above were implemented and has improved the patient engagement. In addition the Governing Body has changed the way they take questions from the public and has included a 10 minute standing agenda item at the beginning of meetings where the CCG encourage questions from members of the public or representative groups.

If members of the public wish to ask a question of the Governing Body, they must inform the secretary to the Governing Body at least seven working days prior to the meeting, summarising the question that they wish to pose. The Governing Body will endeavour to answer all questions but may have to limit it to 3 questions per meeting.

The Governing Body has recently untaken a self-assessment of its effectiveness. Feedback overall was very positive.

Full survey can be found at Appendix 1 – all comments and suggestions for further improvement will be taken forward in 2015/16

The organisation has a number of officers and competent advisors with lead responsibilities for governance and risk management.

The Chief Officer has responsibility for:

- Ensuring that the CCG fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money.
- At all times ensures that the regularity and propriety of expenditure is discharged, that arrangements are put in place to ensure that good practice is embodied and that safeguarding of funds is ensured through effective financial and management systems.
- Works closely with the chair of the Governing Body and ensures that proper constitutional, governance and development arrangements are put in place to assure the members (through the Governing Body) of the organisation's ongoing capability and capacity to meet its duties and responsibilities. This has included arrangements for the ongoing developments of its members and staff.

The Deputy Chief Officer has been responsible for research governance and risk management. He has coordinated the CCG's approach to governance, risk management and measures/monitors overall governance and risk management performance within the organisation.

The Chief Nurse is responsible for the management of serious incidents. The role also has the lead for clinical governance, responsibility for strategic development and operational implementation of patient safety, clinical risk management, safeguarding, quality of commissioned services and infection prevention and control. The Chief Nurse provides written evidence of assurance to the Governing Body on a monthly basis.

The Assistant Chief Officer is responsible for corporate governance, complaints, claims and freedom of information, providing written evidence of assurance to the Governing Body on a quarterly basis.

The Chief Finance Officer has responsibility for the implementation of financial risk management and ensuring strong financial governance processes and procedures are in place.

Lay members, in conjunction with the executive team, have responsibility for reviewing risk management strategies, processes and risk related issues via reports to the relevant committees.

Individuals have particular responsibilities in relation to their membership and chairmanship of various sub-committees.

All staff undertake a workplace induction which raises awareness of risk management policies and procedures and complete core mandatory training.

A mandatory training needs analysis is in place which clearly identifies the mandatory training requirements for all staff.

4.5 Audit and Quality Assurance Committee

The Audit and Quality Assurance Committee was established in April 2013 at the inception of Rotherham CCG as a statutory sub-committee reporting directly to the Governing Body.

The committee's primary role has been to review and report upon the adequacy and effective operation of the organisation's overall governance and internal control system, including risk management, financial, operational and compliance controls, together with the related assurances that underpin the delivery of the organisation's objectives contained within the assurance framework. This role is set out clearly in the committee's terms of reference which were revised during 2014/15 to ensure these key functions are embedded within the constitution and governance arrangements of Rotherham CCG. This will be reviewed again in July 2015.

The committee reviews the effective local operation of internal and external audit, as well as the Counter Fraud Service. In addition it ensures that a professional relationship is maintained between the External and Internal Auditors so that reporting lines can be effectively used. In addition the committee maintains oversight of the assurance processes associated with the quality of services commissioned on behalf of Rotherham patients.

Composition of the Audit and quality Assurance Committee

The committee membership during 2014/15 was comprised of two lay members of the CCG and two General Practitioners (GPs) supported by representatives of both Internal and external audit and senior CCG officers.

AQuA Member	Position	From - To	Possible attendance	Attendance	%
*Mr J Gomersall	Lay member for governance	1st April 2014 – September 2014	2	2	100
*Mr John Barber	Lay member for governance	November 2014 – 31st March 2015	3	3	100
Mr P Moss	Lay member – public and patient engagement	1st April 2014 – 31st March 2015	6	5	83
Dr R Cullen	GP – SCE	1st April 2014 – 31st March 2015	6	5	83
**Dr L Jacob	GP – GPMC	1st April 2014 – November 2014	4	3	75
**Dr S Holden	GP – GPMC	January 2015 – 31st March 2015	2	2	100

Standing invitations to attend:			
• The Chief Finance Officer – Keely Firth	6	5	83
• The Chief Nurse – Sue Cassin	6	4	66
• Assistant Chief Officer – Sarah Whittle	6	5	83
• The CCG'S Internal Auditors - provided by 360 Assurance	6	6	100
• The CCG's external auditors – provided by KPMG	6	6	100
• The local Counter Fraud Officer - provided by 360 Assurance (Agreed work plan to attend 2 out of the 6 meetings)	6	2	100

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 attends one meeting annually. Administration has been provided by Lisa Gash
* New Lay member for Governance **new GPMC member

The Audit and Quality Assurance Committee (AQuA) has met formally on 6 occasions during the year with all members attending regularly. Minutes of these meetings have been reported back directly to the CCG Governing Body.

The chairman attends periodic meetings of the 'chairs of the audit committees' of all the public sector organisations in Rotherham.

Links established between the Audit and Quality Assurance Committee Chair and the Chairs of the Audit committees of other Rotherham public service organisations to discuss areas of mutual interest in partnership working have been continued and extended.

The Audit and Quality Assurance Committee itself has focused upon examining the risks associated with both the new health service structures and also upon the effects of financial constraints particularly upon our major local health provider services. Close working relationships have been maintained with all health providers.

The committee has examined the effectiveness of the governance arrangements of the CCG. The Chair and Vice Chair have both attended and reported back on the functioning of the Strategic Clinical Executive meetings and the work of the Operational Risk, Governance & Quality Management Group.

Additionally the committee has examined in detail a number of proposed new policy documents relating to matters as varied as human resources, conflict of interest, standards of business conduct, media relations and sustainability, all of which contribute to the governance processes of the CCG.

Financial Statements

During the financial year the group has received exception updates on financial issues of the CCG.

The Chief Finance Officer reported on any risks to the financial position together with other miscellaneous matters such as single tender actions and losses and special payments. The committee has also received updates on progress with the agreed efficiency programmes which are integral to both the delivery of the medium term financial plan and the overall commissioning plan.

During the year the committee has been assured by the robustness of the financial arrangements through independent audit reports.

Internal Control and Risk Management Systems

At each meeting the committee has considered reports from its internal and external auditors and has also received updates on the risk management framework operating within the CCG. This has enabled the Audit and Quality Assurance Committee to examine the effectiveness of the organisation's assurance framework, financial performance and the processes for governance. Consideration of these areas has informed further work to ensure that the risk register has been

regularly revised to both reflect the rapidly changing backdrop to the work of the CCG and also to improve the actual maintenance of data within the register itself.

External Audit

During 2014/15 the CCG's external auditors have been KPMG and during the year the Audit and Quality Assurance Committee has worked constructively with the audit director and his team. Areas jointly examined have included:

- The nature and scope of the Annual Audit Plan.
- The extent of the co-ordination between internal and external audit plans.
- Receiving and considering reports derived from the Annual Plan.
- Receiving and considering the Annual Audit letter before its submission to the Board.

The work of external audit is monitored by the committee through regular progress reports. Their work is both timely and professional. The recommendations made are relevant and helpful in our overall assurance and governance arrangements and our work on minimising risk. There are clear and open relationships with officers and the reports produced are comprehensive and well presented.

In addition to local health service matters the committee has been kept appraised by our external auditors of developments elsewhere in public services both nationally and on the world stage. These discussions have been helpful in extending the committee's awareness of the wider context of our work.

Internal Audit

The Audit and Quality Assurance Committee has regularly reviewed and considered the work and findings of Internal Audit. 360 Assurance, our internal auditors, have attended every meeting to discuss their work. The auditors have not indicated any area of particular concern that should be brought to the committee or Governing Body's attention and the committee is highly satisfied with the liaison and coordination with our internal auditors.

During the year the following areas relating to internal audit have been considered:

- The nature and scope of the Annual Audit Plan.
- Progress on implementing the plan including individual audit reports.
- The Head of Internal Audit's annual opinion on the system of governance.

All reports provided by internal audit have given full or significant assurance in this year's plan.

For both internal and external audit, the audit committee have ensured that management actions agreed in response to reported weaknesses are being fully implemented in a timely manner. A new procedure for recommendation tracking and follow-up has been implemented which will ensure all actions have been addressed.

Reports are generally received on time and enable the committee to understand operational and financial risks. In addition, our internal auditors have provided valuable benchmarking information arising from their work elsewhere in the region.

Counter Fraud Specialist

During the year the following was achieved relating to counter fraud:

- Local counter fraud progress reports were provided to each meeting with the Counter Fraud Specialist attending twice a year to provide more detail.
- The counter fraud work, following organisational changes, continues to evolve and the service is appreciated by the Audit and Quality Assurance Committee as it has improved our ability to tackle fraud issues. In particular the committee are assured that the counter fraud training offered to NHS organisations and the widely distributed newsletter are playing an important role in raising awareness of potential fraud within the health service.

Integrated Governance

The Audit and Quality Assurance Committee is responsible for the maintenance of an effective system of integrated governance. It has maintained oversight of the whole process by seeking

specific reports on assurance on clinical, financial and managerial matters. In addition the group has been closely involved with establishing a governance and assurance framework fit for purpose for the Clinical Commissioning Group.

During 2014/15 the Audit and Quality Assurance Committee has reported areas of concern directly to the CCG's Governing Body and played a proactive role in communicating suggested amendments to both the risk assurance framework and the risk register.

Quality

During 2014/15 the Audit and Quality Assurance Committee has given attention to assuring the quality of services the CCG commissioned on behalf of patients. Specifically:

Our committee meetings are organised to allocate a specific part of the agendas to cover quality and patient safety issues together with patient experience and engagement work, including examination of the quality reports of our major providers as well as updates on serious incidents and other quality indicators from the Chief Nurse. The committee also seeks assurance through the presentation and discussion of reports from both the Adult and Children's Safeguarding Boards and reports of liaison with the Care Quality Commission and Local Authority in relation to residential and nursing homes. Reports and updates about healthcare associated infection (HCAI) regarding Rotherham CCG commissioned services are received and discussed by the committee.

Feedback is given to the committee from announced and unannounced clinically led visits to health service providers. Similarly the committee is given details of clinical audits carried out within the services we commission as a CCG. In addition the Audit and Quality committee receive regular reports from the sub group established to give detailed consideration of the operational implications of quality concerns.

Close liaison has been maintained with all our providers and the assurance processes on quality of patient care have been strengthened during the year by board to board meetings with the local hospital foundation trust and mental health trust.

The Serious Incident Committee (SIC) minutes reviewed by Audit and Quality Assurance Committee to ensure a robust process is maintained with regard to performance management and the annual report for 13/14 focused on pressure ulcers as requested by the Governing Body.

Looking Ahead

As a result of its work during the year the committee is satisfied that the CCG has appropriate and robust internal controls in place and that the systems of governance incorporated in the constitution are fully embedded within the organisation. The committee has been assured that there are no areas of significant duplication or omission in the systems of governance and internal control. Constant vigilance has been maintained in relation to the quality of services commissioned.

Looking forward to 2015/16 the Audit and Quality Assurance Committee will continue to explore the financial, management, governance and quality issues that are an essential component of the success of the Rotherham Clinical Commissioning Group.

Specifically the committee will:

- Continue to examine the governance and internal control arrangements of the Clinical Commissioning Group.
- Continue to seek assurance upon quality and patient safety within the services commissioned by the CCG including local providers' responses to the Francis, Winterbourne, Berwick, Keogh, Saville investigation, Alexis Jay and Louise Casey reports.
- Monitor closely risks faced by the CCG itself and also by our major providers.
- Work closely with the local authority audit committee on issues arising from financial and governance matters affecting the public sector community, for example the Better Care Fund.
- Work closely with our external and internal auditors on issues arising from both the current and new agendas for the Clinical Commissioning Group.
- Ensure the CCG is kept aware of our work including both positive and adverse developments.
- Request and discuss in detail a number of 'deep dives' into specific areas to ensure adequate assurance is received by the CCG. The 'deep dives' for 15/16 are A&E, non-elective over

performance, delayed transfer of care, elective over-performance, Yorkshire Ambulance Service and C-Difficile.
- Consider the CCG's compliance against the newly published 'Standards for Commissioners 2015/16 : Fraud, Bribery and Corruption'.

Audit and Quality Assurance Committee self-assessment

Full survey can be found at Appendix 2 – all comments and suggestions for further improvement will be taken forward in 2015-16.

A comparison between the effectiveness of the committee between the years 2012/13, 2013/14 and 2014/15 can be found at Appendix 3

4.6 Remuneration Committee

The Remuneration Committee was established in April 2013 at the inception of the Rotherham Clinical Commissioning Group as a statutory sub-committee reporting directly to the new Governing Body.

The committee has delegated authority on behalf of the Governing Body to determine appropriate terms of service for any appointments that require local determination of terms and conditions.

On behalf of the Governing Body, it determines all aspects of remuneration - including any performance related payments, pensionable pay and other entitlements, as applicable.

It will also determine arrangements for termination of employment and other contractual terms for those staff.

It determines allowances payable to members of the Governing Body the Strategic Clinical Executive and GP Members Committee.

In undertaking these responsibilities it operates within the provisions of the relevant contractual provisions for these staff groups and taking due account of relevant national guidance, directions and legislation.

The committee updated its Terms of reference during 2014/15

Remuneration Committee Membership during 2014/15

Member	Position	From - To
*Mr J Gomersall	Lay member for governance	1st April 2014 – September 2014
*Mr John Barber	Lay member for governance	Nov 2014 – 31st March 2015
Mr P Moss	Lay Member – public and patient engagement	1st April 2014 – 31st March 2015
Dr J Kitlowski	GP (GB Chair)	1st April 2014 – 31st March 2015
Dr R Cullen	GP – SCE (finance & governance)	1st April 2014 – 31st March 2015
Dr L Jacob	GP – GPMC	1st April 2014 – 31st March 2015
In Attendance:	Mrs K Firth, Chief Finance Officer; Mrs S Whittle, Assistant Chief Officer; and Mr P Smith; Head of HR	
*new Lay member		

The Remuneration Committee has met 4 times throughout the year and has approved the following:
The annual allowance for:
- Chief Officer, Chief Finance Officer, Deputy Chief Officer;
- Hospital doctor;
- Lay members; and
- SCE GPs, GP Members Committee (chair and vice chair).

The committee also agreed:
- a new GP post for safeguarding children and vulnerable adults;

- additional days leave for all staff in recognition of achieving 'Investors in Excellence'; and
- an increase in the Chief Officers remuneration.

4.7 Primary Care Sub-Committee

NHS England will delegate to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act from April 2015. As a result the CCG has established a new Primary Care sub-committee.

The committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Rotherham, under delegated authority from NHS England.

In performing its role the committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Rotherham CCG, which will sit alongside the delegation and terms of reference.

The functions of the committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity, value for money and to remove administrative barriers.

The role of the committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, including the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

The CCG will also carry out the following activities:

- To plan, including needs assessment, primary medical care services in Rotherham;
- To undertake reviews of primary medical care services in Rotherham;
- To co-ordinate a common approach to the commissioning of primary care services generally;
- To manage the budget for commissioning of primary medical care services in Rotherham.

The membership shall consist of:

- Three lay members
- The Chief Officer
- The Chief Finance Officer
- The Chief Nurse
- The Head of Co-Commissioning
- NHS England

Non-voting members:

- The lead SCE-GP with the portfolio for Primary Care
- The lead SCE-GP for governance
- A member of the GP members committee

In attendance:

- HealthWatch Representative
- Health & Wellbeing Board representative

4.8 Public And Patient Engagement And Communications Sub-Committee

The PPE & Communications Sub-Committee is established in accordance with Rotherham Clinical Commissioning Group's constitution. This sub-committee provides strategic and operational leadership for the development of effective public and patient engagement.

Strategic direction

- To oversee the development & implementation of the communications & engagement strategies and action plans.
- Ensure that patient and public engagement is central to the business of the CCG and that it is embedded in all decision making processes adopted by the CCG.
- Advise the Governing Body on all matters relating to engagement and the process of formal consultation.
- Ensure that the CCG (and the services it commissions) engage in meaningful dialogue with its public, patients and partners.
- Design the specification and quality standards relating to the process of engagement, communication and consultation that will be used by all members of the Clinical Commissioning Group and by its staff, in particular that which will be used in the process of service transformation and service redesign, at the earliest stages.
- Address ways to increase wider patient & public involvement/engagement, scanning for and implementing new and innovative mechanisms for engagement, especially in regard to under-engaged communities.

Quality and Performance Management

- To monitor delivery of the Communications and Engagement Strategy.
- To monitor delivery against a range of standards relating to engagement, communications and consultation.
- To consider trends of complaints and MP enquiries relating to services commissioned.
- To Secure continuous improvement in the quality of engagement and communication.
- Provide assurance to the Governing Body on communication and patient, carer and public engagement. This includes assurance that the needs, views and aspirations of patients, carers, local community groups and the general public have:

  - ✓ helped shape and influence service delivery;
  - ✓ are being used to develop priorities, strategies and plans;
  - ✓ have helped to procure services; and
  - ✓ are being used to monitor services in terms of safety, quality and positive patient experience.

The meeting met once in 14/15 – This new sub-committee will meet 4 times a year

PPE & Comms Member	Position	From - To	Possible attendance	Attendance	%
Mr P Moss (chair)	CCG Lay Member for Public & Patient Engagement	1st April 2014 – 31st March 2015	1	1	100
TBA	Primary Care - Governing Body member		0	0	
Sue Cassin	Chief Nurse	1st April 2014 – 31st March 2015	1	1	100
Sarah whittle	Assistant Chief Officer	1st April 2014 – 31st March 2015	1	1	100
Lydia George	Planning and Assurance manager	1st April 2014 – 31st March 2015	1	1	100
TBA	GPMC				
Helen Wyatt	Patient and Public Engagement Manager,	1st April 2014 – 31st March 2015	1	1	100

PPE & Comms Member	Position	From - To	Possible attendance	Attendance	%
Janet Wheatley	Voluntary Sector Rep	1st April 2014 – 31st March 2015	1	1	100
TBA	HealthWatch		1	1	100
TBA	Representative from wider reference Group				
TBA	Representative from Public health				
Elaine Barnes	Equality & diversity lead (CSU)	1st April 2014 – 31st March 2015	1	1	100
Gordon Laidlaw	Communications Manager	1st April 2014 – 31st March 2015	1	1	100

The committee may also co-opt other senior clinicians or managers as necessary. These will be non-voting members of the committee. The Chair and Chief Executive of the CCG will attend one meeting of the sub-committee per year.

4.9 Health & Wellbeing Board

The Health and Wellbeing Board is a statutory, sub-committee of Rotherham Metropolitan Borough Council. Locally, it will be the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing in order to secure better health and wellbeing outcomes for the whole Rotherham population, better quality of care for all patients and care users and better value for the taxpayer.

The board brings together key decision makers to address issues of local significance and to seek solutions through integrated and collaborative working, whilst being an advocate and ambassador for Rotherham collectively on regional, national and international forums.

Functions of the board include:

- To enable, advise and support organisations that arrange for the provision of health or social care services to work in an integrated way, for the purpose of advancing the health and wellbeing of people in Rotherham.
- To ensure that public health functions are discharged in a way that help partner agencies to fully contribute to reducing health inequalities.
- To oversee the development of local commissioning plans, to ensure that all commissioning plans take account of the Health and Wellbeing Strategy and are aligned to other policies and plans that have an effect on health and wellbeing, and where necessary initiate discussions with the NHS England if an agreed concern exists regarding a failure to take account of the strategy.
- To hold relevant partners to account for the quality and effectiveness of their commissioning plans.
- To ensure that there are arrangements in place to provide assurance that the standards of service provided and quality of service are safe, meet national standards and local expectations.
- To reduce health inequalities and close the gap in life expectancy by ensuring that partners are targeting services to those who need it the most.
- To develop a shared understanding of the needs of the local community through the statutory joint strategic needs assessment (JSNA), and ensure public engagement and involvement in the development of the JSNA so that the experiences of local people influence policy development and service provision.

- To promote the development and delivery of services which support and empower the citizen taking control and ownership for their own health, whilst ensuring the safeguarding of vulnerable adults and children.
- To develop a joint Health and Wellbeing Strategy to provide the overarching framework for commissioning plans for the NHS, social care and public health and other services that the board agrees to consider such as education, housing and planning and to subject this strategy to regular review and evaluation.
- To assess whether the commissioning arrangements for social care, public health and the NHS are sufficiently aligned to the joint Health and Wellbeing Strategy and promote joined up commissioning plans and pooled budget arrangements where all parties agree this makes sense.
- To prioritise services (through the development of the Health and Wellbeing Strategy) that are focused on prevention and early intervention to deliver reductions in demand for health and social care services.
- To oversee at strategic level the relevant joint communications, marketing/social marketing and public relations programmes and campaigns required to support the delivery of health and wellbeing objectives in the borough and ensure that local people have a voice in shaping and designing programmes for change.
- To ensure that the people of Rotherham are aware of the Health and Wellbeing Board, have access to the relevant information and resources around the different work streams and can contribute where appropriate.

From February 2015 the Health & Wellbeing Board membership from the council is under review as the secretary of state for Communities and Local Government has appointed commissioners to run Rotherham Council following the publication if the Casey report.

5. THE CLINICAL COMMISSIONING GROUP RISK MANAGEMENT FRAMEWORK

NHS Rotherham CCG's risk management and assurance framework was in place throughout 2014/15.

The CCG has a responsibility to ensure that the organisation is properly governed in accordance with best practice corporate, clinical and financial governance. Every activity that the CCG undertakes or commissions others to undertake on its behalf, brings with it some element of risk that has the potential to threaten or prevent the organisation achieving its objectives.

This integrated risk management policy enables the organisation to have a clear view of the risks affecting each area of its activity; how those risks are being mitigated, the likelihood of occurrence and their potential impact on the successful achievement of the CCG objectives. This document sets out the policy for the identification and management of risk within the CCG.

The policy applies to all members of the CCG, the Strategic Clinical Executive, Operational Executive and all managers to ensure that risk management is a fundamental part of the CCG approach to the governance of the organisation and all its activities.

The policy:

- Sets out the organisational attitude to and appetite for risk;
- Clearly defines the structures for the management and ownership of risk;
- Clearly identifies how to manage and mitigate situations in which a potential risk develops into an actual risk;
- Specifies the way in which risk issues are considered at each level of business planning;
- Specifies how new and existing activities are assessed for risk and dependent on the level of risk;
- Uses common terminology and scoring in relation to risk issues which is replicated across the assurance framework and risk register;
- Defines the structures for gaining assurance about the management of risk;
- Defines the way in which the risk register, assurance framework and risk evaluation criteria will be regularly reviewed; and
- Is easily available to all staff on the CCG website.

Risk identification, assessment and monitoring is a continuous structured process in ensuring that the CCG works within the legal and regulatory framework, identifying and assessing possible risks facing the organisation, and planning to prevent and respond to these. The process of risk management covers the following 5 steps to risk assessment:

- Step 1 - Identify the risk;
- Step 2 – Assess the risk;
- Step 3 – Evaluate the risk;
- Step 4 – Record the risk;
- Step 5 – Review the risk.

Risk management is embedded in the activity of the organisation through the above measures and also through assessments of specific risks e.g. information governance, equality impact assessment, business continuity.

The Internal Audit Report on risk management, November 2013, assessed the process as providing significant assurance. The report identified three recommendations all of which have now been actioned.

Control measures are in place to ensure that all the clinical commissioning group's obligations under equality, diversity and human rights legislation are complied with.

6. THE CLINICAL COMMISSIONING GROUP INTERNAL CONTROL FRAMEWORK

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

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

Rotherham CCG has established and maintains, via the Audit and Quality Assurance Committee, continual reporting, auditing and monitoring to ensure standards are being implemented, and therefore, risk is controlled to the lowest reasonably practicable levels.

Methods for identifying and managing levels of risk would include:

Internal methods, such as; Incidents, complaints, claims and audits, project risks based on the achievement of project objectives, patient satisfaction surveys, risk assessments, surveys including staff surveys, whistle-blowing and contract quality monitoring of commissioned services.

External methods, such as; media, national reports, new legislation, NPSA surveys, reports from assessments/inspections by external bodies, reviews of partnership working.

All identified risks will be recorded and managed through the organisational risk register and risks identified which could impact on the achievement of the CCG's strategic objectives are recorded and managed through the assurance framework.

All groups reporting to the CCG Governing Body highlight risks for inclusion within the organisational risk register or assurance framework.

Risk identification is also obtained from member practices through practice visits, locality meetings, GP Members Committee meetings, patient engagement forums, practice feedback forums and practice managers meetings.

Information Governance

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

NHS Rotherham CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We carried out an information governance work programme and undertake assessment by the IG Toolkit annually. Delivery of the information governance work programme was overseen by the Operational Risk, Governance and Quality Management Group, which is chaired by the Caldicott Guardian. We have ensured all staff undertake annual information governance training and have implemented a set of policies and procedures to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. During 2014/15 all reported information governance incidents relating to Rotherham were of minor significance. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

7. RISK ASSESSMENT IN RELATION TO GOVERNANCE, RISK MANAGEMENT & INTERNAL CONTROL

Current risks as at the end of March 2015

The CCG operates a standard 5x5 matrix for assessing risk.

Risk Matrix		Likelihood				
		(1) Rare	(2) Unlikely	(3) Possible	(4) Likely	(5) Almost certain
Consequenc	(1) Negligible	1	2	3	4	5
	(2) Minor	2	4	6	8	10
	(3) Moderate	3	6	9	12	15
	(4) Major	4	8	12	16	20
	(5) Extreme	5	10	15	20	25

1-5	Low
6-11	Medium
12-15	High
16-20	Very High
25	Extreme

The CCG risk register and assurance framework were updated on an ongoing basis to reflect any changes to currently identified risks or to add newly identified risks and were both updated every 2 months up to June 2014. Following the introduction of the Corporate Assurance Report and agreement at the Governing Body time out session that focussed on risk management, the frequency changed to quarterly. The Audit and Quality Assurance Committee and the CCG Governing Body received both the risk register and assurance framework on a quarterly basis during 2014/15.

The table below shows the number of risks on the CCG risk register and Governing Body assurance framework as at 12 March 2015:

Risk Score	assurance framework	risk register	Rating Explained
0-5	5	19	Low Risk Retired
6	1	11	Medium Risk
8	1	10	Medium Risk
9	1	10	Medium Risk
12	12	11	High Risk
15	1	3	High Risk
16	4	7	Very High Risk
20	5	4	Very High Risk
25	0	0	Extreme Risk
Total	**30**	**75**	

2014/15 the following risks were added to the assurance framework:

Date reported to AQuA	AF Number	Description	Score as at March 2015
September 2014	AF29	Child Sexual Exploitation (CSE) - RMBC may not be able to effectively work with NHSR CCG to deliver the partnership agenda as there resources will be targeted to dealing with CSE.	20
September 2014	AF28	Failure of YAS to achieve RED 1 8 minute Target at CCG level and During Yorkshire & Humber wide	20
March 2015	AF31	Patient safety and cost implications of interpretation of individual case meeting health and LD funding responsibility (including section 117, 'who pays' guidance, responsibilities for LD patients transfer at 18, Potential future responsibility for Tier 4 mental health and LD patients).	16
January 2015	AF30	Capacity with TRFT Safeguarding Team - covering Adults & Children	12
January 2015	AF32	Financial risk to the CCG arising from it's duties under developing case law regarding potential Deprivation of Liberties (DoLS)	12
April 2014	AF 27	Named GP for Safeguarding Children due to leave organisation. This will leave a significant gap in safeguarding assurance in primary care	1

The CCG commissioning plan was updated for 2015-19, the key risks to delivering the plan were identified as:

- GP recruitment and retention affecting pathways provided by GPs and the availability of GPs to take part in commissioning.
- Variations in GP services leading to variations in services offered to patients.
- NHS Efficiency challenge:
  - Quality implications – cumulative impact of year on year 4% efficiency requirements causing a negative impact on patient safety;
  - CCG affordable trajectories – CCG not able to keep non-elective and elective activity within affordable trajectories;
  - Providers not being able to deliver efficiency plans;
  - Viability of local services could be affected by efficiency plans.
- NHS funding - central decisions on CCG resource allocation could affect the CCG's viability.
- Loss of local focus and changed role of NHS England:
  - Primary care co-commissioning – resources may not be available to effectively discharge the CCG's new responsibilities;
  - Specialist commissioning - risk of the CCG not being able to address its new specialist responsibilities effectively and risks that over spends in areas of NHS England responsibility could be transferred to the CCG.
- Ability to recruit to senior leadership of the Public Health function in Rotherham - may compromise the CCG's and partner's ability to address public health challenges.
- Inability of partners to deliver the recommendations of the Casey report.
- Patient transport services - Yorkshire Ambulance Service not meeting targets impacting on patient safety.

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

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance. Our constitution delegates responsibility to ensure appropriate arrangements are in place for the CCG to fulfil this duty to the Audit and Quality Assurance Committee. The Chief Finance Officer has delegated responsibility to determine arrangements to ensure a sound system of financial control.

The Audit & Quality Assurance Committee receives opinions from the work of the internal and external auditors to the clinical commissioning group and is able to advise the Governing Body on the assurances available with regards to the economic, efficient and effective use of resources by the clinical commissioning group.

9. REVIEW OF THE EFFECTIVENESS OF GOVERNANCE, RISK MANAGEMENT & INTERNAL CONTROL

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

Capacity to Handle Risk

9.1 NHS Rotherham CCG Governing Body

The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces, and that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Governing Body discharges this duty as follows:

Identifies risks to the achievement of its strategic objectives:

- Monitors these on an ongoing basis via the assurance framework;
- Ensures that there is a structure in place for the effective management of risk throughout the CCG;
- Receives assurance regarding risk management within organisations providing services commissioned by the CCG;
- Approves and reviews strategies for risk management on an annual basis;
- Receives the minutes of the Audit and Quality Assurance Committee, and any items that have been identified for escalation to the Governing Body;
- Receives the risk register and assurance framework quarterly, assures itself of progress on mitigating actions and assurance regarding the significant risks identified in relation to commissioned services; and
- Demonstrates leadership, active involvement and support for risk management.

9.2 The Strategic Clinical Executive and GP Members Committee

The eight GP members of the Strategic Clinical Executive and members of the GP Members Committee promote risk management processes, as part of clinical governance, with all Rotherham CCG member practices. This ensures that practices continuously improve quality of primary care and report risks relating to commissioned services to the CCG, and risks relating to primary care to NHS England to ensure that risks are identified and managed.

9.3 The Chief Officer

The Chief Officer has overall accountability for the management of risk and is responsible for:

- Continually promoting risk management and demonstrating leadership, involvement and support;
- Ensuring an appropriate committee structure is in place, with regular reports to the CCG Governing Body;
- Ensuring that the Operational Executive, Strategic Clinical Executive and senior managers are appointed with managerial responsibility for risk management;
- Ensuring appropriate policies, procedures and guidelines are in place and operating throughout the CCG; and
- Ensuring complaints, claims and health and safety management are managed appropriately.

9.4 Deputy Chief Officer

The Deputy Chief Officer is the executive lead for risk management and has delegated responsibility for:

- Ensuring risk management systems are in place throughout the CCG;
- Ensuring the assurance framework is regularly reviewed and updated and reported to the Audit and Quality Assurance Committee;
- Ensuring that an organisational risk register is established, maintained and reported to the Audit and Quality Assurance Committee;

- Ensuring that there is appropriate external review of the CCG's risk management systems, and that these are reported to the CCG Governing Body;
- Overseeing the management of risks as determined by the executive team; and
- Ensuring that identified risk mitigation and actions are put in place, regularly monitored and implemented.

9.5 Chief Finance Officer

The Chief Finance Officer has delegated responsibility for financial risk management.

9.6 Chief Nurse

The Chief Nurse has delegated responsibility for clinical risk management including:

- The executive lead responsible for safeguarding adults, safeguarding children and infection, prevention and control;
- Managing and overseeing the performance management of serious incidents reported by providers of its commissioned services regarding Rotherham registered patients as per delegated responsibility by NHS England. The Serious Incident Framework can be found at http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf ;
- Ensuring that processes are in place to provide assurance with regard to clinical risk management within commissioned services, this includes (but not exclusively), patient safety regarding commissioned services in line with local and national legislation and guidance; and
- Collating intelligence from the Strategic Clinical Executive GPs with responsibility for quality of primary care, secondary care and mental health services.

9.7 Individuals Responsible

The following individuals: Clinical Chair of CCG Governing Body, Vice Chair of CCG Governing Body, GPs with lead responsibility for Primary Care Quality, Secondary Care, Mental Health Quality, Children's and Adult Safeguarding, have responsibility for identifying risks in their specific areas and discussing these with the Chief Nurse and ensuring that assessment and mitigation is carried out providing assurance to the CCG Governing Body via the Audit and Quality Assurance Committee.

9.8 Planning and Assurance Manager

The Planning and Assurance Manager, has responsibility for:

- Ensuring that an organisational risk register and an assurance framework are developed and maintained and reviewed by the Executive Team;
- Ensuring that risks are reviewed on a bi-monthly basis by the senior managers designated as risk holders;
- Ensuring that the Operational Executive have the opportunity to review risks jointly;
- Providing advice on the risk management process;
- Ensuring that the CCG assurance framework and risk register are up to date for the CCG Governing Body and all of its sub–committees;
- Working collaboratively with Internal Audit; and
- Ensuring that the Integrated Risk Management Policy is updated on an annual basis and approved by the CCG Governing Body.

9.9 All Senior Managers

Senior Managers are responsible for incorporating risk management within all aspects of their work and for directing the implementation of the CCG Integrated Risk Management Policy by:

- Demonstrating personal involvement and support for the promotion of risk management;
- Ensuring that staff accountable to them understand and pursue risk management in their areas of responsibility;
- Setting personal objectives for risk management and monitoring their achievement;
- Ensuring risks are identified and managed and mitigating actions implemented in functions for which they are accountable and are included in the organisational risk register as appropriate;
- Ensuring risks are escalated where they are of a strategic nature; and
- Implementing the framework in relation to Health & Safety and other employment legislation by:

a) Ensuring that they have adequate knowledge and/or access to all legislation relevant to their area and as advised by appropriate specialist officers ensure that compliance to such legislation is maintained;
b) Ensuring that adequate resources are made available to provide safe systems of work;
c) Ensuring that all employees attend appropriate mandatory training, as relevant to the role, e.g. health & safety, fire, moving and handling and risk management training;
d) Ensuring that all staff are aware of the system for the reporting of accidents and near misses
e) Monitoring of health and safety standards, including risk assessments, and ensuring that these are reviewed and updated regularly;
f) Ensuring the identification of all employees who require Health Surveillance according to risk assessments; ensuring that where Health surveillance is required no individual carries out those specific duties until they have attended the Occupational Health Department and have been passed fit;
g) Ensuring that the arrangements for the first-aiders and first aid equipment required within the organisation are complied with. That the location of first aid facilities are known to employees; ensuring that proper care is taken of casualties and that employees know where to obtain appropriate assistance in the event of serious injury;
h) Making adequate provision to ensure that fire and other emergencies are appropriately dealt with.

9.10 All Staff

All staff working for the CCG are responsible for:

- Being aware that they have a duty under legislation to take reasonable care of their own safety and the safety of others who may be affected by the CCG's business and to comply with appropriate CCG rules, regulations, instructions, policies, procedures and guidelines.
- Taking action to protect themselves and others from risks.
- Identifying and reporting risks to their line manager.
- Ensuring incidents, claims and complaints are reported using the appropriate procedures and channels of communication.
- Co-operating with others in the management of the CCG's risks.
- Attending mandatory and statutory training as determined by the CCG or their Line Manager.
- Being aware of emergency procedures relating to their particular locations.
- Being aware of the CCG's Integrated Risk Management Policy and complying with the procedures.

9.11 Contractors, Agency and Locum Staff

- Managers must ensure that where they are employing or contracting agency and locum staff they are made aware of and adhere to, all relevant policies, procedures and guidance of the CCG, including the CCG Incident reporting policy and procedure and the Health and Safety Policy.
- Take action to protect themselves and others from risks.
- Bring to the attention of others the nature of risks which they are facing in order to ensure that they are taking appropriate protective action.

10. REVIEW OF EFFECTIVENESS

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

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body and the Audit Quality and Assurance Sub-committee if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

> ***Overall Opinion***
>
> *I am pleased to report that we are providing the CCG with **Significant Assurance** as there is a generally sound system of internal control, designed to meet objectives, and that controls are generally being applied consistently. This opinion is determined through our review of your Governing Board Assurance Framework (GBAF) and associated processes and the work that we have undertaken throughout the year.*

The full report can be viewed under Appendix 3.

My review is also informed by:

- Internal and external audit reports
- Local Authority scrutiny process
- NHS Staff Survey
- Performance management systems
- Internal committee structure with delegated responsibility for risk identification, evaluation, control, review and assurance.
- Review of the assurance framework
- Risk registers
- Annual commissioning plan
- Quality schedules and dashboards
- Investors in Excellence accreditation

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the:

- NHS England Area Team
- Audit and Quality Assurance Committee
- Operation-al Risk Governance and Quality Management Group
- NHS Rotherham Clinical Commissioning Group Governing Body

The assurance framework is used as the plan to address weakness and ensure continuous improvement of the system. NHS Rotherham Clinical Commissioning Group have been involved with the development of the assurance framework and have maintained an overview of the assurance framework, commenting as appropriate and endorsing actions. The assurance framework has been approved by Audit & Quality Assurance Committee.

The Governing Body has overseen the work of Audit & Quality Assurance Committee, determines the CCG's approach to risk management and ensures that systems of internal control exist and are functioning properly. Audit & Quality Assurance Committee oversee all issues of risk management within the CCG, ensuring that all significant risk management concerns are considered and communicated appropriately to the Governing Body. The Governance systems and Governing Body agreed a process to ensure that the assurance framework is monitored and updated as a live document.

The CCG Governing Body and Audit & Quality Assurance Committee review the establishment and maintenance of an effective system of internal control and risk management and also received and reviewed the assurance framework.

11. DATA QUALITY

The majority of numerical data presented to the Governing Body is produced by Yorkshire & Humber Commissioning Support Unit who process provider information under an SLA with the CCG. The CCG has regular performance meetings with the CSU and gives monthly feedback on quality. The CCG's

major providers including The Rotherham Foundation Trust (TRFT) and Rotherham, Doncaster and South Humber Foundation Trust (RDaSH) participate in internal and external audits of their data quality. Although TRFT data is in the middle range according to the audit commission, local GPs provide feedback to improve data quality. Data quality for Mental Health Trusts nationally is not as high as for acute trusts. RDASH is in the first wave of trusts who are improving data quality as part of the Mental Health payment by results (PBR) project.

12. BUSINESS CRITICAL MODELS

An appropriate framework and environment is in place to provide quality assurance of business critical models, in line with the recommendations in the Macpherson report.

13. DATA SECURITY

We have submitted a satisfactory level of compliance with the information governance toolkit assessment. There have been no significant lapses in data security.

14. DISCHARGE OF STATUTORY FUNCTIONS

During establishment, the arrangements put in place by the clinical commissioning group and explained within the *Corporate Governance Framework* were developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

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

15. CONCLUSION

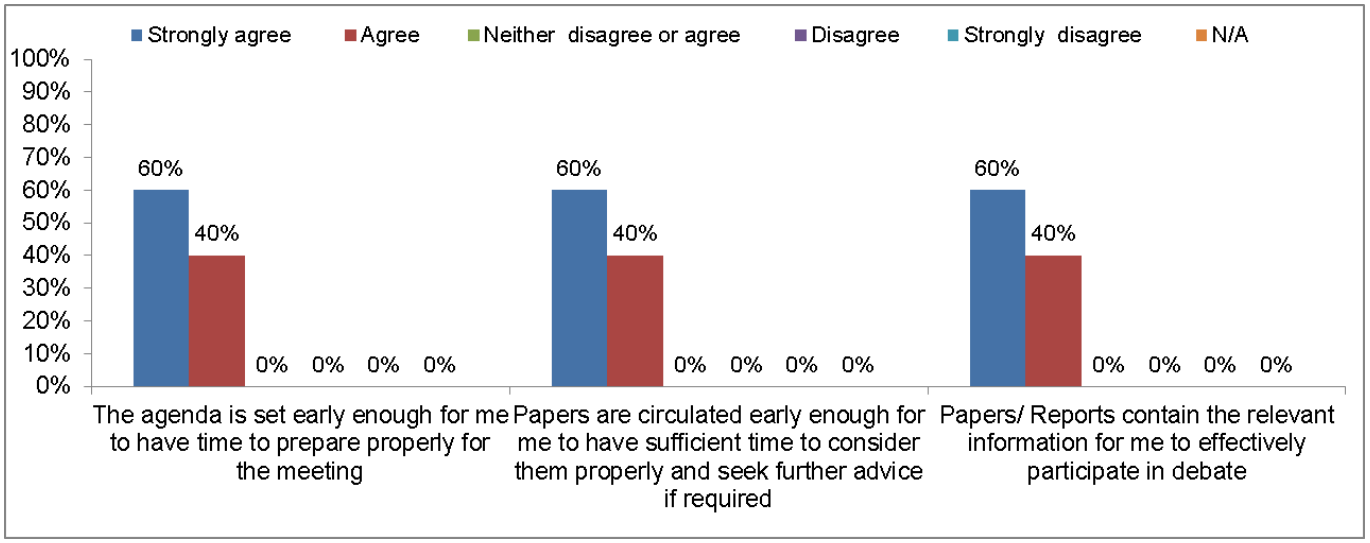
No significant control weaknesses have been identified during the year. The CCG has received positive feedback from Internal Audit on the assurance framework and this, in conjunction with other sources of assurance, leads the CCG to conclude that it has a robust system of control.

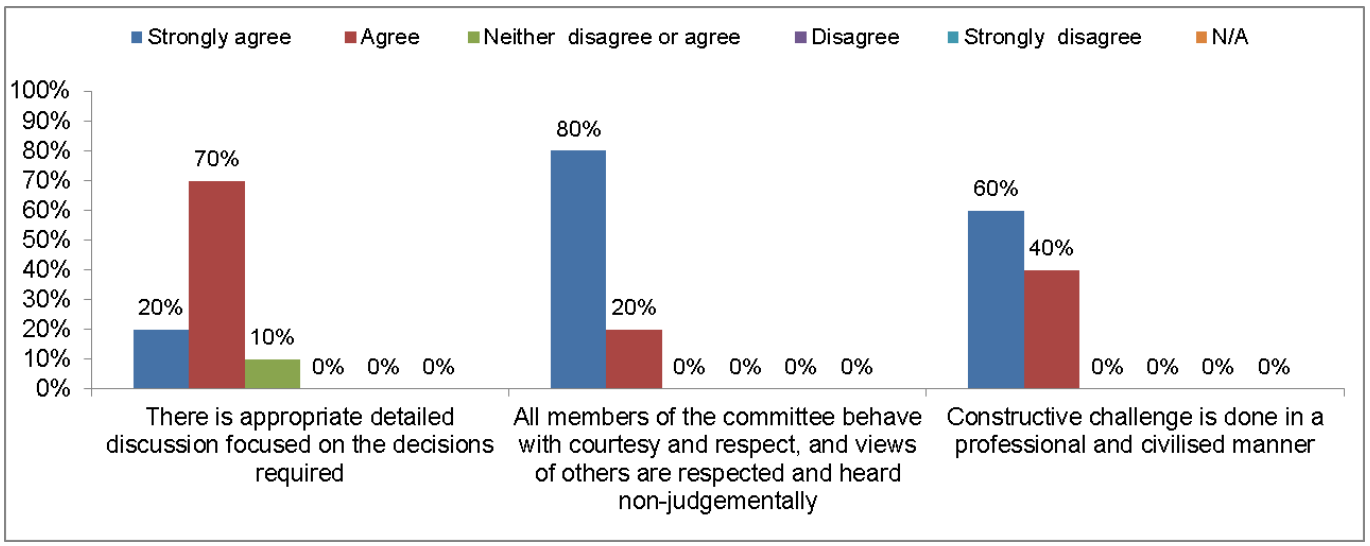
Chris Edwards
Accountable Officer - May 2015

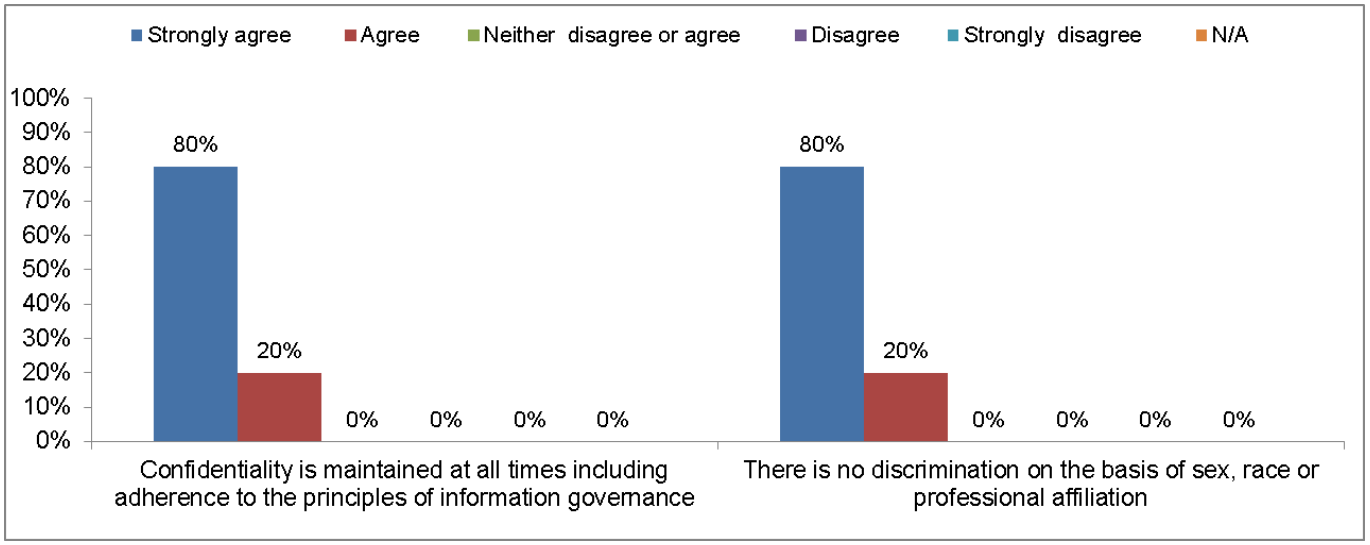
APPENDIX 1 - CCG GOVERNING BODY COMMITTEE MEMBERS EFFECTIVENESS 2014/15

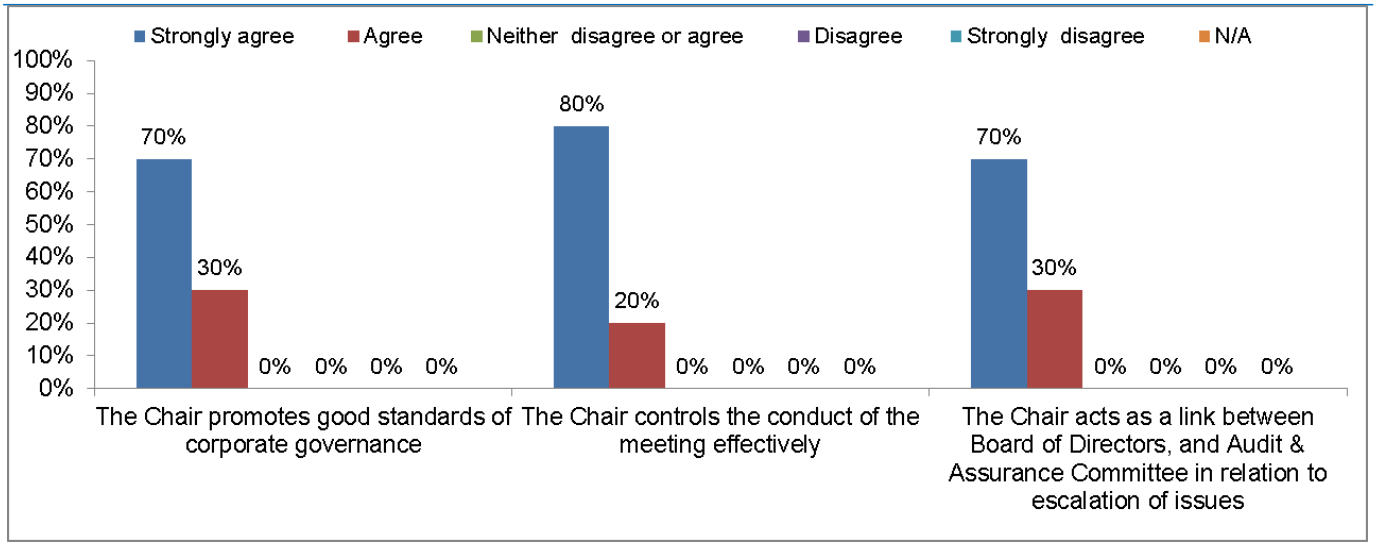
Results from the committee members effectiveness review of the Governing Body Meetings.

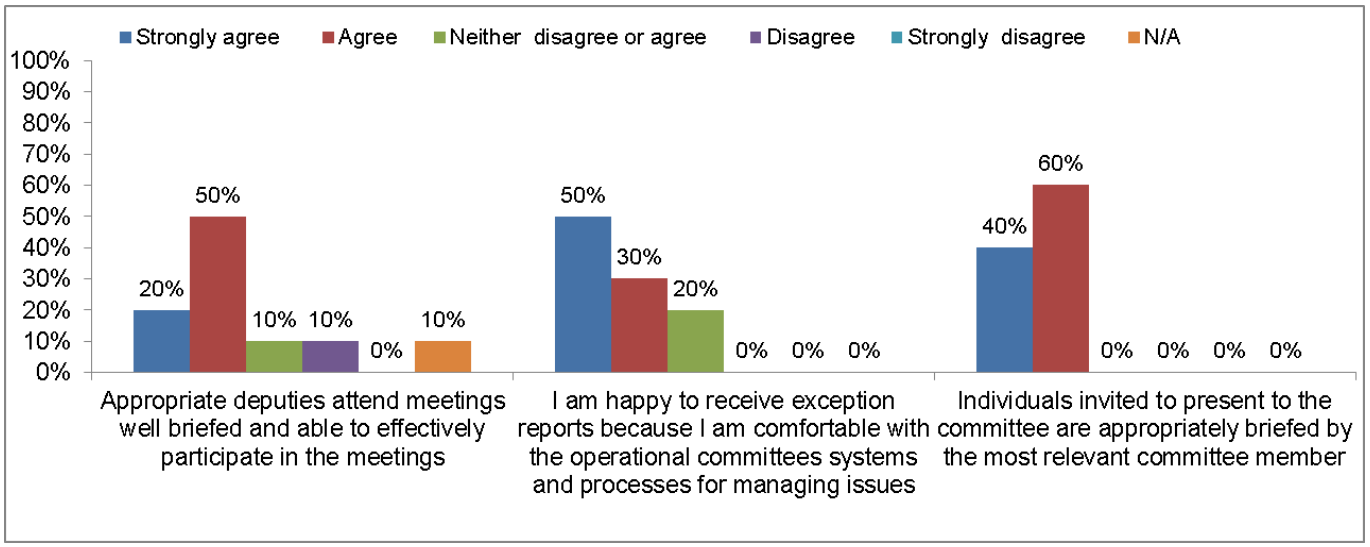
Sample Size = 10

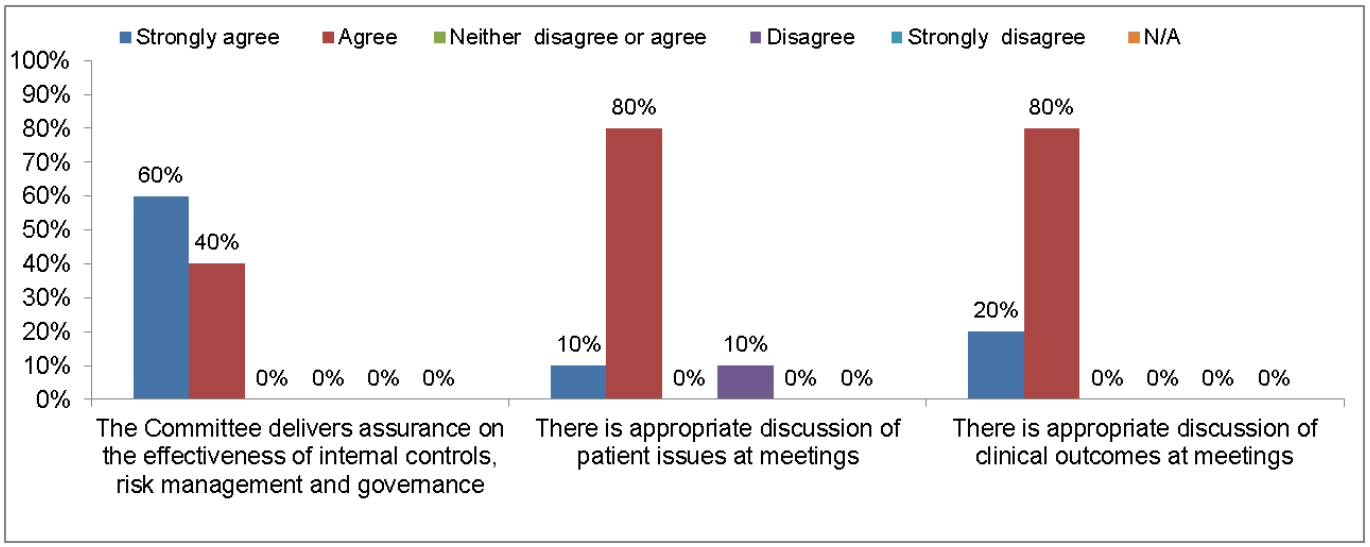












Comments

- I would like to see more scrutiny of the performance and the delivery of our stakeholders as regards our commissioning contract with them especially the Community and Mental Health services. Also to start changing the culture of treating the Primary Care, as providers, differently from the rest of our other Stakeholders and deal with them on equitable basis when it comes to allocation of resources and investment. This can be encouraged more through the awaited LLP (Federation).

- Would like to have more public attending. With questions. We should consider a patient story. The acoustics of the room are troublesome.
- Good meetings, well prepared and well led.
- Public health and council replacement members are important - worry that they are not present (e.g low score for deputies in Q2).
- Chair does a good job and is very professional, conflicts of interest are well managed, 3 hours for a meeting feels about right.

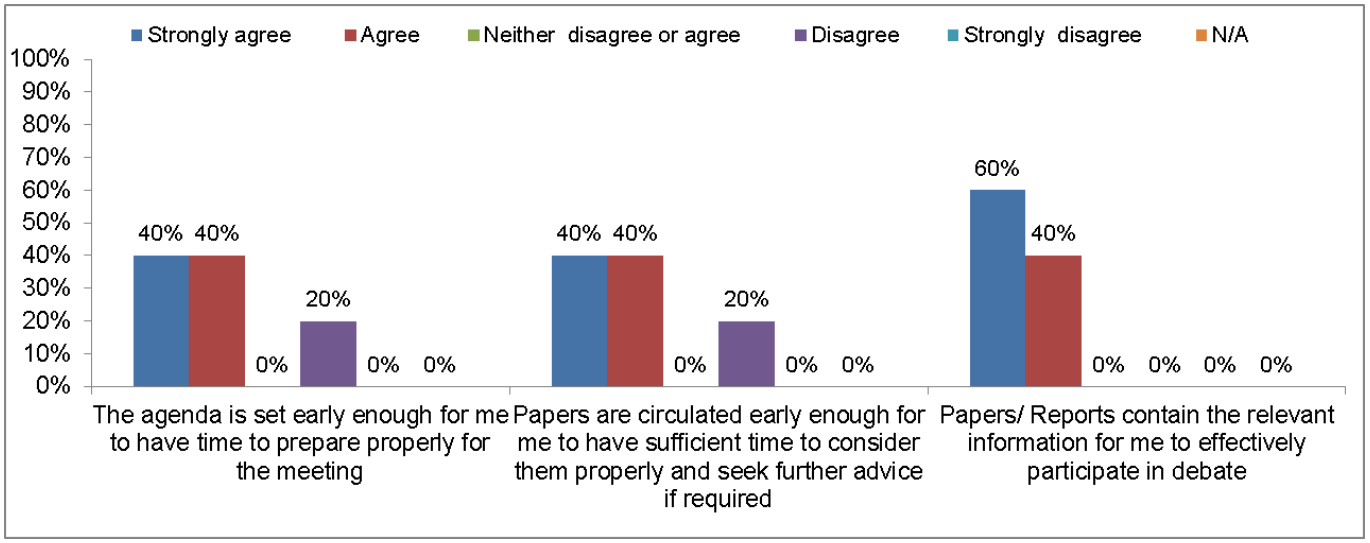
Suggestions for Improvements

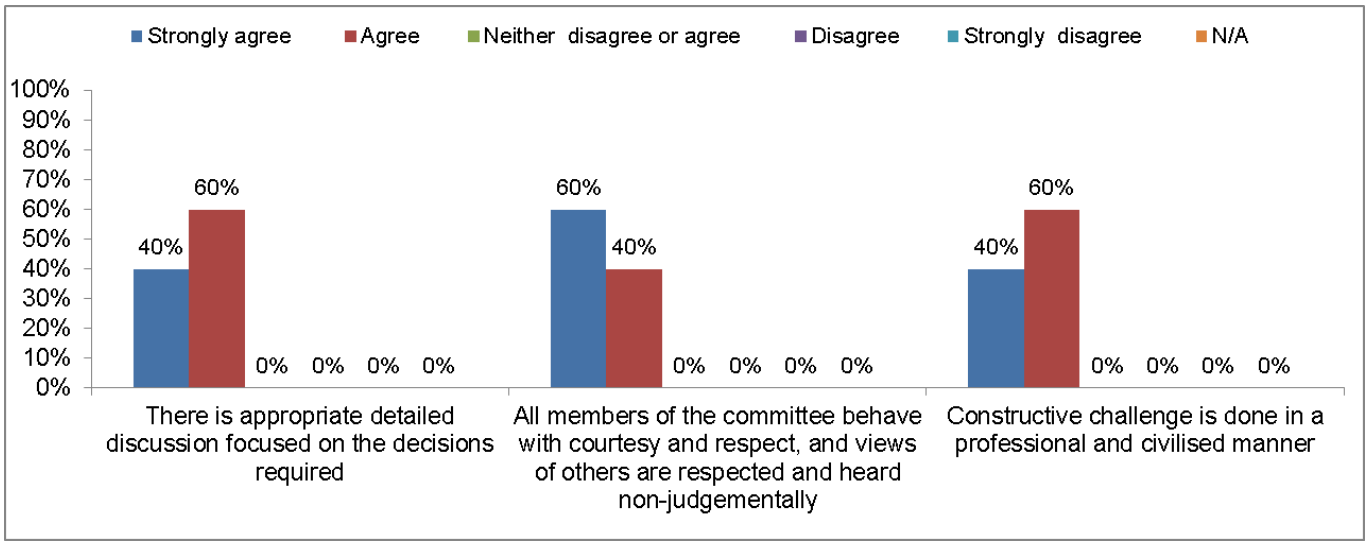
- Perhaps we should be more careful to observe the adherence of our providers to the agreements that we, as a CCG, hold with them and be observant of any subtle dilution of the original agreements or change the goal posts in successive meetings of our joint committees like the Community Transformation, the Mental Health and the Urgent care project.
- Feedback is welcomed.
- More direct involvement of the public would be good.
- When there are questions regarding points of fact sometimes members could use email to get information in advance so that time can be best used to debate issues rather than give information.
- Ensure that 'good / innovative' commissioning decisions for primary care are not prevented by worries about COI / 'Daily Mail' tests. Promote more radical innovative schemes that move patients from a hospital based treatments to more cost-effective community based care.
- Possibly meet in a more public arena at least once a year. Ensure quarterly development sessions keep board members up to date on the fast moving NHS so time isn't taken up at meetings.

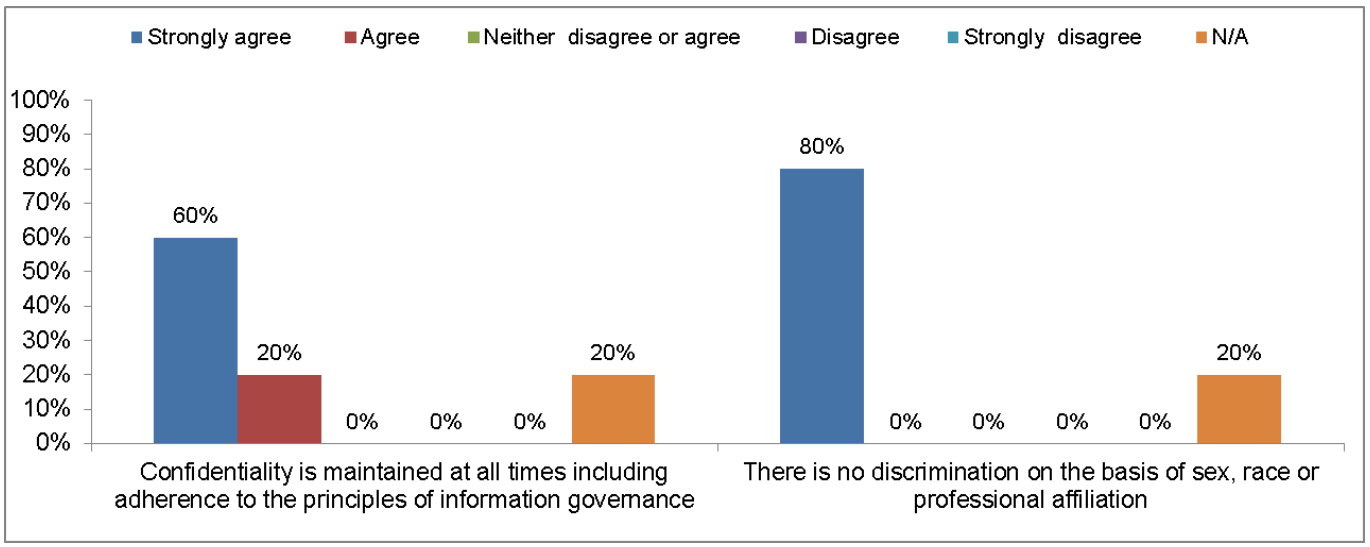
APPENDIX 2 - AQUA COMMITTEE MEMBERS EFFECTIVENESS

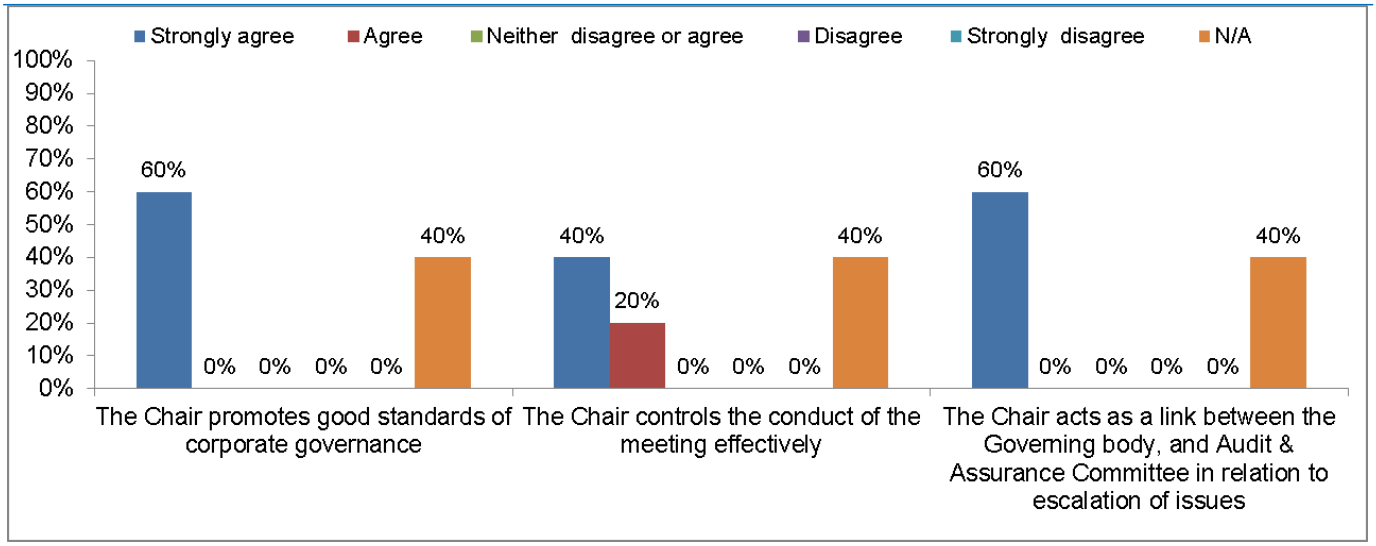
Results from the committee members effectiveness at the Audit and Quality Assurance Committee Meetings.

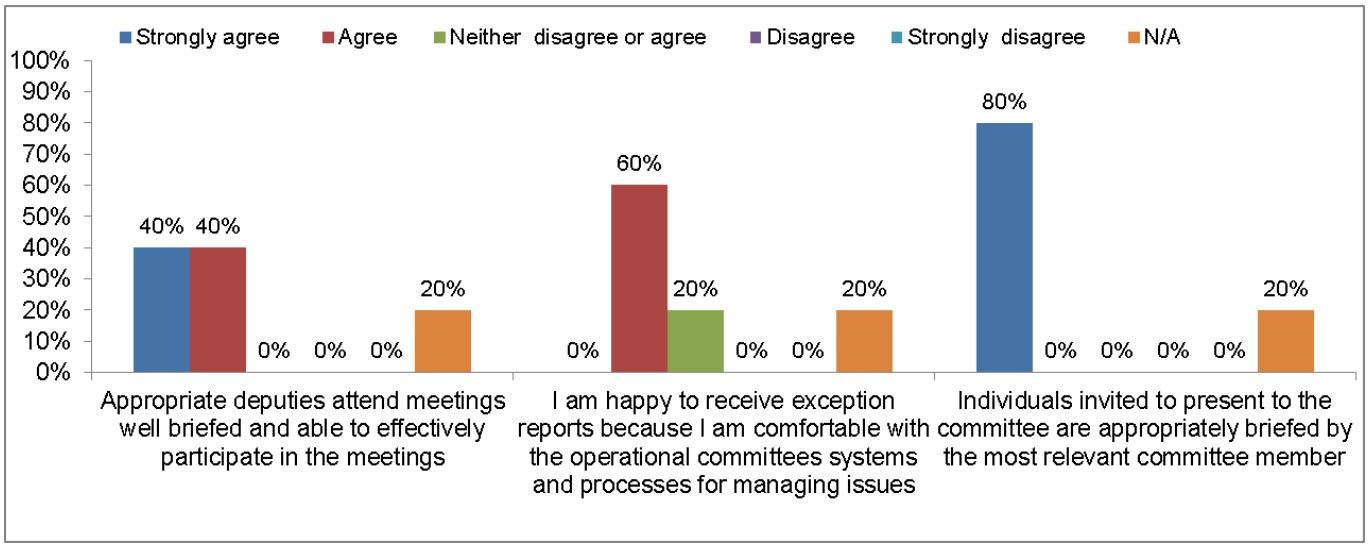
Sample Size = 5

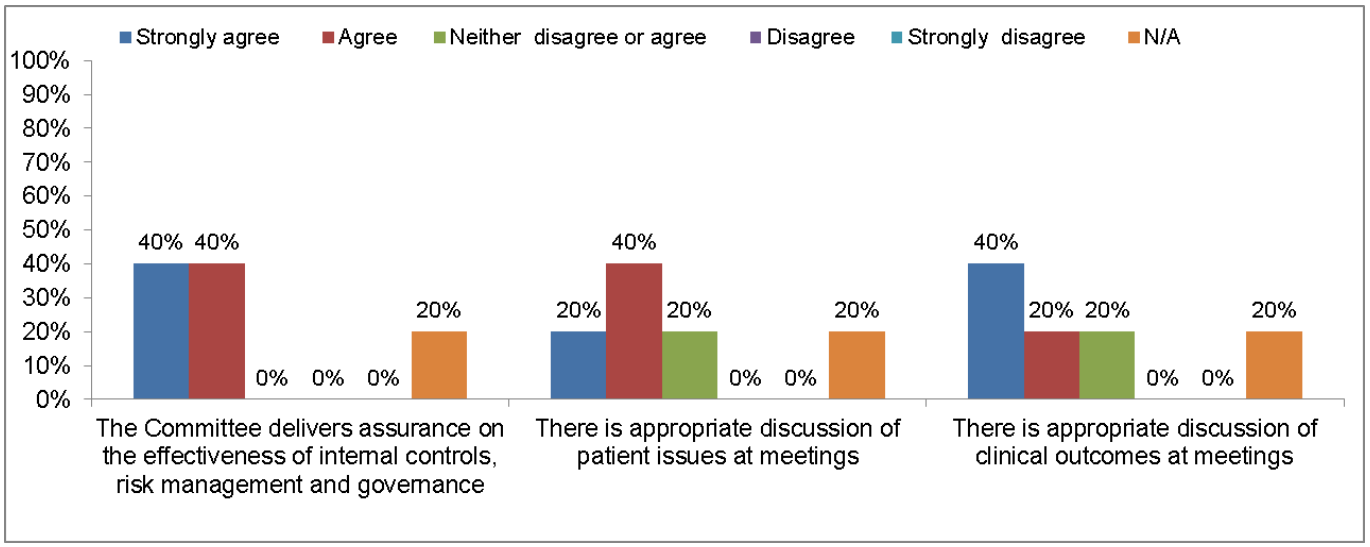










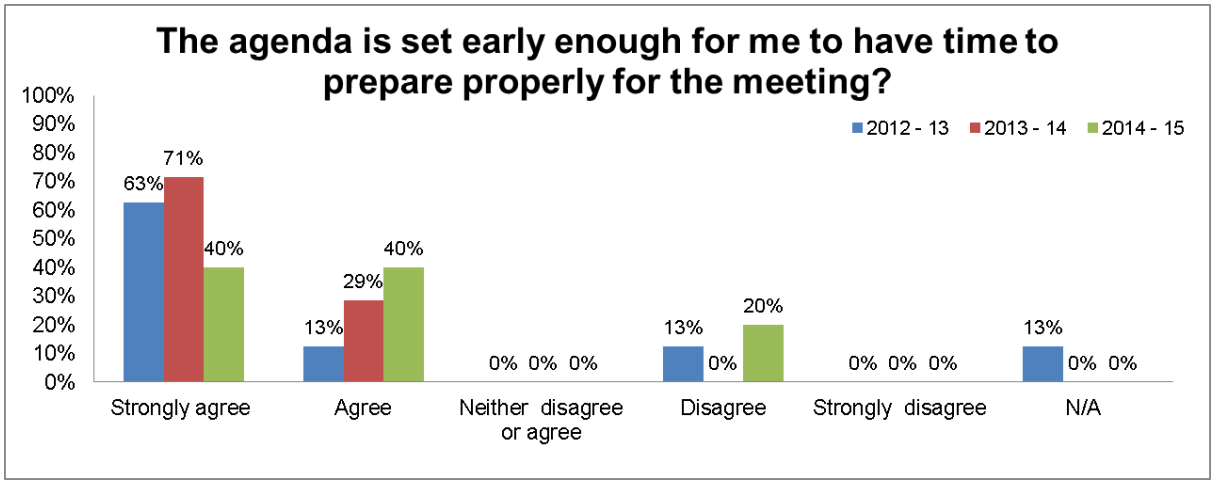


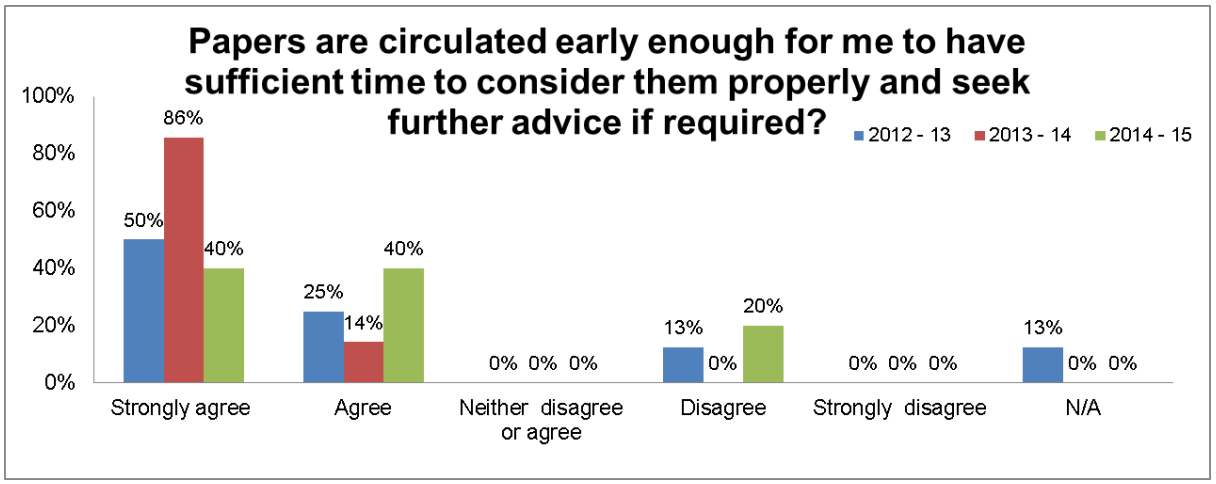
Comments

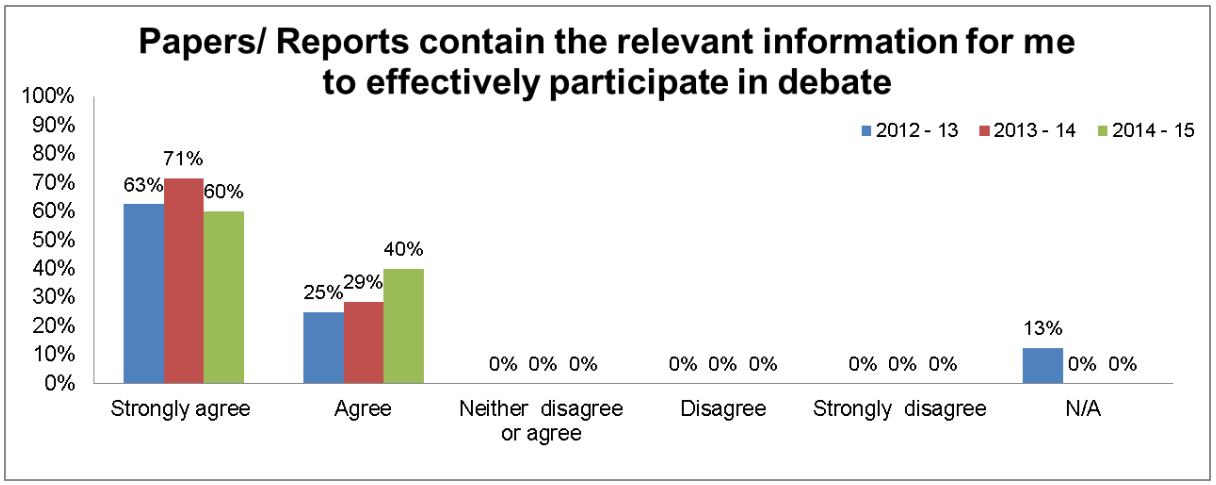
- I have only attended one meeting to date, so I feel unable to give constructive comments at present.

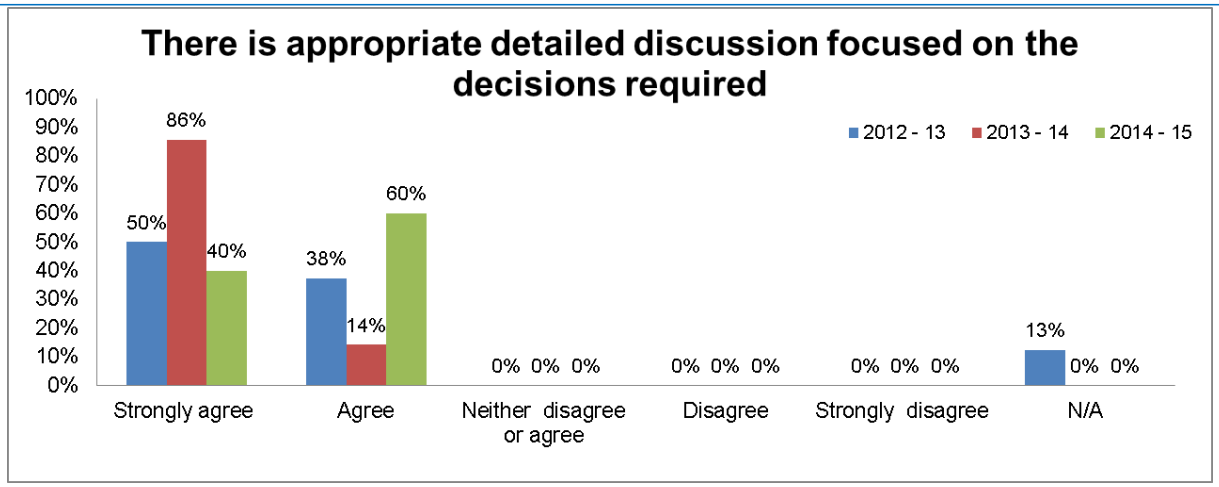
APPENDIX 3 - AQUA COMMITTEE MEMBERS EFFECTIVENESS COMPARISON 12/13 13/14 & 14/15

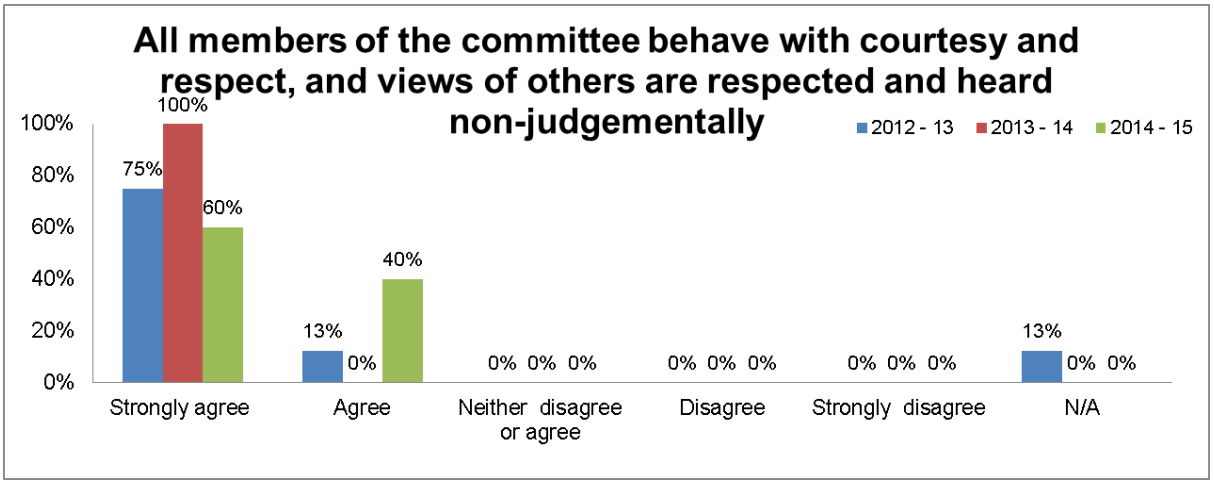
Results from the committee members effectiveness at the Audit and Quality Assurance Meetings - Comparison between 2012/13, 2013/14 and 2014/15.

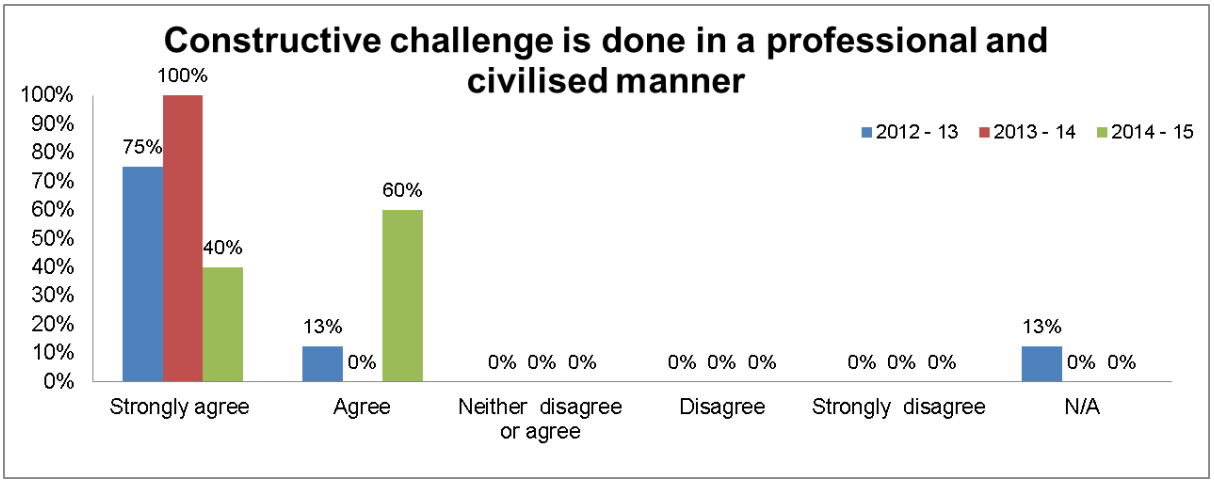


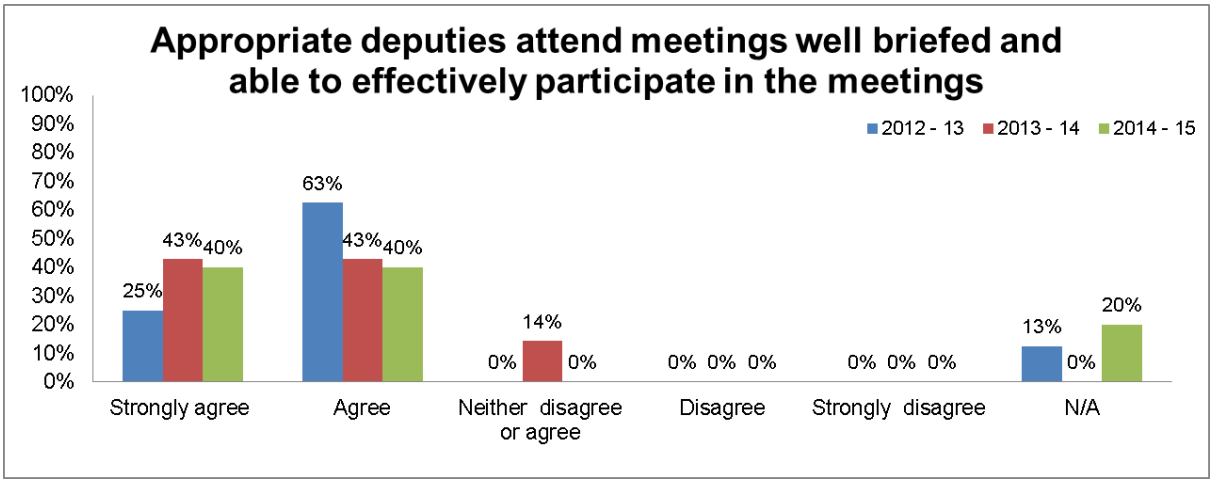


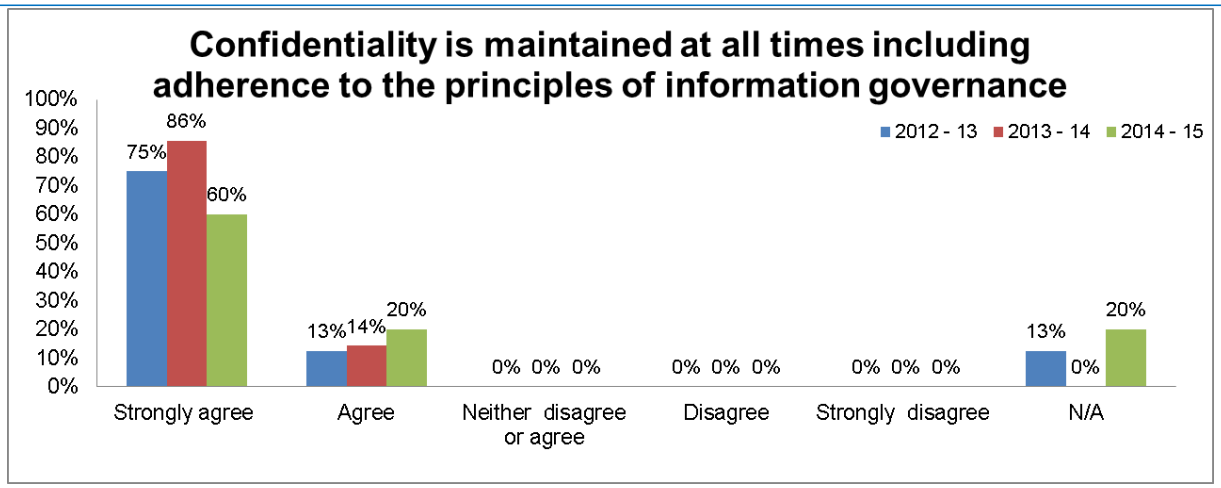


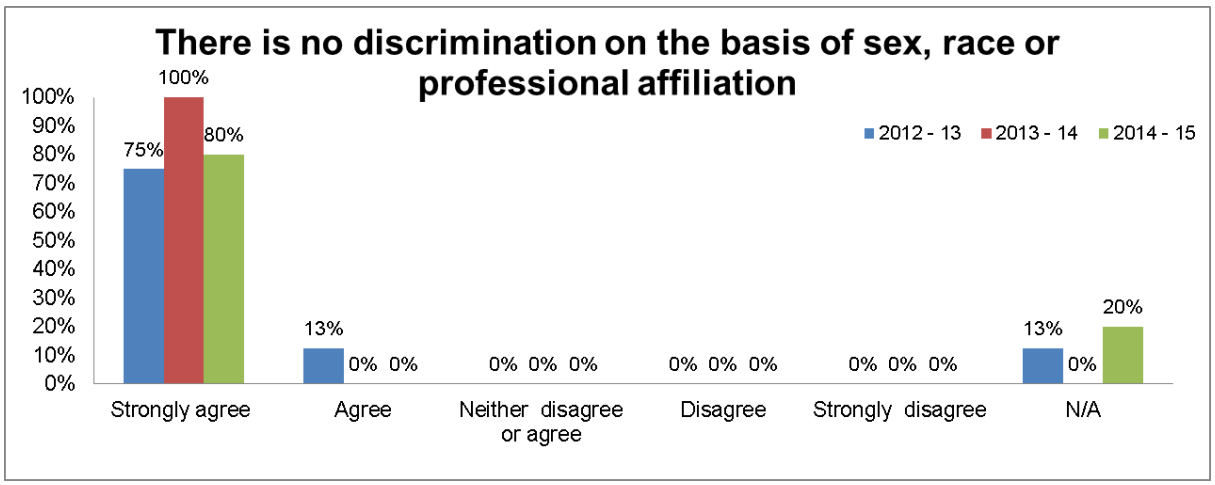

There is appropriate detailed discussion focused on the decisions required
2012 - 13
2013 - 14
2014 - 15
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
50%
86%
40%
38%
14%
60%
0% 0% 0%
0% 0% 0%
0% 0% 0%
13%
0% 0%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A

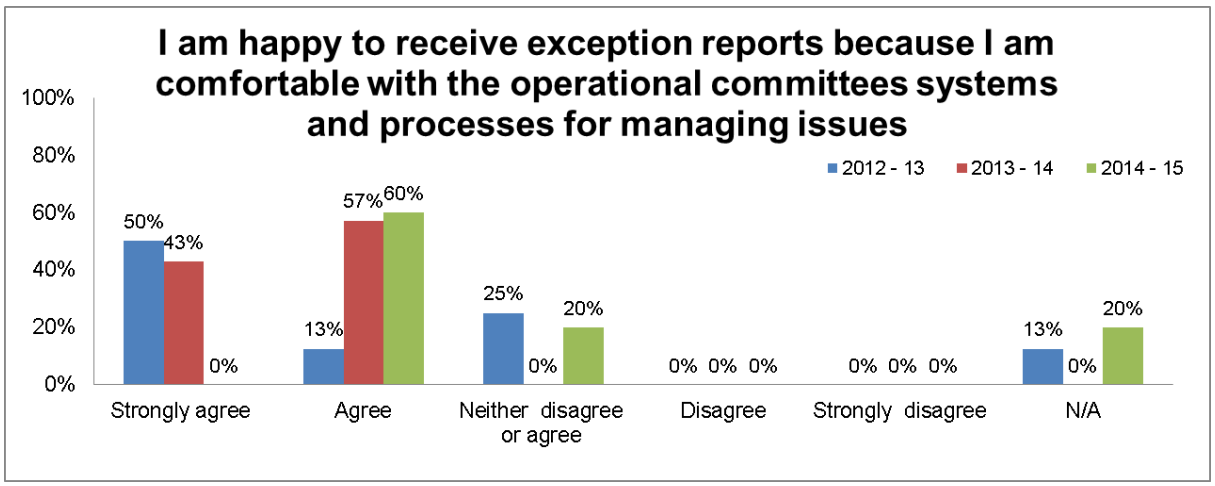

All members of the committee behave with courtesy and respect, and views of others are respected and heard non-judgementally
2012 - 13
2013 - 14
2014 - 15
100%
80%
60%
40%
20%
0%
75%
100%
60%
13%
0%
40%
0% 0% 0%
0% 0% 0%
0% 0% 0%
13%
0% 0%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A

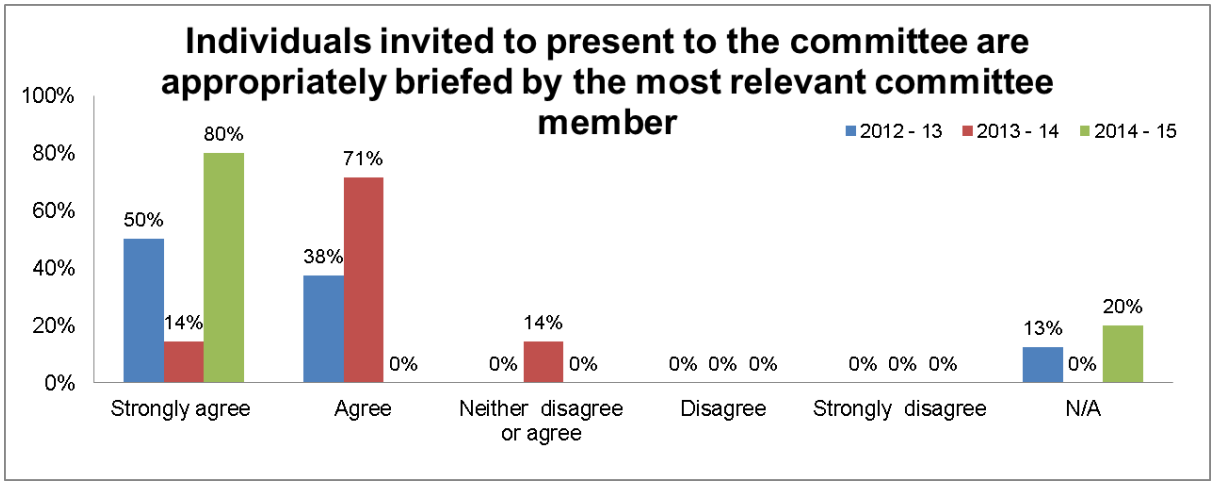

Constructive challenge is done in a professional and civilised manner
2012 - 13
2013 - 14
2014 - 15
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
75%
100%
40%
13%
0%
60%
0% 0% 0%
0% 0% 0%
0% 0% 0%
13%
0% 0%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A

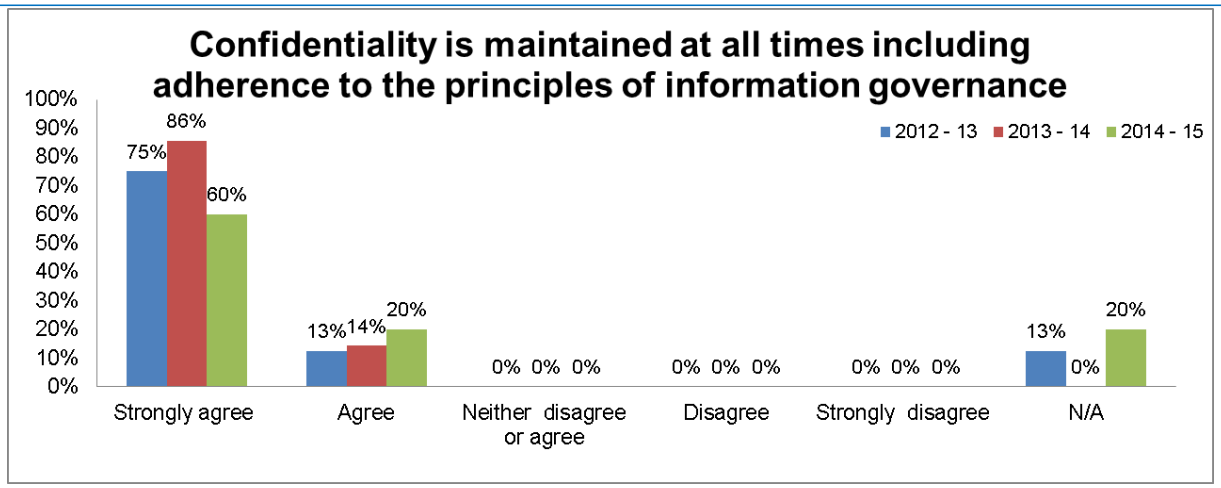

Appropriate deputies attend meetings well briefed and able to effectively participate in the meetings
2012 - 13
2013 - 14
2014 - 15
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
25%
43%
40%
63%
43%
40%
0%
14%
0%
0% 0% 0%
0% 0% 0%
13%
0%
20%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A

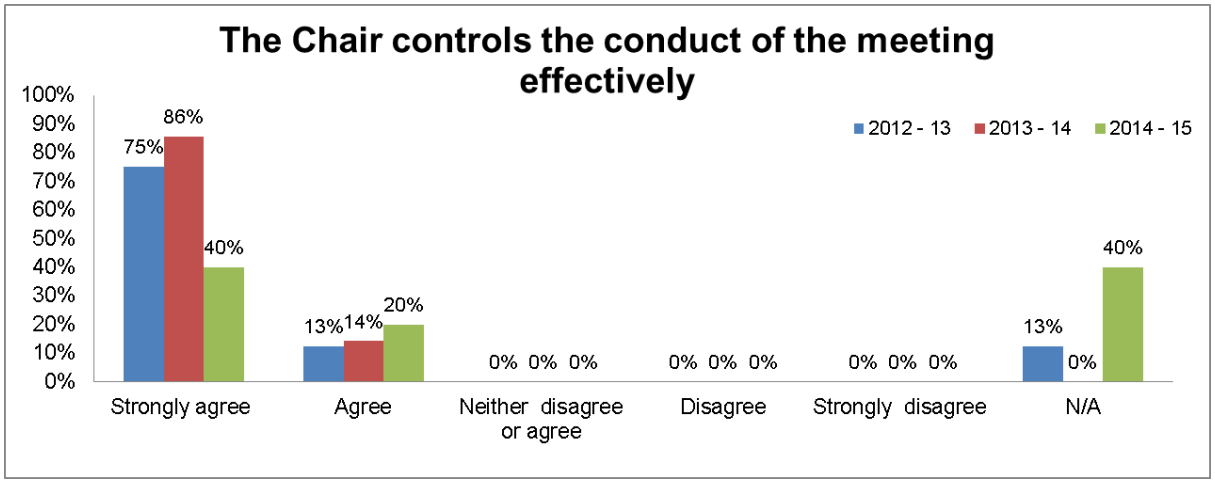

Confidentiality is maintained at all times including adherence to the principles of information governance
2012 - 13
2013 - 14
2014 - 15
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
75%
86%
60%
13%
14%
20%
0% 0% 0%
0% 0% 0%
0% 0% 0%
13%
0%
20%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A

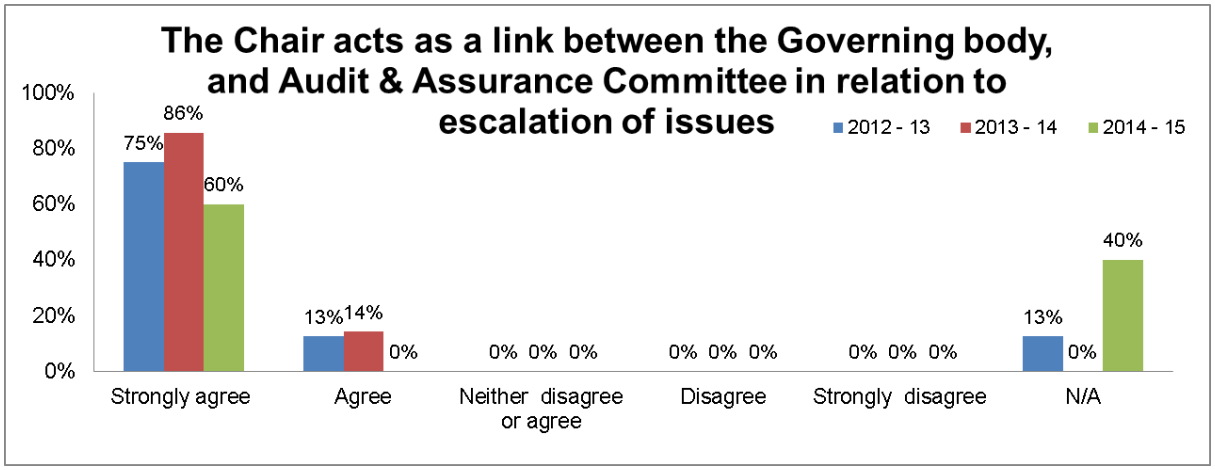

There is no discrimination on the basis of sex, race or professional affiliation
2012 - 13
2013 - 14
2014 - 15
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
75%
100%
80%
13%
0% 0%
0% 0% 0%
0% 0% 0%
0% 0% 0%
13%
0%
20%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A

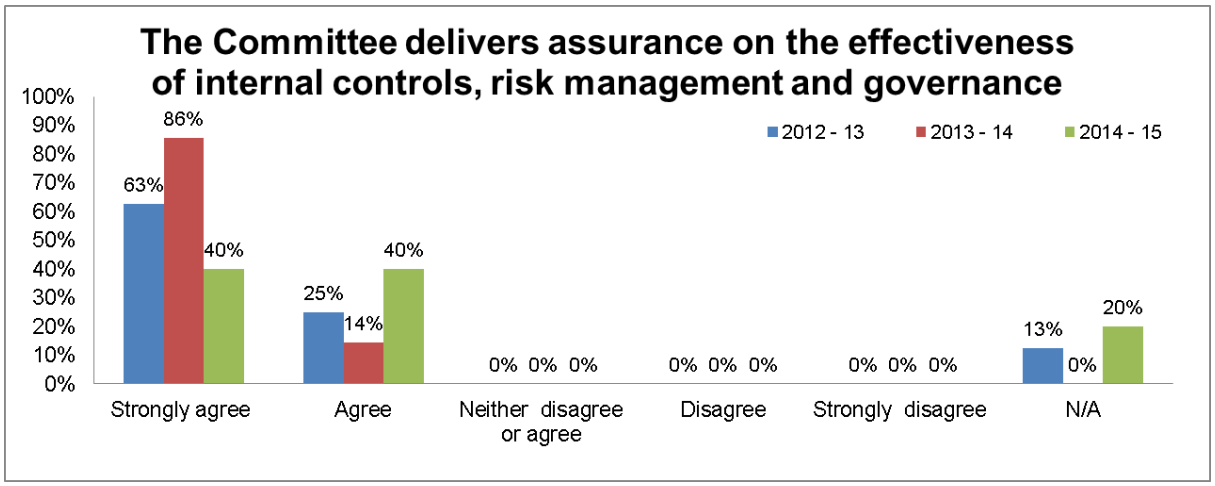

I am happy to receive exception reports because I am comfortable with the operational committees systems and processes for managing issues
2012 - 13
2013 - 14
2014 - 15
100%
80%
60%
40%
20%
0%
50%
43%
0%
13%
57%
60%
25%
0%
20%
0% 0% 0%
0% 0% 0%
13%
0%
20%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A

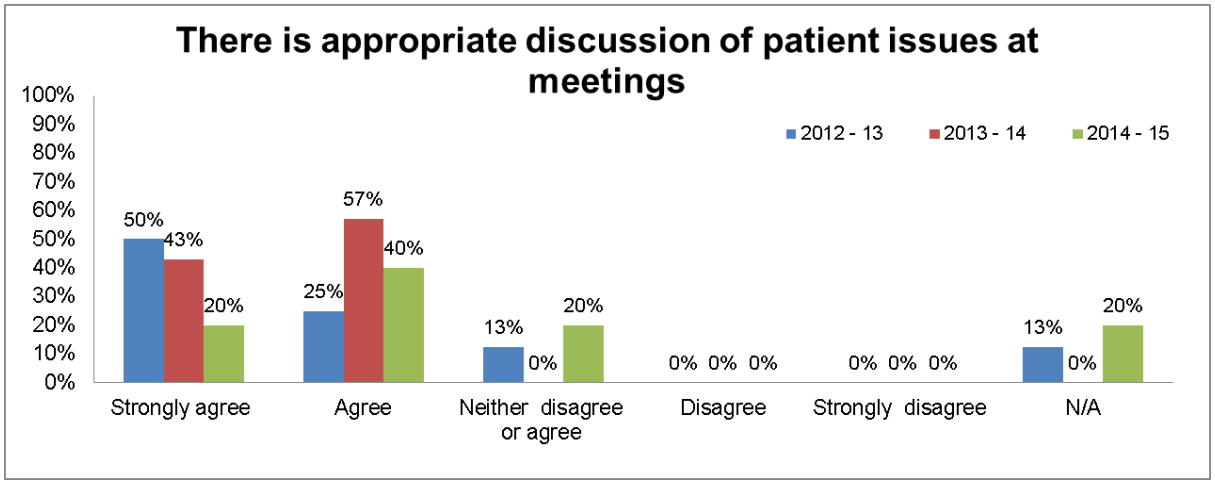

Individuals invited to present to the committee are appropriately briefed by the most relevant committee member
2012 - 13
2013 - 14
2014 - 15
100%
80%
60%
40%
20%
0%
50%
14%
80%
38%
71%
0%
0%
14%
0%
0% 0% 0%
0% 0% 0%
13%
0%
20%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A

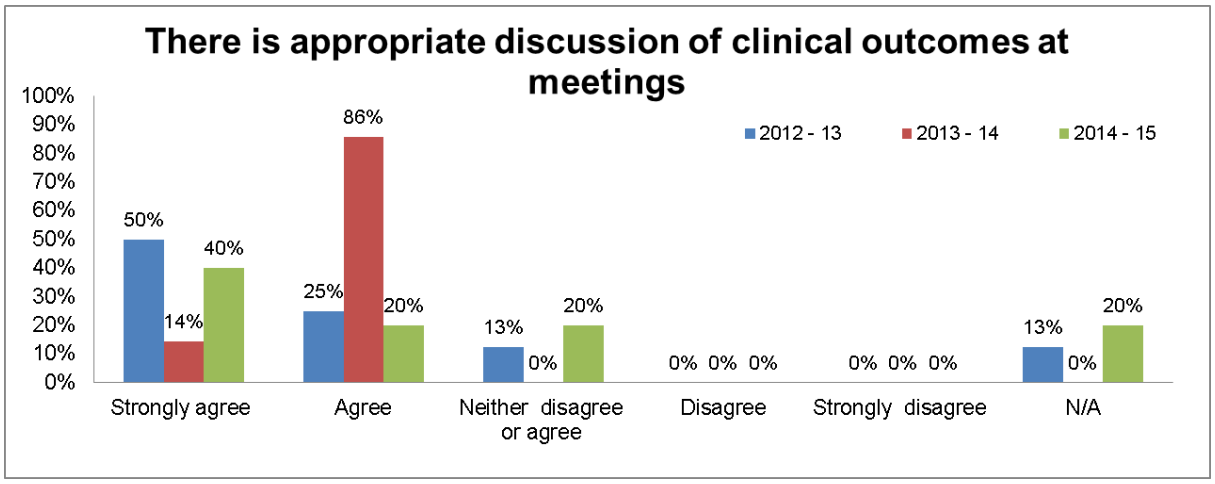

Confidentiality is maintained at all times including adherence to the principles of information governance
2012 - 13
2013 - 14
2014 - 15
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
75%
86%
60%
13%
14%
20%
0% 0% 0%
0% 0% 0%
0% 0% 0%
13%
0%
20%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A


The Chair controls the conduct of the meeting effectively
2012 - 13
2013 - 14
2014 - 15
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
75%
86%
40%
13%
14%
20%
0% 0% 0%
0% 0% 0%
0% 0% 0%
13%
0%
40%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A


The Chair acts as a link between the Governing body, and Audit & Assurance Committee in relation to escalation of issues
2012 - 13
2013 - 14
2014 - 15
100%
80%
60%
40%
20%
0%
75%
86%
60%
13%
14%
0%
0% 0% 0%
0% 0% 0%
0% 0% 0%
13%
0%
40%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A


The Committee delivers assurance on the effectiveness of internal controls, risk management and governance
2012 - 13
2013 - 14
2014 - 15
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
63%
86%
40%
25%
14%
40%
0% 0% 0%
0% 0% 0%
0% 0% 0%
13%
0%
20%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A


There is appropriate discussion of patient issues at meetings
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2012 - 13
2013 - 14
2014 - 15
50%
43%
20%
25%
57%
40%
13%
0%
20%
0% 0% 0%
0% 0% 0%
13%
0%
20%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A


There is appropriate discussion of clinical outcomes at meetings
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2012 - 13
2013 - 14
2014 - 15
50%
14%
40%
25%
86%
20%
13%
0%
20%
0% 0% 0%
0% 0% 0%
13%
0%
20%
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree
N/A

Appendix 3

NHS Rotherham CCG

2014/15 Head of Internal Audit Opinion and Annual Report

Contents

1. Executive Summary

This report is provided in support of your draft accounts and Annual Governance Statement and details my Interim Head of Internal Audit Opinion and a summary of the delivery of your internal audit service for the 2014/15 financial year. This opinion will remain open until the submission of the final accounts at the end of May 2015 so may be subject to revision should there be any changes within the organisations control environment, specifically in relation to any work within your Internal Audit Plan for 2014/15 which is currently being finalised or which was deferred at the request of the organisation. Prior to the submission of the final accounts, I will re-issue a letter to the organisation to confirm my opinion.

2014/15 has continued to be a year of significant change for the NHS and commissioning organisations in particular, with, amongst other areas, the applications for the devolvement of functions as part of co-commissioning and the challenges around developing joint working relationships with Local Authorities as part of the establishment of the Better Care Funds. Commissioning organisations face on-going issues around working with their providers in support of the transformation agenda and the development of quality services for the populations that they serve, all within reducing management costs. Commissioning organisations continue to seek independent assurances across an ever-increasing range of services and the delivery of these assurances is reflected within our Internal Audit Plans.

The completion of individual assignments within our agreed Audit Plan and our assessment of your overall governance and assurance arrangements has enabled us to form an opinion on your arrangements for internal control as follows:

Overall Opinion

I am pleased to report that we are providing the CCG with **Significant Assurance** as there is a generally sound system of internal control, designed to meet objectives, and that controls are generally being applied consistently. This opinion is determined through our review of your Governing Board Assurance Framework (GBAF) and associated processes and the work that we have undertaken throughout the year.

This opinion will remain open until the submission of the final accounts at the end of May 2015 so may be subject to revision should there be any changes within the organisation's control environment, specifically in relation to any work within your Internal Audit Plan for 2014/15 which is currently being finalised. Prior to the submission of the final accounts, I will re-issue a letter to the organisation to confirm my opinion.

Your Internal Audit Plan for 2014/15

Your Internal Audit Plan was developed in line with the mandatory requirements of the Public Sector Internal Audit Standards (PSIAS), and was aligned to your Governing Body's Assurance Framework and strategic objectives. We also engaged with the Executive Team and the Audit Committee to identify priority areas for audit review. As such, the plan was designed to enable us to satisfy our statutory responsibility to provide a balanced annual Head of Internal Audit Opinion. Our work, as always, was discussed with External Audit and Counter Fraud to ensure effective use of resources.

Progress in relation to the delivery of your Internal Audit Plan has been reported to each Audit Committee meeting.

We have applied a flexible approach to the delivery of our work which has allowed us to respond to requests from senior management and the Audit Committee, in order to reflect the organisation's changing assurance needs and to address emerging risks.

Performance Against Service Level Agreement

The 2014/15 year was one of challenge for the CCG and we have been mindful of staff workload and priorities when undertaking our audit work. This has, however, meant that on occasion, work planned and scheduled has been delayed at the request of the CCG as a result of internal calls on the time of Executive and Operational Leads. We have also recognised that in response to the rapidly changing environment, some of the reviews originally agreed at the commencement of the 2014/15 financial year required amendment to reflect a change in risk profile.

Our audit work has been delivered in line with our SLA with the CCG. Section 3 of this report demonstrates our performance against the SLA, including adherence to the mandatory Public Sector Internal Audit Standards. We have provided a breakdown of our delivery of your plan and evidence our achievement against the Key Performance Indicators included within our SLA (see Appendix B). In addition, we have provided analysis of the feedback from the Client Satisfaction Questionnaires completed across the service delivered by our Commissioner Services Team for 2014/15.

360 Assurance

This has also been a year of change for our organisation as we have built upon the foundations of our merger in July 2013.

Our focus has been on continuing to develop the strength of our audit team, specifically we have been able to significantly develop our Clinical Quality and Performance and Information Teams. This has allowed us to consolidate our position as one of the leading UK providers of internal audit, assurance and counter fraud services to the NHS.

We look forward to building on these successes, with the support of our clients.

I would like to take this opportunity to thank the CCG for the co-operation and assistance provided to my team during the year.

Tim Thomas

Director

2. Head of Internal Audit Opinion

In accordance with Public Sector Internal Audit Standards, I am required to provide an annual opinion, based upon work performed by Internal Audit to assess the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. This is achieved through the completion of an annual internal audit plan (Appendix A), which is based on the organisation's key risks.

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body (GB) which underpin the GB's own assessment of the effectiveness of the Organisation's system of internal control. This opinion, in turn, assists the Board in the completion of its Annual Governance Statement (AGS).

The opinion does not imply that Internal Audit has reviewed all risks and assurances related to the organisation.

HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL FOR THE YEAR ENDED 31ST MARCH 2015.

My opinion is set out as follows:

2.1 Overall opinion;

2.2 Basis for the opinion; and

2.3 Commentary.

2.1 Overall Opinion

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

2.2 Basis for the Opinion

The basis for forming my opinion is as follows:

a) An assessment of the design and operation of the underpinning Assurance Framework and supporting processes. *(Guidance requires that I weight the opinion towards the suitability of the Governing Body Assurance Framework. and indicates that where I am unable to conclude that an appropriate Assurance Framework process is in place, I am obligated to issue an overall opinion of Limited Assurance. This is regardless of the level of assurances provided in respect of individual audit assignments).*

b) An assessment of the range of individual opinions arising from risk-based audit assignments contained within Internal Audit risk-based plans that have been reported upon throughout the year. This assessment has taken account of the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified.

c) An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

Department of Health guidance requires that, when determining my opinion, I place greatest emphasis on points a) and b) above.

My opinion is one source of assurance that the CCG has to support its Annual Governance Statement. Other third party and independent assurances should also be considered.

2.3 Commentary

The commentary below provides the context for my opinion and, together with the opinion, should be read in its entirety. The issues highlighted in this commentary should be considered by the Organisation when completing its AGS.

2.3.1 The Design and Operation of the Governing Body Assurance Framework (GBAF) and Associated Processes

The GBAF provides a simple and comprehensive method for the effective and focused management of the principle risks to meeting the CCG's strategic objectives.

The review and update of the Assurance Framework and Risk Register has continued throughout the financial year, with both documents, including amendments, being submitted to the Audit & Quality Assurance Group (AQuA) in May & November 2014 and March 2015.

The Governing Body last reviewed the Assurance Framework in January 2015 as part of the Corporate Assurance Report. It was also presented to the Governing Body through the Corporate Assurance Report in November 2014 and is scheduled for discussion at the April 2015 meeting of the Governing Body.

We have been able to confirm, from sample testing, that assurances detailed within the Assurance Framework had actually been received by the Governing Body.

In summary:

- Senior officers of the CCG have been involved in the development of the Assurance Framework, and are involved in the regular review updates;
- The function of the Assurance Framework is well understood by members of the Governing Body who have had experience of operating with an Assurance Framework prior to the establishment of the CCG;
- The terms of reference for the Audit & Quality Assurance Group specifies its role in respect of the Assurance Framework;
- The Assurance Framework refers to the CCG's key priorities and the principle risks flow from these priorities;
- Controls are described clearly and in appropriate detail in the Assurance Framework;
- Gaps in assurance are expressed in terms of additional steps to be taken in order for these gaps to be addressed; and
- There is an established Integrated Risk Management Policy;

2.3.2 The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year.

In line with Public Sector Internal Audit Standards, the 2014/15 Internal Audit Plan was produced using a risk-based approach. The audit plan was developed following a review of the organisation's principal level risks to the achievement of its strategic objectives, as detailed within its Assurance Framework, and following consultation with the organisation's Executive Team and Audit Committee members.

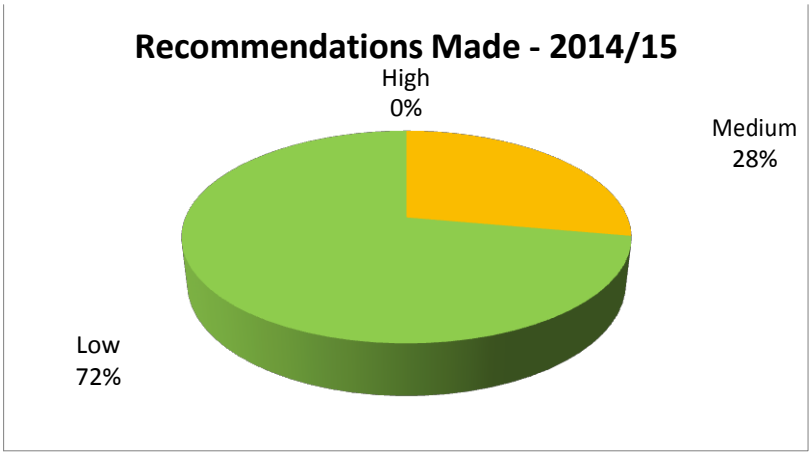
At the time of producing this Annual Report, we have issued 8 reports, of which:

- Full assurance was provided in relation to one review;
- Four reports were issued with Significant Assurance;
- Two reports related to our delivery of the Project Assurance role for the Emergency Centre Project Board. Issuing of formal opinions were not, therefore, appropriate; &
- One report summarised the findings of follow-up work undertaken in respect of all recommendations made in 2013/14.

At the time of writing, there is one assignment still in the process of being finalised; this relates to the CCG's arrangements for ensuring appropriate Continuing Healthcare to patients with long term conditions is provided where necessary. Once this exercise has been concluded we will issue the final version of the Head of Internal Audit Opinion. We do not anticipate any change to the overall Opinion although we will highlight any high risk issues should any be identified in the review in order that the CCG can take an informed decision as to whether it chooses to amend the 2014/15 Annual Governance Statement.

At the time of writing, no high risk issues have been formally reported as a result of our 2014/15 work to date.

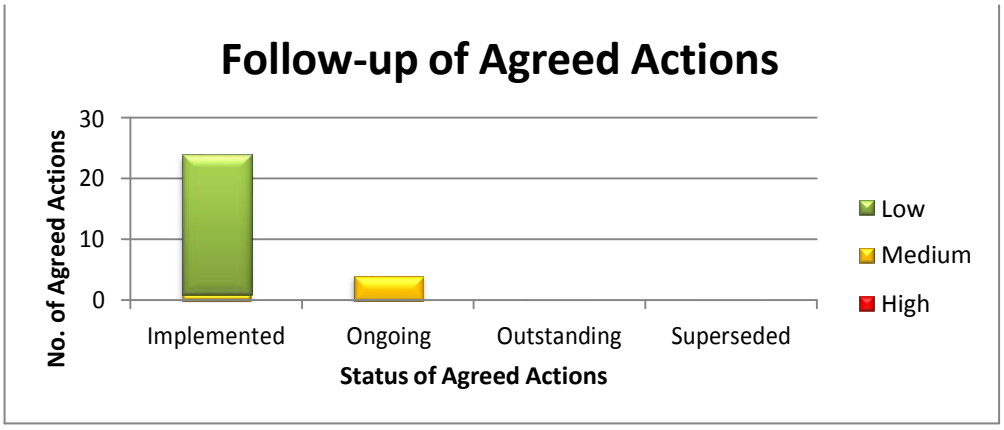
Appendix A provides details of all work completed within the 2014/15 plan. In total, this work has resulted in **18** recommendations to date. The chart below provides a breakdown of the risk ratings of these recommendations for the year.



2.3.3 The Organisation's response to Internal Audit recommendations and the extent to which they have been implemented

As part of PSIAS, I am required to consider the appropriateness of the organisation's response to Internal Audit recommendations made and action subsequently implemented.

As part of our follow-up process, we seek to assess whether management has taken appropriate action to address risks identified during our original review and the extent to which action taken has had the desired impact on outcomes. With the agreement of the CCG, we implemented a new follow-up process during the year which allows us to work in partnership with the CCG's own arrangements for monitoring implementation of our recommendations. Using this process we were able to undertake a follow-up review of actions agreed during almost all the exercises we completed in 2013/14, the outcome of which was reported to the March 2015 meeting of the AQuA Committee. The graph below summarises the outcome of this exercise:



3. 360 Assurance Performance

3.1 Compliance with Public Sector Internal Audit Standards

As Internal Auditors we are required to comply with the mandatory Public Sector Internal Audit Standards. The delivery of our service adheres to these standards and our working processes are clearly documented in our Internal Audit Manual, which is aligned to the requirements of the standards. These are reviewed on a regular basis and all staff are required to formally acknowledge receipt and adherence.

During 2014/15 we engaged with BHP Chartered Accountants who have undertaken an external assessment of our compliance with PSIAS. This review confirmed our compliance with the standards and a copy of the resulting report and actions agreed in order to enhance our processes has been shared with the Chief Finance Officer.

3.2 Achievement of the Plan

The 2014/15 Internal Audit Plan for 115 days was approved at the Audit Committee meeting on the 21st of May 2014. All but one assignment (CHC review) within the Plan have been completed at the time of writing.

During 2014/15 we have had discussions with representatives from your External Audit provider to ensure that our work programmes did not overlap and that our reviews could be referenced by External Audit, where appropriate.

3.3 Staffing

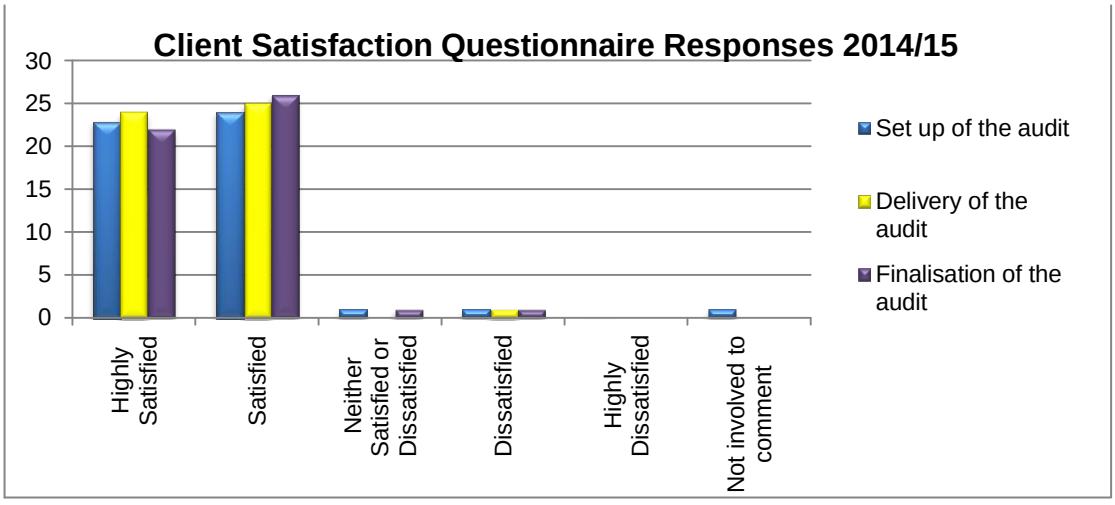
As the Director of 360 Assurance, I have a strategic responsibility for overseeing the effective delivery of the audit services to the organisation. The contract is delivered by a team of staff led by your nominated Assistant Director, Kevin Watkins. Throughout 2014/15 we have been sufficiently staffed to meet the requirements of the audit plan.

3.4 Key Performance Indicators (KPIs)

Appendix B sets out the KPIs that have been agreed as part of our SLA with the Organisation. We have demonstrated our achievement against each of the indicators within the Appendix

Client Satisfaction Questionnaires

As part of our drive to improve quality we issue Client Satisfaction Questionnaires following the conclusion of all audit reviews. The questionnaire seeks to confirm that the auditee was appropriately engaged in the planning and reporting process and that our approach to the review and subsequent report provided added value to the CCG. Responses received from all our CCG clients during 2014/15 are summarised in the graph below:



Appendix A – Internal Audit Outturn for 2014/15

Audit Assignment	Report Ref.	Status	Assurance Level/Comment
Emergency Centre Project – 2nd Project Assurance Report	1415/RCCG/01PA	Issued	N/A
Patient & Public Engagement	1415/RCCG/02R	Issued	Significant
Emergency Centre Project – Project Governance Report	1415/RCCG/03PA	Issued	N/A
Conflicts of Interest	1415/RCCG/04R	Issued	Significant
Follow-up of 2013/14 Recommendations	1415/RCCG/05R	Issued	N/A
Better Care Fund	1415/RCCG/06R	Issued	Significant
Information Governance Toolkit	1415/RCCG/07R	Issued	Significant
Budgetary Control & Key Financial Systems	1415/RCCG/08R	Issued	Full
Continuing Healthcare	1415/RCCG/09R	Fieldwork Ongoing	TBC

Appendix B – Performance Indicators

Key Performance Indicator (From the SLA)	360 Assurance Performance 2014/15
Strategic and Operational Internal Audit Plans will be produced for client agreement by 31st March annually.	The 2014/15 Operational Plan was agreed at the Audit Committee meeting on the 21st of May 2014. This failure to meet the KPI's timing has been rectified for the 2015/16 Plan, which was approved by the Audit & Quality Assurance Committee at its meeting on the 20th of March 2015.
All high-risk issues and any significant issues which could result in a no assurance opinion identified during the course of Internal Audit work will be brought to the immediate attention of the Chief Finance Officer, and other senior officers as appropriate).	No high risk issues were identified during the course of our audit work for 2014/15.
A final draft audit report will be issued within three weeks of the exit meeting. Exceptions resulting from extenuating circumstances will be agreed with the Chief Finance Officer	Final draft reports have been issued within the timescales outlined in this performance measure and the progress of each audit, including the reporting information, is contained within the report issued.
The Assistant Director will meet with the nominated Audit Lead at the client organisation at an agreed frequency at the request of the client (minimum quarterly).	Meetings were held with the Chief Finance Officer to discuss progress of the audit plan.
A report will be presented to the Audit Committee for each meeting, which details progress made towards the completion of the Internal Audit Operational Plan.	A progress report was presented by the Director, 360 Assurance or Associate Director at all Audit Committee meetings in the financial year.
Audit follow-up work will be completed in line with agreed timeframes.	A new follow-up process was implemented with the approval of the Audit & Quality Assurance Committee in January 2015. .
General enquiries will be responded to within two working days.	All requests for ad hoc advice have been responded to within the required timeframe.
As far as possible and reasonable, a consistent team will be provided.	The client has a dedicated team of professionally qualified auditors which has been consistent through-out the year. The client has been provided with details of nominated senior staff leads.
All work undertaken will be made available to the clients' External Auditors in order that they can place reliance upon Internal Audit activity, thereby avoiding unnecessary overlapping of work.	We have provided final reports to External Audit leads as a matter of routine. Completed audit files and other relevant documentary evidence are available to the External Auditors as required.
Internal Audit work is undertaken in compliance with the requirements of Public Sector Internal Audit Standards (PSIAS).	During 2014/15 we engaged with BHP Chartered Accountants who have undertaken an external assessment of our compliance with PSIAS. This review confirmed our compliance with the standards and a copy of the resulting report and actions agreed in order to enhance our processes has been shared with the Chief Finance Officer.
An Annual Report and Head of Internal Audit Opinion Statement will be provided in line with DH reporting timeframes.	This is provided on an annual basis and is in line with DH reporting timeframes.