Corporate Assurance Report

Quarter 1 & 2

(1st April - 30th September 2014)

Contents

Executive summary
The corporate assurance report will in future be a quarterly report summarising the corporate governance functions of the CCG. This particular report covers half the year Quarter 1 & 2. Your thoughts and comments would be appreciated, so that I can improve its presentation.

Sarah Whittle - Assistant Chief Officer

Ref	Risk Management
CAR01 /14	**Governing Body Assurance Framework (GBAF)**

The GBAF provides a simple and comprehensive method for the effective and focused management of the principal risks to meeting our strategic objectives. Principal risks are defined as those that threaten the achievement of the organisations' strategic objectives.

The GBAF is updated every 2 months and reported to AQuA at each of their meetings.

Following the GB/SCE development session in June, the GBAF was revised to reflect the 6 domains of the national assurance framework:

- Domain 1 – Clinically commissioned, high quality services
- Domain 2 – Patients and public actively engaged
- Domain 3 – Plans deliver better outcomes for patients
- Domain 4 – Robust governance arrangements
- Domain 5 – Work in partnership with others
- Domain 6 - Strong and robust leadership

Appendix 8A summarises the high scoring principle risks, against the above set of strategic objectives. This was presented to AQuA in September and subsequently to OE in October following amendments to address comments raised by AQuA. Attached is the final agreed format following consideration by OE.

Appendix 8B is the full GBAF it sets out the strategic risks and the controls and assurances in place.

Only those risks classed as "strategic" rather than operational and with a consequence score of either "high" or "extreme" are eligible for entry to the GBAF and linked to a strategic objective. All other risks are managed through the risk register, and each of our risk register risks is linked to an overarching GBAF risk.

As at September 2014:

Current controlled Risk Score	GB Assurance Framework	Rating Explained
0	n/a	Low Risk Retired
2	n/a	Low Risk Retired
3	3	Low Risk Retired
4	n/a	Low Risk Retired
5	n/a	Low Risk Retired
6	1	Medium Risk
8	3	Medium Risk
9	3	Medium Risk
12	7	High Risk
15	2	High Risk
16	4	Very High Risk
20	3	Very High Risk
25	0	Extreme Risk
Total	**26 (16 scoring 12 or above)**	

Of the 25 risks on the GBAF, 16 of these score 12 or above:

AF Number	Risk Description	Risk Score
11	Failure to improve GP quality and efficiency in partnership with NHS England (current concerns are due to overall GP capacity and morale)	**20**
28	Failure of YAS to achieve RED 1 8 minute Target at CCG level and Yorkshire & Humber wide	**20**
29	Child Sexual Exploitation (CSE) - RMBC may not be able to effectively work with CCG to deliver the partnership agenda as there resources will be targeted to dealing with CSE.	**20**
12	Failure to deliver system wide efficiency programmes for prescribing, planned care and unscheduled care	**16**
09	Failure to maintain and improve quality of services and ensure effective quality and safety assurance processes are in place regarding CCG commissioned services	**16**
26	Impact on CCG of other commissioners efficiency plan	**16**
27	Named GP for Safeguarding Children due to leave organisation. This will leave a significant gap in safeguarding assurance in primary care	**16**
19	Adverse impact on patient care due to problems at TRFT evidenced by: leadership change, liquidity pressures and unresolved EPR implementation issues.	**15**
25	Reduction in resources through introduction of Better Care Fund	**15**
02	Failure to meet financial targets and statutory financial duties	**12**
12	Failure to improve Child and Adolescent Mental Health Services	**12**
06	Failure to ensure robust systems of risk management and governance are in place, not fulfilling statutory responsibilities	**12**
08	Failure to ensure effective workforce planning and capability to deliver organisations business, maintain performance and meet statutory requirements with reduced workforce	**12**
21	Failure to meet A&E targets	**12**
23	Financial allocations reduced by Government. Review of Allocations by NHSE	**12**
20	Impact of NHS 111 on the local health community. Specifically potential for increase in number of patients being referred to A&E / 999	**12**

Since April there have been three additions to the GBAF, see above for scores and **appendix 8B** for the assurances and mitigations:

- AF27: Named GP for Safeguarding Children due to leave organisation. This will leave a significant gap in safeguarding assurance in primary care
- AF28: Failure of YAS to achieve RED 1 8 minute Target at CCG level and Yorkshire & Humber wide
- AF 29: Child Sexual Exploitation (CSE) - RMBC may not be able to effectively work with CCG to deliver the partnership agenda as their resources will be targeted to dealing with CSE.

CAR02 /14

Risk register

The risk register is updated every 2 months and received by AQuA at each of their meetings, it is a management tool which enables us to undertake a suitable and sufficient risk assessment of our significant risks and therefore to understand our risk profile.

Risks can be:

a) treated,
b) tolerated,
c) terminated or
d) transferred.

The risk tolerance (appetite at which risks can be tolerated) is a score of 11 or below where the assessment has been undertaken following the implementation of controls and assurances. Risks scoring 11 or above and which are strategic are escalated to the GBAF.

	As at September 2014: **Current controlled Risk Score** / **Risk Register** / **Rating Explained** **0** / n/a / Low Risk Retired **2** / 3 / Low Risk Retired **3** / 6 / Low Risk Retired **4** / 4 / Low Risk Retired **5** / 3 / Low Risk Retired **6** / 10 / Medium Risk **8** / 12 / Medium Risk **9** / 10 / Medium Risk **12** / 9 / High Risk **15** / 4 / High Risk **16** / 5 / Very High Risk **20** / 4 / Very High Risk **25** / 0 / Extreme Risk **Total** / **70 (22 scoring 12 or above)** / Since April there have been five additions to the Risk Register. The following three risks were scored above 11 and escalated to the GBAF: • AF27: Named GP for Safeguarding Children due to leave organisation. This will leave a significant gap in safeguarding assurance in primary care • AF28: Failure of YAS to achieve RED 1 8 minute Target at CCG level and Yorkshire & Humber wide • AF 29: Child Sexual Exploitation (CSE) - RMBC may not be able to effectively work with CCG to deliver the partnership agenda as their resources will be targeted to dealing with CSE. The following two were scored below 11 and therefore managed through the risk register: • Communicable Diseases (Ebola) • Road works in central Rotherham impacting on efficiency of community staff, GPs and emergency services.
CAR03 /14	**Claims and Legal Issues** Insurance for the CCG is commissioned from the NHS Litigation Authority (NHSLA). The limitation period during which claims can be made is 3 years from the affected individual becoming aware of the issue. No new claims were received in the last two quarters and there are no claims outstanding for the CCG.
	Internal/External assessments
CAR04 /14	**Investors in Excellence** On 4th June 2014 NHS Rotherham CCG was awarded 'Investors in Excellence'. The Investors in Excellence Standard is a prestigious mark of excellence awarded to those organisations that demonstrate a high standard of all-round business performance. It is a very testing standard covering all key business areas including leadership, people and customer results. Its scope makes a powerful improvement tool. An improvement plan is being taken forward to address the areas identified for further development and an update was received by OE on the 20 October 2014. Progress of most note since June is: • improvements to the PDR process • development of staff behaviours statements to compliment the staff values work • development of a CCG organisational and facilities induction pack

- stakeholder management system
- staff suggestion box, where all suggestions are considered by OE

CAR05 /14

HSJ - CCG of the Year 2014 Award

The CCG has been shortlisted along with 5 other CCG's to win this prestigious award.
Judges from the HSJ Awards panel will visit the CCG on Friday 7th November, followed by a presentation to the full panel on Monday 10th November. The decision for CCG of the Year will be announced at an awards ceremony on Wednesday 19th November.

CAR06 /14

Internal Audit

The following is a summary of work undertaken by Internal Audit since April 2014 and presented and discussed at the Audit Quality and Assurance Committee. (AQuA)

360 Assurance provide audit opinions based upon a sound methodology and using accepted best practice.
The opinions are:

- **Full Assurance** can be provided that the system of internal control has been effectively designed to meet the system's objectives, and controls are consistently applied in all areas reviewed.
- **Significant Assurance** can be provided that there is a generally sound system of control designed to meet the system's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk.
- **Limited Assurance** can be provided as weaknesses in the design or inconsistent application of controls put the achievement of the system's objectives at risk in the areas reviewed.
- **No Assurance** can be provided as weaknesses in control, or consistent non-compliance with key controls, could result in failure to achieve the system's objectives in the areas reviewed.

Audit Assignments	Planned start date	Status	Audit committee date	Comment/Assurance Level Provided
Governance arrangement review	2013/14 review	Issued	25/7/14	Significant assurance
Enhanced Services	2013/14 review	Issued	25/7/14	Significant assurance
Governance Arrangements for Responding to National Quality Reports	2013/14 review	Issued	25/7/14	Full assurance
Collaborative commissioning – contract monitoring	2013/14 review	Draft Issued	17/9/14	Significant assurance
Patient & Public Engagement	Q1	Draft issued	19/11/14	
Conflicts of interest	Q2	Field work on-going	19/11/14	

Work in progress

Assignment	Status
Collaborative Commissioning – Contract Monitoring	Draft report issued. Significant assurance provided. Awaiting final notification from CCG of actioning officers and implementation dates.
Conflicts of Interest	Fieldwork on-going.
Patient & Public Engagement	Fieldwork complete & Draft Report issued.
Continuing Healthcare	Initial assessment taking place week commencing 15th September 2014; main fieldwork planned for February 2015

CAR07 /14	**External Audit** **Annual Audit Letter 2013/14 – Received July 2014** **Audit Committee handbook** On 3 July 2014, HFMA published an updated version of the *NHS Audit Committee Handbook*. This is the third edition of the *Handbook* and the first update since 2011. The handbook aims to assist governing bodies and audit committees within the NHS as they continually re-assess their system of governance, risk management and control to ensure that it remains effective and 'fit for purpose' across all that the organisation does. Its format and content follow a similar structure to previous editions, updated to reflect the changes implemented across the NHS over the past three years. It provides audit committee members with summaries of what is expected from them, as well as providing practical guidelines, examples and case studies. The handbook outlines how governing bodies need Audit Committees to provide support in fulfilling statutory duties and organisational objectives. The Handbook then moves on to look at how audit committees should be set up and explains in detail what they do and how they work with other key players including internal, external and clinical auditors. Notable changes from previous editions include: • A new section on collaboration agreements; • Sections on regulatory compliance updated to reflect recent changes; • Additional detail in relation to whistleblowing, conflicts of interest, quality accounts and assurance frameworks; and • Cross-referencing to other documentation, such as the FRC's *Guidance on Audit Committees*. To obtain a copy of the new edition of the *NHS Audit Committee Handbook*, see http://www.hfma.org.uk/publications-and-guidance/publicationitem.htm?publicationid=69&catid=2.
CAR08 /14	**Health and Safety, Fire Safety and Security Management.** The information contained within this report has been compiled to update and inform The CCG of the current position with regards to the issues found during the statutory compliance inspections that took place under the fire, health and safety and security agenda. In supporting the CCG in its statutory compliance Yorkshire & Humber Commissioning Support (YHCS) has completed 3 assessments as required by legislation and good practice, to enable the CCG to pick up any issues that may need addressing, relating to the areas of fire safety, health and safety and security management. These three assessments are completely 'regularly' to ensure the CCG is a safe organisation for its members, staff and visitors. None of the actions highlighted in the three assessments are classified as a major risk for the CCG. A meeting was arranged between YHCS and the CCG in September 2014 and all 40 action points from the three assessments were discussed in turn. 12 action points have been resolved. The remaining 28 open action points are divided as follows. • NHS Property Services (NHSPS) – 17 action points • NHS Rotherham CCG - 11 action points Some of the hazards/risks are not for the CCG to action, and are the responsibility of the landlord(s) or other 3rd party organisations. In which case the YHCS will continue to manage these hazards/risks on behalf of the CCG, with NHS PS. All relevant outstanding action points have been forwarded to NHS PS for their attention. We are currently waiting for a reply from NHS PS regarding their response, a meeting is diarised to follow up with NHS PS to ensure action and feedback is received. **Examples of Health & Safety issues**: a. covers need to be added to florescent lighting in the fire escape stairwells b. The toilet areas remain a cause for concern due to the bubbling of the floor coverings

	c. Ensure emergency procedures are available in the lift d. Ensure there is a system in place to identify disabled visitors. **Examples of fire risks**: a. Fire safety checks are undertaken on a regular basis by fire marshals Communal areas of the building: a. Hotel services equipment is being stored under the fire escape stairs b. Assurant to be sought from Property services that the external fire doors are fit for purpose. The above will be raised with Property Services by CSU staff. The CSU confirms that the CCG is a very low risk organisation in relation to fire hazards. **Security risks** No security reports have been completed by CCG staff during quarters 1 & 2. Tailgating was raised as a potential issue but measures such as CCG staff challenging unexpected people in our area and the notice placed on the entrance have proved effective. Tailgating was raised as a potential issue but measures in place to control such eventuality have proved effective.
	Committee Activity
CAR09 /14	**Audit and Quality Assurance Committee** The Audit and Quality Assurance Committee reports directly to the Governing Body and meets approximately bi-monthly. Three meetings have been held in the first half of the year. The Committee considered and noted assurance on: • Annual accounts and associated documents, Annual report and Annual Governance Statement • Head of Internal Audit Opinion and letter of representation • Confidential code of conduct • Risk Assurance Framework and Risk Register • Internal Audit – progress report • External Audit - Technical Update and Progress Report March 2014 - ISA260 Report • Annual audit letter • Counter Fraud 2014/15 Annual Report • Counter Fraud Summary Report • HFMA – Audit Committee Handbook - Review of Effectiveness of Audit and Quality Assurance Committee • Review of AQuA Terms of Reference • Policies • Statutory Compliance Reports, ✓ Health and Safety, ✓ Fire Safety and ✓ Security Management. • Property Transfer Scheme • NHS CCGs Code of Governance - mapping performance against the 6 principles within the Code of Governance. • Noted YAS's Quality Accounts 2013/14 • Rotherham Safeguarding Vulnerable Clients Draft Annual Report • Quality Assurance Team Annual Report
CAR10 /14	**Remuneration Committee** 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 Remuneration Committee has met 2 times in the first two quarters and has approved the following, • Pay awards for Chief Officer, Deputy Chief Officer, Chief Finance Officer, Lay members, GP Governing Members and Lead GP's • Additional 1 day leave for all staff following the Investors in Excellence award; this does not apply to board members or GP's. • Extending the Contract for the Secondary Care Governing Body member.
	Corporate Governance
CAR11 /14	**Review of Constitution** At its October meeting the Governing Body approved the amendments to its constitution. Since then NHS England have written to all CCGs informing them that the date for NHSE approval has been put back until January to take into account any constitutional changes needed for Primary care co-commissioning.
CAR12 /14	**Policies and procedure update** During quarter 1 and 2 the following policies were either ratified as a new policy or ratified following a review of existing policies ✓ Confidentiality Code of Conduct ✓ Rotherham DNACPR Policy ✓ Employment Break Policy ✓ Secondment Policy ✓ Acceptable Standards of Behaviour Policy ✓ Sustainability ✓ Standards of Business Conduct ✓ Individual Funding Requests (IFR)
CAR13 /14	**Emergency Resilience and Business Continuity** South Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2014-15 The 2014/15 Emergency Preparedness, Resilience and Response (EPRR) assurance process is based on the NHS England Core Standards for Emergency Preparedness, Resilience and Response which were revised in July 2014 and are available on the NHS England internet site http://www.england.nhs.uk/ourwork/eprr The 2014/15 assurance process builds on the 2013/14 process and this year includes Clinical Commissioning Groups alongside the previously assessed provider Trusts. To comply with the national requirements, Accountable Emergency Officers are required to: 1. Undertake a self-assessment against the relevant core standards identifying the level of compliance for each standard - red, amber, green 2. Review the improvement plans developed as part of the 2013/14 assurance process (not applicable to CCGs), and if applicable include further actions required from this year's self-assessment. 3. Complete the Statement of Compliance identifying the organisation's overall level of compliance full, substantial, partial, none 4. Present the above outcomes to the board (or equivalent) or through appropriate governance arrangements where the board has delegated it's responsibility for EPRR 5. Submit the board paper to the Local Health Resilience Partnership. We are not required to submit evidence in respect of each individual standard. However, following receipt of submission, further evidence may be requested against specific standards.

	The Local Health Resilience Partnership (LHRP) will peer-review all evidence of compliance in the form of the board paper (or equivalent) including the Statement of Compliance, the results of the organisation's self-assessment against the core standards and the resulting Improvement Plan. Accountable Emergency Officer will attend a meeting of the Local Health Resilience Partnership to present the results and to participate in the assurance of partner organisations. Statements of compliance and improvement plans will form part of the assurance to the NHS England Board and the Department of Health that robust and resilient EPRR arrangements are established and are maintained within NHS Organisations. NHS Rotherham CCG has worked in partnership across the South Yorkshire and Bassetlaw CCGs on EPRR compliance over the past 18 months and continues to do so. The draft self-assessment has therefore been developed and peer-reviewed jointly across the South Yorkshire and Bassetlaw CCGs. The self-assessment has been reviewed by the Assistant Chief Officer as NHS Rotherham CCG's operational EPRR Lead, and by the Accountable Emergency Officer (Chief Officer). NHS Rotherham CCG's self-assessment has resulted in a green rating across all criteria. No separate action plan is therefore been devised. However the Governing Body receives assurance on on-going EPRR action and testing via the quarterly Corporate Assurance Reports, **Recommendation** The Governing Body is asked to agree the submission to the Local Health Resilience Partnership of the EPRR Compliance Statement. **Appendices** • **Self-Assessment - 8C** • **Statement of compliance – 8D** **Business continuity plan test** On the 20th October 2014 The CCG tested the 'emergency contact' element of its Business continuity plan. The CCG has a cascade system to contact all staff, out of hours, in the event of an emergency. 41 of 56 staff were contacted and spoken to on the night, the rest were left messages and returned calls on their return.
CAR14 /14	**Sustainability Responsibility** The CCGs Sustainability Strategy action plan based on the Good Corporate Citizenship Assessment Model has been ratified by the October 2014 Governing Body. Work will now commence to implement the action/development plan.
CAR15 /14	**Complaints Management** Complaints brought to RCCG are dealt with in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. Six complaints were received in quarter 1, with two complaints being received during quarter 2. All were acknowledged within 3 working days. The Chief Officer signs off all responses to complaints.
CAR16 /14	**Equality & diversity** Equality Delivery System (EDS) The Refreshed Equality Delivery System (EDS2) that was launched on 4th November 2013 by Sir David Nicholson. The refreshed EDS2 Framework is designed to helped NHS Organisation deliver on the Public Sector Equality Duty (PSED). It encourages organisations to use it flexibly and to embrace key local health inequalities. The refreshed EDS2 has arisen out of NHS England's commitment to an inclusive NHS that is fair and accessible to all. EDS2 applies to people whose characteristics are protected by the Equality Act 2010 which are as follows: • Age

	• Disability • Gender • Gender re-assignment • Marriage and civil partnership • Pregnancy and maternity • Race including nationality and ethnic origin • Religion or belief • Sexual orientation RCCG's Equality Objectives have been developed and supported by underpinning actions and linked to the four EDS 2 goals. Attached is the Equality Implementation plan which is for two years. **Appendix 8E**
CAR17 /14	**Declarations of Interest:** Annually Declarations of Business Interest are sought from all staff and entered into one or more registers. The register is available for public viewing via our website. In line with the RCCG Constitution, changes to a persons' declaration should be submitted to the Assistant Chief Officer within 14 days of the change with the register being updated within 28 more days. Since the relevant registers were published in April 2014, three changes have taken place and the registers have been updated and published.
CAR18 /14	**Disclosure of Gifts and Hospitalities:** The gifts and hospitality register is updated with every disclosure and monitored by the Assistant Chief officer on a regular basis.
	Information Governance
CAR19 /14	**Information Governance Quarterly Assurance Report – Sept 14** **Introduction** Information governance is the term used to describe the principles, processes, legal and ethical responsibilities for managing and handling information. It sets out the requirements and standards that health and social care organisations need to achieve to ensure they fulfill their obligations so that information is handled legally, securely, efficiently and effectively. Key areas within Information Governance include: • The protection and use of personal confidential data • The Information Governance Toolkit • Freedom of Information Act Requests • Data Protection Act Requests • Information Management & Technology • Records Management and records retention • Information risk reporting • Information Security breaches. **The protection and use of Personal Confidential Data** The Health & Social Care Act 2012 amended previous legislation, leading to healthcare commissioners including CCGs and NHS England not being permitted to use Personal Confidential Data (PCD) for commissioning purposes. From 1st April 2013 such data could only be used by commissioning organisations a) with patient consent, or b) for direct patient care or c) through a statutory gateway such as Safeguarding. Personal Confidential Data for commissioning purposes may only be accessed and analysed by the Health & Social Care Information Centre (HSCIC) or by their Data Service for Commissioners (DSC) which has regional offices (DSCRO). NHS Rotherham CCG has ensured appropriate controls are in place for assurance while waiting for

confirmation from HSCIC and NHS England to operate within the Section 251 exemptions agreed by the national Confidentiality Advisory Group:

- CAG 2-03(a)/2013 Application for transfer of data from the Health and Social Care Information Centre (HSCIC) to commissioning organisation Accredited Safe Havens (ASH). Organisations who are successfully assessed as Accredited Safe Havens (ASHs) may receive weakly pseudonymised data in the form of either postcode or NHS Number.
    - In May 2014 Rotherham CCG submitted its application to HSCIC to become an Accredited Safe Haven (ASH) As of 01 October 2014 HSCIC have not yet confirmed Rotherham's ASH statues but are sending regular updates to IG Leads.

- CAG 7-04(a)/2013 Disclosure of commissioning data sets and GP data for risk stratification purposes to data processors working on behalf of GPs. This Section 251 expires on March 2015.
    - Rotherham CCG has submitted a risk stratification assurance statement to NHS England for formal approval to use risk stratification and is awaiting their response.

NHS Rotherham CCG also recognises the 7th Caldicott principle regarding sharing information for the benefit of patients.

Information Governance Toolkit

The Information Governance Toolkit is a national toolkit administered by the Health & Social Care Information Centre (HSCIC) which enables us to measure our compliance across the areas of:

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

The attainment score ranges from 0 (little or no compliance with the requirement) to 3 (full compliance). Level 2 is the required standard. As at 31st March 2014 NHS Rotherham CCG self-assessed as a full Level 2.

The current self-assessed CCG position is shown below. The last published assessment is available online via https://www.igt.hscic.gov.uk/reportsnew.aspx

Ref	Standard	Level met
130	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	**3**
131	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	**3**
132	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	**2**
133	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	**2**
134	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	**2**
230	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	**3**
231	Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users	**2**
232	Personal information is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	**2**

234	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	**3**
235	There are appropriate confidentiality audit procedures to monitor access to confidential personal information	**2**
236	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	**Not Relevant**
237	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	**2**
250	Individuals are informed about the proposed uses of their personal information	**3**
340	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	**2**
341	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	**2**
342	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	**Not Relevant**
343	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	**2**
344	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	**2**
345	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	**2**
346	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	**2**
347	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	**2**
348	Policy and procedures ensure that mobile computing and teleworking are secure	**2**
349	There are documented incident management and reporting procedures	**2**
350	All transfers of hardcopy and digital personal and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	**2**
351	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	**2**
352	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	**2**
420	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	**2**
421	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	**Exempt**

To progress from the current scores and improve compliance statues an IG Work programme and IG Toolkit improvement plan has been developed to keep track of requirements and progress which needs to be approved as evidence for the toolkit.
Activity in the last quarter to support the safe information governance of the organisation and compliance with the Information Governance Toolkit has included:

- Development of IG Work plan and IGT improvement plan to be approved.
- Updating the evidence log for the Information Governance Toolkit.
- Refresh of the Caldicott Work plan.

- Annual re-registration with the Information Commissioner under the Data Protection Act.
- Reviewed and updated the following policies:
  - Information Governance Policy and Management Framework
    - Minor changes
  - Information Risk Policy
    - Update on SIRI and IGT
  - Records Management Policy
    - Minor formatting changes
  - Safe haven Policy
    - Minor formatting changes
  - Data Protection and Access to Health Records Policy
    - Minor changes and updates to organisational name
  - Internet / Intranet Acceptable Use Policy
    - Update of review date.

CAR20 /14

Freedom of Information

The CCG has had enquiries from: The BBC, business members of the public, educational establishments, journalists, media, MPs, public authorities, research and charities.

April to June 2014 Quarter 1		July to September 2014 Quarter 2	
Category of request	Number of requests	Category of request	Number of requests
Contacts	7 (11%)	IT	4 (8%)
Continuing Healthcare	3 (4.5%)	Mental Health	4 (8%)
Contracting	29 (44.5%)	Contracting	27 (50%)
Communications	2 (3.5%)	Corporate	4 (8%)
IT	2 (3.5%)	Survey	1 (1%)
Medicines Management	8 (12%)	Medicines Management	6 (11%)
Corporate	10 (15%)	GP	1 (1%)
Finance	4 (6%)	Finance	7 (13%)
	65		54

During both quarter 1 and 2 all the requests made under the FOI Act 2000 were acknowledged within 3 working days.

During quarter 1, 80% of all enquiries were responded to within 20 working days. In all instances where the timescale was not met the requester was contacted informing them of the delay. During quarter 2 all responses due were responded to within 20 working days.

Organisational Development & Staffing Governance

CAR21 /14

Structure Review

The new management structure is attached.

Appendix 8F

CAR22 /14

	Staffing breakdown:	Count / %	Commentary
Staffing numbers	Headcount	69	Including Governing Body members
	Whole Time Equivalent	54.43	
	Turnover	1.0%	3 starters (one of which SCE Member) and 4 leavers (One SCE Member and one Lay member included)
	Cumulative sickness rate	1.3%	This is a 1% decrease on the last quarter
	Formal cases of discipline, grievance, poor performance or bullying and harassment		No changes
Gender	Female	47	Increase of males since March 2014
	Male	22	

	Age		20-25	1	The average age of the workforce is 45 years.
			26-30	4	
			31-35	6	
			36-40	7	
			41-45	21	
			46-50	12	
			51-55	10	
			56-60	5	
			61-65	3	
			66-70	0	
	Ethnicity	White	British	58	No changes
			Other	1	
		Mixed	White & Black Caribbean	0	
			White & Black African	0	
			White & Asian	0	
			Other	0	
		Asian / Asian British	Indian	2	
			Pakistani	1	
			Bangladeshi	0	
			Chinese	0	
			Other	1	
		Black / Black British	African	0	
			Caribbean	0	
			Other	1	
		Other	Arab	0	
			Other	0	
		------	Prefer not to say	5	
	Disability		Declared disability	4	The staff survey shows that 17% of respondents stated they had a disability or long term condition
			No declared disability	58	
			Prefer not to say	7	
	Religion / Belief		No religion / Atheism	2	No changes
			Christianity	49	
			Buddhism	0	
			Hinduism	1	
			Judaism	0	
			Islam	1	
			Sikhism	1	
			Any other religion	0	
			Prefer not to say	15	
	Sexual orientation		Bisexual	0	No changes
			Gay man	0	
			Gay Woman / Lesbian	0	
			Heterosexual	55	
			Other	0	
			Do not wish to declare	14	

	Pregnancy, maternity and gender reassignment	Due to the small numbers associated with pregnancy/maternity and gender reassignment which may make individuals personally identifiable, these are not included in a public report.		N/A

Mandatory Training

Name of Training	Compliance %
Equality & Diversity	98
Fire Safety	100
Fraud	98
Health & Safety incorporating Risk Management	100
Information Governance	100
Moving & Handling	100
Safeguarding Adults	100
Safeguarding Children & Young People	100
Infection Prevention	100
Induction	100

The RCCG has achieved the highest electronic training compliance rate in the Country.

Miscellaneous

CAR23/14

Individual Funding Requests

The West and South Yorkshire and Bassetlaw Commissioning Support Unit manage the IFR referrals on behalf of Rotherham CCG and make recommendations on the decision whether to agree to fund an IFR or not on behalf of the CCG.

IFRs are received and processed by the CSU IFR team based in Sheffield. The process is clinically led and all requests are considered by two experienced Medical Advisors at a weekly panel meeting. Recommendations on the decisions are then submitted to the CCG for sign off prior to clinicians being notified of the decision.

The Annual report 2013-2014 is attached.

Appendix 8G

GB Assurance Framework Summary

Background

The Governing Body (GB) Assurance Framework was discussed at the GB/SCE development session in June. It was agreed that the CCG strategic objectives used to categorise risk would be amended to reflect the 6 domains of the national CCG Assurance Framework. The table below sets out the domains/strategic objectives and their sub-categories. For full details of what this covers refer to the CCG Assurance Framework at the following link: http://www.england.nhs.uk/wp-content/uploads/2013/11/ccg-ass-op-guid.pdf

	Strategic Objective		Sub-Category
Domain 1	Clinically commissioned, high quality services	1.1	Quality of commissioned services
		1.2	Patient Safety
		1.3	Prevention
Domain 2	Patients and public actively engaged	2.1	Patient engagement
		2.2	Equality
Domain 3	Plans deliver better outcomes for patients	3.1	Outcomes/ performance measures
		3.2	Productivity/efficiencies
		3.3	Contracting/service delivery
Domain 4	Robust governance arrangements	4.1	Corporate (including employment) /constitutional
		4.2	Safeguarding
		4.3	Finance
		4.4	VFM/impact on commissioning system
		4.5	Risk management
		4.6	Commissioning Support
Domain 5	Work in partnership with others	5.1	Other commissioners (e.g. RMBC)
		5.2	Other CCGs
		5.3	NHS England
		5.4	Providers
Domain 6	Strong and robust leadership	6.1	Workforce capacity and capability
		6.2	Reputation
		6.3	Innovation

The following table summarises, by domain, strategic risks rated 12 and above on the GB Assurance Framework set out by main sub-category and any relevant secondary sub-category.

Date Added to AF	AF number	Risk	Lead	Uncontrolled Risk	May Score	August Score	Sub-Category		Linked organisation (if applicable)	Secondary Sub-category (s)		Linked organisation (if applicable)	Gaps in Control	Gaps in Assurance
Domain 1: Clinically commissioned, high quality services														
31.03.12	AF11	Failure to improve GP quality and efficiency in partnership with NHS England (current concerns are due to overall GP capacity and morale)	*Robin Carlisle*	**20**	**20**	**20**	**1.1**	**Quality of commissioned services**	**GPs**	**3.2**	**Productivity/ Efficiency**		**√**	**√**
31.03.12	AF09	Failure to maintain and improve quality of services and ensure effective quality and safety assurance processes are in place regarding NHSR CCG commissioned services (e.g. provider CIPs).	*Sue Cassin*	**20**	**16**	**16**	**1.1**	**Quality of commissioned services**	**TRFT RDASH**	**1.2**	**Patient Safety**	**TRFT RDASH**	**√**	**√**
05.03.13	AF19	Adverse impact on patient care due to problems at TRFT evidenced by: leadership change, liquidity pressures and unresolved EPR implementation issues.	*Robin Carlisle*	**25**	**20**	**15**	**1.2**	**Safety**	**TRFT**	**1.3** **3.3**	**Prevention** **Contracting/ Service delivery**	**TRFT**	**√**	**√**
13.11.13	AF24	Failure to improve Child and Adolescent Mental Health Services (CAMHS)	*Kate Tufnell*	**16**	**12**	**12**	**1.1**	**Quality of commissioned services**	**RDASH**				**√**	**√**
Domain 2: Patients and the public are actively engaged														
None														
Domain 3: Plans deliver better outcomes for patients														
01.09.14	AF28	Failure of YAS to achieve RED 1 8 minute Target at CCG level and Yorkshire & Humber wide	*Dominic Blaydon*	**20**	**NEW**	**20**	**3.1**	**Outcomes/ Performance measures**	**YAS**	**1.1** **1.2**	**Quality of commissioned services** **Patient Safety**	**YAS**	**×**	**√**
31.03.12	AF12	Failure to deliver system wide efficiency programmes for prescribing, planned care and unscheduled care	*Robin Carlisle*	**16**	**16**	**16**	**3.2**	**Productivity/ Efficiency**		**4.4**	**VFM/ Impact on commissioning system**	**TRFT**	**×**	**×**
09.01.14	AF26	Impact on CCG of other commissioners efficiency plan	*Robin Carlisle*	**16**	**16**	**16**	**3.2**	**Productivity/ Efficiency**	**RMBC NHSE**	**4.4**	**VFM/Impact on commissioning system**		**√**	**×**
03.06.13	AF21	Failure to meet A&E targets	*Sarah Lever/ Becci Chadburn*	**16**	**12**	**12**	**3.1**	**Outcomes/ Performance measures**	**TRFT**				**×**	**×**

Date Added to AF	AF number	Risk	Lead	Uncontrolled Risk	May Score	August Score	Sub-Category		Linked organisation (if applicable)	Secondary Sub-category (s)		Linked organisation (if applicable)	Gaps in Control	Gaps in Assurance
29.01.13	AF20	Impact of NHS 111 on local health community. Specifically potential for increase in no. of patients being referred to A&E/ 999	*Dominic Blaydon*	**20**	**12**	**12**	**3.1**	**Outcomes/ Performance measures**	**YAS TRFT**				√	×
Domain 4: Robust Governance Arrangements														
17.03.14	AF27	Named GP for Safeguarding Children due to leave organisation. This will leave a significant gap in safeguarding assurance in primary care	*Sue Cassin/ Catherine Hall*	**16**	**16**	**16**	**4.2**	**Safeguarding**		**6.1**	**Workforce capacity and capability**		√	√
09.01.14	AF25	Reduction in resources through introduction of Better Care Fund	*Keely Firth*	**20**	**15**	**15**	**4.3**	**Finance**		**5.1**	**Other Commissioners**	**RMBC**	×	×
31.03.12	AF02	Failure to meet financial targets and statutory financial duties	*Keely Firth*	**16**	**12**	**12**	**4.3**	**Finance**					√	×
31.03.12	AF06	Failure to ensure robust systems of risk management and governance are in place, not fulfilling statutory responsibilities	*Robin Carlisle*	**16**	**12**	**12**	**4.5**	**Risk Management**		**4.2**	**Corporate/ Constitutional**		×	×
15 09 13	AF23	Financial allocations reduced by Government. Review of Allocations by NHS England	*Keely Firth*	**12**	**12**	**12**	**4.3**	**Finance**					√	×
01.09.14	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.	*Chris Edwards*	**20**	**NEW**	**20**	**4.2**	**Safeguarding**					√	√
Domain 5: Work in partnership														
None														
Domain 6: Strong robust leadership														
31.03.12	AF08	Failure to ensure effective workforce planning and capability to deliver organisations business, maintain performance and meet statutory requirements with reduced workforce	*Chris Edwards*	**16**	**12**	**12**	**6.1**	**Capacity and capability**					×	×

CCG Assurance Framework Aug 2014 - arranged by highest risk first (for September AQA)

Appendix 8B

The principal risks in the assurance framework are **high strategic potential** risks which require ongoing control. These risks are linked to one of the Strategic CCG Objectives rather than operational risks which are eligible for entry to the Risk Register.

The CCG risk tolerance (appetite under which risks can be tolerated) is a score of 11 or below where the assessment has been undertaken following the implementation of controls and assurances.

Risk Matrix		Likelihood				
		(1) Rare	(2) Unlikely	(3) Possible	(4) Likely	(5) Almost certain
Consequence	(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

Note that all controls and assurance logged in this AF are actual and have been received, and are not 'planned' for the future unless stated

Date Added to AF	AF number	Objective	Sub-category	Sub-category	Sub-cat	Principle Risk	Exec Lead	Uncontrolled C	Uncontrolled L	Uncontrolled CxL	Current Risk C	Current Risk L	Current Risk CxL	Key controls	Internal Assurance	External Assurance	Positive Assurances	Gaps in control	Gaps in Assurance	Outcome	Actions	Date Reviewed
31.03.12	AF11	1	1.1	3.2		**Failure to improve GP quality and efficiency in partnership with NHS England (current concerns are due to overall GP capacity and morale)**	R Carlisle	4	5	20	4	5	20	• Annual quality and efficiency review visits •Contract monitoring •Monitoring of complaints, compliments and incidents •The CCG carries out a programme of quality visits, concentrating on areas of CCG responsibility and shares intelligence with NHS England as appropriate. •The CCG meets with NHS England including quarterly assurance meetings and CCG Chair & Chief Officer meetings with Area team Director and Medical Director.	• AQuA minutes reported to NHSR CCG Governing Body, 3 lay members of AQuA AQER visits reported to AQuA • Annual GP comparative data produced • Good medical practice committee	None	MOU agreed with NHS England	GP capacity in NHS England Primary Care Strategy. Concerns over implications of Personal Medical Services (PMS) for Rotherham GP capacity and morale are key to enabling the CCG to meet its strategy. Currently serious concerns about the impact of the PMS changes on GP capacity, recruitment, retention and morale in Rotherham, the strategic performance of NHS England in terms of addressing the CCGs concerns about the primary care strategy and operational performance of NHS England in terms of effective communication to GPs as providers all impacting on the CCGs ability to transform pathways and improve quality.	NHSR CCG chair working with NHS England on primary care strategy Area team capacity to deliver their responsibilities at both strategic and operational level NHSE Area Team have to implement further running cost reductions.	TREAT	Communication with NHS England collectively with the other 4 SY CCGs and individually through Chair and Chief Officer meetings and sharing risk register at quarterly assurance meetings. Longer term discussions about the possibility of the CCG assuming a greater co-commissioning role	Sep-14
01.09.14	AF28	3	3.1	1.1	1.2	**Failure of YAS to achieve RED 1 8 minute Target at CCG level and Yorkshire & Humber wide**	Dominic Blaydon	5	4	20	5	4	20	Bi weekly conference calls between YAS and Lead Commissioner Recovery Plan in place to deliver 67.5% Year End Performance for Rotherham (72.6% Y& H) which includes recruitment of additional staff and the use of private providers	Bi monthly joint South Yorkshire Commissioners performance meeting with YAS and Bi monthly performance meeting between NHSR CCG commissioners and YAS local area team GP Urgent Transport Pilot project extended to reduce demand on YAS	Commissioners have secured the resource of "The Good Governance Group" as an independent reviewer of the YAS recovery plan. South Yorkshire Lead Commissioner Quality lead is monitoring Quality with a focus focusing on minimisation of patient harm during the period of poor performance. YAS have shared a review of incident reporting including monitoring of potential harm from delayed response	GP Urgent Transport Pilot project extended to reduce demand on YAS		Increase in activity Demand. Recent resignation of the Operations Director, interim support in place	TREAT	Continue performance management. Review options for contract penalties at year end	Sep-14
01.09.14	AF29	4	4.2	0		**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.**	Chris Edwards	5	4	20	5	4	20	Single issue safeguarding board in 17 September. CCG CO meeting with other agencies to discuss provision of services for victims - 15/9 relective session for CCG GB 2 October Assurance requested from key providers - to be considered at next contract meetings	PLT event in November focussed on safeguarding/CSE Meeting taking place on 18/9 to review impact on partnerships			Revisit at the next TRFT/RDaSH board to Board meetings in November.		TREAT		Sep-14

Date Added to AF	AF number	Objective	Sub-category	Sub-category	Sub-cat	Principle Risk	Exec Lead	Uncontrolled C	Uncontrolled L	Uncontrolled CxL	Current Risk C	Current Risk L	Current Risk CxL	Key controls	Internal Assurance	External Assurance	Positive Assurances	Gaps in control	Gaps in Assurance	Outcome	Actions	Date Reviewed
31.03.12	AF12	3	3.2	4.4		**Failure to deliver system wide efficiency programmes for prescribing, planned care and unscheduled care**	R Carlisle	4	4	16	4	4	16	• Rotherham wide QIPP management structure - overseen by multi-agency QIPP Delivery Group • 4 main efficiency programmes managed by 2 and 4 weekly multi-agency management committees • Efficiency programmes detailed in commissioning plan • Identified SCE GP and senior officer for each efficiency programme. • Alignment of finance, activity and QIPP to ensure early identification of plans going off track • Regular clinician to clinician meetings with TRFT. • 2014 Commissioning plan set out programmes.	• Monthly financial reporting •Reports to NHSR CCG Governing Body and Audit and Quality assurance group • Programme & Project level KPI's developed and measured QIPP Delivery Groups meets every 2 months, it has very senior level representation from all CCG, TRFT, TMBC and RDaSH, and receives progress on efficiency targets and oversees the efficiency programmes.	• Quarterly assurance meetings with NHS England on key issues.	NHSR CCG met high level efficiency targets in 2013/14. 2014/15 QIPP structures and plans agreed at January 2014 QIPP Delivery Group			TREAT	Continue to monitor QIPP delivery across the 4 key programmes via 4 specific management committees.	Sep-14
31.03.12	AF09	1	1.1	1.2		**Failure to maintain and improve quality of services and ensure effective quality and safety assurance processes are in place regarding NHSR CCG commissioned services (e.g. assurance on provider CIPs).**	S Cassin	5	4	20	4	4	16	• 3 officers are responsible for quality of each major contract area (commissioning manager, quality and safety lead and GP) • TRFT - we maintain quality assurance by monitoring the standard contract, national, regional and locally agreed CQUIN incentives and quality metrics • Participate in provider assurance meetings • Ad hoc and planned visits to provider units • Manage assurance of response to SIs • Monitor a wide range of benchmarking HSMR & SHMI data • CQC risk ratings • Similar processes in place for RDASH • A wide range of assurance of GP quality • Assurance from lead commissioners i.e. for STH, SCH and representation at these quality contract meetings • NHSR CCG Chief Nurse joins TRFT Chief Nurse on unannounced 'out of hours' visits. • Clinical member of Quality Assurance Team attends TRFT Senior Nurse unannounced walk rounds. • TRFT/NHSR CCG Chief Nurse monthly 1-1s Quality and Safety are harder to be assured on as providers have to deliver incremental cost improvement plans each year. The NHSR CCG is required to be assured of providers CIPs • New post of Head of Clinical Quality from August 2014 to support NHSR CCG quality agenda.	• AQuA minutes reported to NHSR CCG Governing Body, 2 Lay members • Monthly contract performance and contract quality meetings - reporting a wide range of metrics including CQUINS and HSMRs reporting to AQuA • SIs reported to each AQuA/OE/NHSE Area Team and NHSR CCG Governing Body • Provider quality accounts reported to AQuA • Patient experience and incidents reported to AQuA and NHSR CCG Governing Body • Annual GP comparative data produced, and 3 yearly programme of peer review quality visits planned. • Providers will continue to be held to account including quality contract meetings, monitoring safety metrics, incident reports and programme of clinically led visits and contract review processes • Chief Nurse is member of Clinical Quality Groups for STH & SCH. • Health Protection Nurse provides Infection Prevention and Control support via NHSR CCG SLA with Public Health. • Monthly Quality and Safety and Patient Experience reports to NHSR CCG Governing Body Appreciative Enquiry Policy in place, to deal with concerns about level of assurance. Quality Impact Assessment for RDaSH and TRFT requested and reviewed via (TRFT Contract Quality meetings and RDaSH Mental Health LD & QIPP Group)	• Reports go to NHSE Quality Surveillance Group • NHSR CCG Chief Officer and Chief Nurse members of Quality Surveillance Group • NHS England Area Team Quality Leads Group, SI Group and Chief Nurse Group •Friends & Family test becoming available for Mental Health, Community Services and Primary Care in December 2014. Methods of feedback are online, patient opinion and national surveys. NHSE Chief Nurse Forum CQC Monitor Staff survey Patient Surveys Feedback from overview and scrutiny	• CQC reports • Audit commission Report regarding data quality • SI reporting • Cost Improvement Plans (CIPs) to be reviewed by NHSR CCG during Qtr 1 2014 including assurance from Chief Nurse and Medical Director. AQuA group. Robust internal mechanisms, e.g. SI committee. Lead SCE GP for each major provider Quality schedules in contracts Provider quality accounts Quality and patient safety lead in post Monthly reports to NHSR CCG Governing Body and at SY&B level.	Substantial shifts in responsibilities for quality assurance as a result of becoming a commissioner only organisation Main provider Quality Impact Assessment plans will be received by SCE, AQuA and NHSR CCG Governing Body in 2014.	• We believe that the allocation of responsibilities following the last re-organisation and staff losses is proportionate and robust. AQuA will have to be assured this is the case as part of its regular programme. • Potential lack of assurance from organisations where NHSR is not the Lead Commissioner	TREAT	Continue to monitor through robust internal mechanisms including designated officer and GP leads for major contracts and continue to report, via Operational Risk, Governance and Quality meeting and Audit and Quality Assurance Group	Sep-14
09.01.14	AF26	3	3.2	4.4		**Impact on CCG of other commissioners efficiency plan**	R Carlisle	4	4	16	4	4	16	All commissioners discuss their plans at H&WBB and multi-agency QIPP Delivery Group	CCG chairs a series of QIPP groups that allow joint discussion of areas where the commissioner is not clear	meeting with NHS E re: tier 4 mental health meeting with RMBC around continuing care	Better Care Fund and CCG plans agreed at Feb H&WBB	Full impact of RMBC plans in Public Health, CAMHS and Learning Disabilities not yet clear. Potential impact on CCG of NHSE specialist commissioning plans.		TREAT	RMBC plans discussed at BCF, H&WBB and QIPP Delivery Group. NHSE plans discussed at quarterly assurance meetings.	Sep-14

Date Added to AF	AF number	Objective	Sub-category	Sub-category	Sub-cat	Principle Risk	Exec Lead	Uncontrolled C	Uncontrolled L	Uncontrolled CxL	Current Risk C	Current Risk L	Current Risk CxL	Key controls	Internal Assurance	External Assurance	Positive Assurances	Gaps in control	Gaps in Assurance	Outcome	Actions	Date Reviewed
17.03.14	AF 27	4	4.2	6.1		**Named GP for Safeguarding Children due to leave organisation. This will leave a significant gap in safeguarding assurance in primary care**	Sue Cassin /Catherine Hall	4	4	16	4	4	16	• GP/SCE recruitment and training process in place • Interviews booked for 16th May • Overlap of previous Named GP agreed at OE	•SCE review of individual responsibilities	• GP lead attendance at RLSCB and other relevant meetings	• Regular review of GP Lead responsibility •Adaptation of the national job profile for Named GP to be recruited to.	Significant gap in NHSR CCG provision and assurance processes when Named GP for Safeguarding Children leaves the organisation Succession planning in place.	Safeguarding Children is a crucial role for CCGs following the reforms 01/04/2013 to the health service. Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework document see page 17 section 3.2.2 External assurance - NHSR CCG needs to assure NHSE & Rotherham LSCB that this risk has been identified and actions are being taken to rectify the gap in assurance.	**TREAT**	•SCE have reviewed member roles and responsibilities to ensure all areas covered and GP Leads aware of responsibilities • Interim arrangements to provide GP Lead role to safeguarding - role commences October 2014 Cover arrangements continue to support process. • Recruitment underway to this permanent post - •Development programme needed to ensure future long-term cover arrangements.	Sep-14
05.03.13	AF19	1	1.2	1.3	3.3	**Adverse impact on patient care due to problems at TRFT evidenced by: leadership change, liquidity pressures and unresolved EPR implementation issues.** **THIS LINKS WITH AF'S 3, 5 and 18** **THIS RISK LINKS RISKS 55, 69 AND 71 ON THE RISK REGISTER**	R Carlisle	5	5	25	5	3	15	1) Assurance on TRFT action plan agreed by Monitor 2) Regular contact at Board and exec level 3) NHSR CCG quality assurance processes including soft intelligence and clinically led visits 4) contract processes including contract quality meeting 5) Non recurrent funds invested to support transformational changes TRFT has a Board assured project group and recovery plan advising the clinical and financial implications of EPR implementation. TRFT have declared this a serious incident and have been investigated accordingly. • Contractual framework • Monitor FT compliance framework	Assurance from quality performance meetings, AQuA and Board Quality meetings TRFT successfully appointed to 4 Clinical Director posts in Sept 2014 and appointed an 18 months Chief Executive in December 2013. Quarterly evidencing of non recurrent schemes Commissioner investment based upon mandate principles e.g. national tariff • Transitional support provided by NHSR CCG to fund exceptional costs e.g. Redundancy and Estate rationalisation. Series of discussions at Board to Board in May and September and a standing item at Contract Quality meetings.	NHSR CCG have seen interim reports to Monitor. Position agreed at Quality review meeting with CQC and monitor on 22 October. Leadership change noted to be a continuing risk. - Key acute provider in significant breach of its conditions of authorisation therefore. Monitor regime escalated throughout this year. - Refresh of board membership - Non recurrent investment approved by NHS England Options appraisal for 5 year plan to be submitted to Monitor in December 2013 showing around 60% of savings requirements achievable. TRFT submitted 2 year plan to Monitor in May 2014 and -5 year plan in June 2014 Positive TRFT engagement ongoing with community transformation project TRFT providing appropriate high level input to all multi agency QIPP groups	Page 14 of Monitor letter states 'the Trust's analysis has shown no permanent harm events have arisen from EPR issues to date, and one instance of semi-permanent harm'. TRFT Medical Director has given assurance to NHSR CCG and Monitor they have been no actual incidence of patient harm. TRFT are giving regular update on delivery of EPR recovery plan at Contract Quality Meeting Trust have appointed substantive Chairman, Chief Nurse and Chief Executive Assurance given at Board to Board in May 2014 that TRFT expect to reassure monitor conditions on EPR and Governance.	NHSR CCG assured that risks of patient harm have been mitigated but system is still problematic for clinicians to use and to extract information from. NHSR CCG to scrutinise 5 year plan and providers, quality impact assessment of cost improvement plans.	1) Leadership 2) EPR 3) Liquidity 4) Quality The 4 issues will be assessed in TRFT Monitor action plan. NHSR CCG received its assurance at Board to Board in September. 1)Impact of EPR upon financial valuations of activity and lost capacity 2) Risk arising from national efficiency requirements via tariff. 3) Risk of non achievement of CQUIN targets 4) Non achievement of QIPP plans Further Board to Board in March 2014 TRFT are not aware of any patient harm but are making reviewed attempts to ensure every incident is logged and investigated to increase our assurance. A plan was submitted to Monitor and commented on by NHSR CCG at Board to Board on 1 May. Written progress report in September Board to Board papers. Recovery Plan is still ongoing and will be further reviewed at Board to Board in March 2014.	**TREAT**	Support TRFT with their plans. Deliver NHSR CCGs 2014/15 plan. Review assurance and TRFT plans at Board to Board in November 2014. 1) Monthly update at CCGC. 2) QIAs provided for savings schemes 3) Audit Committee chair attended TRFT audit meetings 4) See additional actions under risk 073	Sep-14
09.01.14	AF25	4	4.3	5.1		**Reduction in resources through introduction of Better Care Fund**	Keely Firth	5	4	20	5	3	15	Task group established with joint membership between NHSR CCG and RMBC Stocktake of existing commitments and funding streams undertaken.	Appropriate financial plans in place for 2014/15 onwards	Plans signed off by H&WBB in February 2014 and April 2014 • Rotherham selected as an exemplar site				**TREAT**	Update Dec 2014	Sep-14

Date Added to AF	AF number	Objective	Sub-category	Sub-category	Sub-cat	Principle Risk	Exec Lead	Uncontrolled C	Uncontrolled L	Uncontrolled CxL	Current Risk C	Current Risk L	Current Risk CxL	Key controls	Internal Assurance	External Assurance	Positive Assurances	Gaps in control	Gaps in Assurance	Outcome	Actions	Date Reviewed
31.03.12	AF02	4	4.3			**Failure to meet financial targets and statutory financial duties**	Keely Firth	4	4	16	4	3	12	• SFIs/ Scheme of Delegation • Monthly CFO meetings • Regular budgetary monitoring • Monitoring of ACP and QIPP programmes via QIPP Delivery Groups • Contracting framework • Annual internal and external audits. • Performance report monthly to NHSR CCG Governing Body •0.5% Contingency in plan • 1.5% recurrent headroom in plan. • an additional 1% to be invested non-recurrently in 2014/15.	• Audit and Quality assurance Committee • Performance Reports • Internal audit reports •Comprehensive fraud reports received by AQuA group • Regular updates to SCE and NHSR CCG Governing Body • Contract management including sanctions and incentives in line with national contract and guidance • Standard processes documented, finance team assigned objectives and have regular 1:1s • Systematic monitoring of performance against plan and regular review of planned actions • Information embedded within the Performance Report presented to NHSR CCG Governing Body • Annual updates to NHSR CCG Governing Body and exception reporting.	• NHSR CCG likely to get minimum growth levels for next 5 years at 1.7% • Growth assumptions in 4 year Commissioning Plan approved by NHSE • External audit of annual accounts which include a review of annual governance statement and value for money. • Quality Impact Assessments signed off by Provider and Commissioner governing bodies	• Good track record of meeting financial duties	Allocations published but NHSE advised that they are not guaranteed.	None	TREAT	Continue to monitor through robust mechanisms including monthly reports to SCE and NHSR CCG Governing Body, Contract meetings, Clinical Referral Management Committee and System Resilience Group	Sep-14
13.11.13	AF24	1	1.1			**Failure to improve Child and Adolescent Mental Health Services (CAMHS)**	Kate Tufnell	4	4	16	4	3	12	• Standard contract with RDaSH, including partnership agreement for additional RMBC funding. Utilisation of Contract Query process. Monthly Contract Performance meetings • CAMHS Strategy & Partnership Meetings • RDaSH QIPP meetings with RMBC. • Ad-hoc CAMHS Interface meetings to manage the relationship between RCCG, RDaSH, RMBC and NHS England relating to the CAMHS Tier 3/Tier 4 interface. • Development & Implementation of an 'Emotional Wellbeing & Mental Health Strategy for Children & Young People' for Rotherham in conjunction with RMBC & RDaSH. • Commissioning of Attain review of CAMHS services. • CAMHS issues discussed at SCE, OE and GPMC meetings. • RDaSH participating in the Children & Young people's Improving Access to Psychological Therapies (CYP-IAPT) initiative. • Series of GP CAMHS surveys undertaken. • RDaSH employ Peer Support Workers to manage the transition of patients from CAMHS to Adult services.	• Russell Brynes (SCE), supported by Simon Mackeown (GPMC), lead on CAMHS for the CCG. • Direct contact with RDaSH clinicians through the CAMHS 'Clinician to Clinician' meetings. • Various reports on CAMHS presented to OE, SCE & GPMC.	• CQC visits/reports. • CAMHS Strategy & Partnership Group meetings • Attain Review. • Healthwatch. • Consultation with various patient/public groups on the Development & Implementation of an 'Emotional Wellbeing & Mental Health Strategy for Children & Young People'.	• Some improvements in GP satisfaction of CAMHS through the CAMHS Survey Monkey exercises. • Contract Query signed off by the CCG in March 2014.	• Fairly regular changes in RDaSH senior CAMHS management. • Volatility of the RDaSH CAMHS grant funding.	• True 18 week waiting time information not yet available. • Patient/Parent representation on the CAMHS Strategy & Partnership Group.	TREAT	• Contract Query issued in October 2013 to address issues raised by GPs. • CAMHS Joint Implementation Plan (JIP) developed to undertake the actions identified in the Contract Query. • Service Development & Improvement Plan (SDIP) developed as part of the contract process. This incorporates the results of the Attain Review. • Development of an Action Plan relating to the 'Emotional Wellbeing & Mental Health Strategy for Children & Young People' for Rotherham in conjunction with RMBC & RDaSH. • RDaSH completed Service Development Plan in July 2014 to address issues identified through various routes including; GP satisfaction survey, Attain Review, Healthwatch and Patient & Family feedback.	Sep-14

Date Added to AF	AF number	Objective	Sub-category	Sub-category	Sub-cat	Principle Risk	Exec Lead	Uncontrolled C	Uncontrolled L	Uncontrolled CxL	Current Risk C	Current Risk L	Current Risk CxL	Key controls	Internal Assurance	External Assurance	Positive Assurances	Gaps in control	Gaps in Assurance	Outcome	Actions	Date Reviewed
31.03.12	AF06	4	4.5	4.2		**Failure to ensure robust systems of risk management and governance are in place, not fulfilling statutory responsibilities**	R Carlisle	4	4	16	4	3	12	• NHS SY&B and local governance structures agreed • Scheme of Delegation • OE, SCE and AQuA • SFOs • NHSR CCG organisational structures agreed • OE/SMT/ Team meetings/ASM •regular liaison with CSU/NHSE/PH regarding future transfers, identified GP and executive lead RR and AF updated every 2 months fully • Additional staff appointed	• AQuA group provides overall assurance • Regular reports to AQuA • Engagement with NHS SY&B governance leads meetings • Internal audit reports on assurance framework/AGS and risk management • External Audit reports reviewed at CCG GB RR and AF reviewed by AQuA at each 2 monthly meeting and twice a year at SCE and CCG GB CCG quarterly checkpoint assurance meetings with NHSE • Enhanced monitoring with senior CHC clinicians by NHSR CCG Lead Officer	• Annual governance letter • External and internal audit reports NHSE quarterly checkpoint assurance meetings, balanced scorecard and CCG action plan and letter from NHSE with outcome of meeting	NHSR CCG high level risks assured as part of discussions on 2013 ACP by SCE and CCG Committee on 9 January 2013 Positive outcome from Q1 and Q2 checkpoint meetings - see website		None	TREAT	Organisational Structures agreed to ensure governance and risk is covered (corporate, financial, clinical aspects). AQuA will continue to oversee sound governance and will receive updates. Governing Body development session on risk in June 2014	Sep-14
31.03.12	AF08	6	6.1			**Failure to ensure effective workforce planning and capability to deliver organisations business, maintain performance and meet statutory requirements with reduced workforce**	C Edwards	4	4	16	4	3	12	• NHSR CCG has comprehensive OD plan • Staff alignment plans • Communication between OE and staff to identify capacity gaps • Staff training • Partnership work with NHSSY&B (CSU)/other CCGs • Counselling and Occupational Health Services supporting staff • Targeted Board & SCE development as part of NHSR CCG authorisation. • Executive weekly meeting. Monthly whole organisation meeting and senior manager meetings • Structure review to take place every 6 months by the Operational Executive	• Regular assessment of workforce alignment against priorities at OE • Staff communication including monthly whole organisation briefings • Performance reports to board on 6 monthly basis	Commitment to investors in excellence standard	Following review in January 2014 added Head of It post and Head of Quality post to NHSR CCG workforce. Next review September 8th at OE	None	None	TREAT	Continue to monitor via comprehensive OD plan, and staff alignments plans. Continued communication with all staff. Further review of workforce on 8th September 2014	Sep-14
03.06.13	AF21	3	3.1			**Failure to meet A&E targets**	S Lever/ B Chadburn	4	4	16	3	4	12	Daily reports from TRFT Establishment of System Resilience Group - with membership from TRFT, RMBC, NHSE, Care UK and YAS If a shortfall on target/performance is identified it is then escalated via email to NHS England Area Team and OE members. Funding investments in System Resilience Group initiatives Action plan incorporating ECIST work. Outcomes to be monitored.	Performance currently in line with standard. Reports to OE & SCE when performance goes off track.	Contract Performance meetings. Contract Quality meetings. ECIST visit and perfect weeks Ongoing visits planned. Perfect weeks and months - September 2014. Some actions (ECIST have already been completed). Ongoing executive level management – priority given to A&E performance quality standard	Strong performance evident as a result of these changes Year to date target has exceeded 95% as at August 2014			TREAT	A&E Recovery Plan to Urgent Care Board on quarterly basis for assurance. Continued monitoring through the System Resilience Group and contract meetings.	Sep-14
15 09 13	AF23	4	4.3			**Financial allocations reduced by Government. Review of Allocations by NHS England**	Keely Firth	4	3	12	4	3	12	A Commissioning Plan predicated on national growth assumptions. Requirement to utilise 2.5% of recurrent allocations non-recurrently is embedded within the recurrent plan.	2.5% Headroom and 0.5% contingency covered recurrently in the financial plan.	• NHSR CCG likely to get minimum growth levels for next 5 years at 1.7% • Growth assumptions and pace of change details issued by NHSE		No clear national consultation process NHSE's decision Allocations published but NHSE advised that they are not guaranteed.		TREAT	KF ~~to~~ attended workshop and briefing session in September. Briefing provided to MPs. Letter setting out concerns sent to NHS England. Embed NHSE planning assumptions in the January 2014 NHSR CCG plan.	Sep-14

Date Added to AF	AF number	Objective	Sub-category	Sub-category	Sub-cat	Principle Risk	Exec Lead	Uncontrolled C	Uncontrolled L	Uncontrolled CxL	Current Risk C	Current Risk L	Current Risk CxL	Key controls	Internal Assurance	External Assurance	Positive Assurances	Gaps in control	Gaps in Assurance	Outcome	Actions	Date Reviewed
29.01.13	AF20	3	3.1			**Impact of NHS 111 on the local health community. Specifically potential for increase in number of patients being referred to A&E / 999**	D Blaydon	4	5	20	3	4	12	Feedback mechanism in place to pick up any spikes in demand at A&E. Care UK call handling service is still in place. Calls routed from GP surgeries will continue to go to the GP OOH Service Recent decision by OE to decommission the call handling service. 111 performing well in South Yorkshire so no longer any need for this contingency. Regional Clinical Governance Group have now been fully tested. CareUK call handling service to be decommissioned on 12th June 2014. NHS111 will take full control of GP OOHs call handling from this date. This will bring Rotherham into line with other CCGs nationally. Level of risk does increase though because it removes back up for GP OO calls.	Regular reports to OE on NHS 111 and risk management. Regular item on the Care UK Performance /Quality Meetings. GP lead, officer lead and NHSR CCG lead nurse all actively participate in the NHS 111 governance structures. Rotherham has a 111 Rapid Response Team in place to pick up local issues Emergency Care Network and the CareUK Performance Group are overseeing local implementation of NHS 111 Clinical Governance & Quality meeting for NHS 111 reports no significant impact on A&E and 999. Service intention is to reduce demand in these areas. This has not happened but conversely we are not experiencing significant increased demand either.	Regional Clinical Governance Board has now been set up. Any issues re: NHS 111 operations dealt with here. Local issues relating to Directory of Services (DOS) or service response are passed to CCGs. The SY Clinical Governance Group is overseeing issues sub regionally on post event messaging.	Regular reports received from YAS on the number of referrals to 999 and A&E. Numbers are high but not out of line with other areas regionally and nationally. Also YAS & TRFT are not reporting any operational difficulties with 999 and A&E respectively as a result of 111.	111 contract is regionally commissioned d this restricts NHSR CCGs ability to respond to systemic pressures. Recent transfer of OOH class from CareUK to 11 has led to an increase in referrals to 999/A&E. Concern that system of triage at 111 is more likely to result in 999 call-out.		TREAT	Monitoring in place to pick up any impact from changes to call handling service. Commissioners liaising with YAS and CareUK to explore full extent of problem. System Resilience Group have agreed Winter Pressure money used to support the YAS path finder.	Sep-14
31.03.12	AF17	5	5.1	5.2	5.4	**Failure to further develop partnerships and relationships (with LA, other key partners, key providers, neighbouring CCGs and NHSE)**	C Edwards	3	3	9	3	3	9	• Work to develop strong relationships with NHSE • Regular 1:1 meetings between CO and CEO at partner organisations • Multi agency governance of QIPP • H&WBB, Adult Board, Community Strategy, LSP. • Regular Board to Board meetings with main providers (TRFT & RDaSH)	• CO to CEO meetings • Provider engagement in multi-agency meetings	• H&WBB Forum for Strategic Partnerships • Chief Executive Officers group in Rotherham	None			TOLERATE		Sep-14
31.08.12	AF01	4	4.3			**Financial Implications of Metal on Metal Hip replacements**	Keely Firth	4	4	16	3	3	9	Public Health consultant and SCE contract lead working to identify number of cases, and level of follow up required and clinical pathway. Going forward contracts will stipulate replacements with long term safety later	Individual cases needing revision will be managed as they are identified.		The NHSR CCG have agreed stricter standards with regard to hip replacements from providers in future			TOLERATE	Plan to review all patients agreed by NHSR CCG and being implemented by TRFT	Sep-14
31.03.12	AF15	1	1.1	3.3		**Failure to effectively manage and engage with providers during transition and following reconfiguration to ensure continuity of commissioned services and contract management**	R Carlisle	3	4	12	3	3	9	• Contract negotiations • Contract monitoring including regular contract monitoring meetings • Quality indicators in contracts • Commissioning intentions set in Commissioning Plan • Effective procurement team	• Integrated Performance Report • Contract and quality monitoring • Reports to Audit and Quality Assurance committee	None	2014/15 plan has clear statements about transforming community services and delivering Better Care Fund outcomes.	None	None	TOLERATE	NHSR CCG ACP and 2013 contract negotiation will explain new relationships and requirements from providers 2014 Commissioning Plan Development and contracting round will test new relationships and see it this risk is now effectively mitigated.	Sep-14
3.6.13	AF22	3	3.3	1.1	4.4	**Impact of Caldicott 2 inhibiting NHSR CCGs efficiency programmes, quality assurance and financial governance**	R Carlisle	4	4	16	4	2	8	NHSR CCG has begun an internal and shared risk assessment with SY CCGs. First draft plan has been reviewed by AQuA. Assurance paper to AQuA 26 March 2014	Reviewed at AQuA on 26 March 2014	Aspects of this will be picked up in 2013/14 IG Toolkit. NHSR CCG provisionally accepted as an accredited safe haven in November 2013. IG toolkit submitted March 2014			Awaiting accredited safe haven status from HSCIC	TOLERATE		Sep-14

Date Added to AF	AF number	Objective	Sub-category	Sub-category	Sub-cat	Principle Risk	Exec Lead	Uncontrolled			Current Risk			Key controls	Internal Assurance	External Assurance	Positive Assurances	Gaps in control	Gaps in Assurance	Outcome	Actions	Date Reviewed
								C	L	CxL	C	L	CxL									
31.03.12	AF04	3	3.1	6.2		**Failure to deliver improving outcomes and key performance targets, leading to poor patient experience, impact on reputation and poor external assessment results**	R Carlisle	4	4	16	4	2	8	• System of monitoring a wide range of outcome measures with approved escalation policy • Use all available data to commission effectively - JSNA, public health data, health needs assessments etc. • GPSCE membership on H&WBB.	• Monthly Performance Reports • Regular monitoring by performance team with escalation as necessary • Internal Audit Report on performance processes • Monitor national outcomes framework and take necessary action to address any issues • Monthly contracting Meetings with all main providers	Quarterly assurance meetings with NHSE	NHSR CCG 2014/15 plan received positive feedback at meeting with NHSE in February 2014	• Lack of clarity from external regulators on key assessment measures		TOLERATE		Sep-14
31.03.12	AF07	4	4.2	1.3		**Failure to ensure that vulnerable children and adults have effective safeguarding processes**	S Cassin	4	5	20	4	2	8	• Safeguarding policies and procedures • Representation on Local Adult and Children safeguarding Boards • Mandatory training requirement for clinical and non clinical staff in place • Monitoring of provider safeguarding via monthly quality meetings • NHSR CCG Head of Safeguarding in place • Safeguarding standards incorporated in all main provider contracts • NHSR CCG Commissioning Safeguarding Vulnerable Clients Policy in place • GP/SCE recruitment and training process in place	• Assurance via AQuA committee • Clear lines of accountability were maintained during transition • Safeguarding leads attendance at Safeguarding Boards • Provision of training • Commissioning Safeguarding Vulnerable Clients Policy in place Head of Safeguarding covers Adults and Children reporting to Chief Nurse and supported by the Adult Safeguarding and Quality Lead and the Safeguarding and Quality Assurance Officer Children Working Together 2013 implements findings from the Munro review in relation to SCRs. This includes the establishment of a national SCR panel. More flexibility in the approach that LSCBs can take when conducting SCRs. Lead professionals identified in all health providers and NHSR CCG •SCE review of individual responsibilities	• Reports to Safeguarding Adults Board • Reports to Safeguarding children Board • Ofsted and CQC inspections • Serious case reviews and SI/IMRs • Homicide reviews undertaken • Improvement Panel in place. • NHS England Area team reports and assurances • RLSCB • RSAB • Two yearly Section 11 Challenge meeting on 25/04/2013 LSCB to NHSR CCG. NB - TRFT and RDaSH are also being challenged. Designated Nurse to attend • CQC Framework for Safeguarding & LAC in place until March 2015 External company Tri-x Safeguarding South Yorkshire procedures is reviewing policies across South Yorkshire. • Membership of child sexual exploitation (CSE) Gold and Silver groups •Multi- agency strategy meetings regarding Child Sexual Exploitation and action plan in place. • GP lead attendance at Rotherham LSCB & Rotherham SAB and other relevant meetings	• Child death overview panels • Safeguarding rated green by NHSR CCG authorisation panel Main provider Annual Safeguarding Children's reports published internally and externally. Annual Adults Safeguarding report published November 2013 Domestic Homicide review process re-aligned to new health economy. In 2013/14 NHSR CCG have provided financial support to the Domestic Homicide review process. •Regular review of GP Lead responsibility	There are no national IT systems in place. Prevent NHSR CCG Lead identified and training plan being developed Children at risk or known to be Sexually Exploited who subsequently go missing from home and services.	Training Data not electronically available due to a discrepancy in the IT system. Gap is in a robust process for alerting agencies' at the earliest opportunity when young people go missing. Commissioning with Continuing Healthcare and Quality Assurance. • Regarding patient placement and having a robust process. • Continued support of patient's needs whilst in placement. Both the above are currently in development with the CSU Safeguarding Children is a crucial role for CCGs following the reforms 01/04/2013 to the health service. Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework document see page 17 section 3.2.2 External assurance - NHSR CCG needs to assure NHSE & RLSCB and RASB that this risk has been identified and actions are being taken to rectify the gap in assurance.	TOLERATE	Continue to monitor through robust internal mechanisms and partnership structure for safeguarding. Continue to report, via Operational Risk, Governance and Quality meeting and Audit and Quality Assurance Group. Action re training - CSU looking into another mechanism and track results •Procurement has taken place and training dates to be arranged by RMBC. A recent Child Sexual Exploitation case and missing individual is due to change processes nationally. • SCE have reviewed member roles and responsibilities to ensure all areas covered and GP Leads aware of responsibilities • Interim arrangements to provide GP Lead role to safeguarding • Development programme needed to ensure future long-term cover arrangements.	Sep-14

Date Added to AF	AF number	Objective	Sub-category	Sub-category	Sub-cat	Principle Risk	Exec Lead	Uncontrolled			Current Risk			Key controls	Internal Assurance	External Assurance	Positive Assurances	Gaps in control	Gaps in Assurance	Outcome	Actions	Date Reviewed
								C	L	CxL	C	L	CxL									
31.03.12	AF10	2	2.2			**Failure to engage effectively with patients, the public and seldom heard groups in line with the NHS Constitution resulting in potential disengagement, discrimination and health inequalities**	S Whittle/ S Cassin	3	3	9	3	2	6	• Patient engagement plans in place Annual stakeholder events around Commissioning Plan • Patient & Public Engagement strategy, signed off by NHSR CCG Governing Body on 01/05/2013 and implementation plan in place and on track. • Use of 'Patient Opinion' • Equality & Diversity Strategy • Equality Delivery System • Continued support to building a network of patient participation groups; this currently is meeting quarterly • E&D Policy developed to be presented at OE on 05/08/2013 and AQuA 25/09/2013 and NHSR CCG Governing Body 06/11/2013 • NHSR CCG are Adopting EDS2 - information shared with all CCG Staff at the all staff meeting on 24/09/2013 NHSR CCG Head of Communications in post - information shared with all NHSR CCG Staff at the all staff meeting NHSR CCG communications plan in place for 2014/15 - information shared with all NHSR CCG Staff at the all staff meeting Stakeholder management tool in place September 2014.	• NHSR CCG PPE Plan and structure • Systematic PPE activities and feedback into commissioning cycle and benchmarked against 5 CCGs • Integrated Patient Safety & Quality Reports to AQuA & NHSR CCG Governing Body • Patient & Public Engagement and Experience report monthly to NHSR CCG Governing Body from November 2013 • Links with scrutiny and Healthwatch • Patient & Public Engagement strategy approved at NHSR CCG Governing Body on 01/05/2013. Strategy links activity to Engagement cycle. An implementation plan is in place and actions are on target. • Lay member role in place and being developed. New lay member took up post in December 2013. • Work streams and priorities from the Commissioning Plan mapped for all types of engagement activity to systematically identify gaps, priorities and offer internal and external assurance. •Commissioning Plan for 2014/15 discussed at PPG network 29/10/2013 • use of a variety of techniques and mechanisms identified in PPE strategy • EDS assessment completed • Equality & Diversity Steering Group Annual PPE report Communication report to NHSR CCG Governing Body included in Chief Officers report.	• H&WBB • Work streams and priorities from the ACP 2013/14 mapped for all types of engagement activity to systematically identify gaps, priorities and offer internal and external assurance. A variety of mechanisms in place to hear patient voice:- • Patient Opinion • Links to community networks • TRFT Friends & Family Test • Information sharing with Healthwatch • Internal audit report • Membership of SY&B Surveillance Group together with other commissioners, regulators and stakeholders. Friends & Family test becoming available for Mental Health, Community Services and Primary Care in December 2014 Commissioning Plan 2014/15 Communications plan on a page is included in the 5 year commissioning plan 2014/15 Readers panel in place to review key publications.	• Above average performance on Rotherham patient surveys • EDS benchmarking outcome • Equality & Diversity Strategy • E&D Policy • New website for NHSR CCG NHSR CCG new staff intranet site is now live.	None	None	TOLERATE		Sep-14

NHS England Core Standards for Emergency preparedness, resilience and response
v2.0

The attached EPRR Core Standards spreadsheet has 3 tabs:

EPRR Core Standards tab - with core standards nos 1 - 37.

HAZMAT/ CBRN core standards tab: with core standards 38- 51. Please note this is designed as a stand alone tab.

HAZMAT/ CBRN equipment checklist: designed to support acute and ambulance service providers in core standard 43.

Amended on behalf of NHS England North Region by the West Yorkshire EPRR team by comparing the 2014/15(v2.0) core standards with the 2013-/14core standards. The results of this comparison are shown in the extra column (Column P on the main tab, J on the CBRN core standards tab).

Please note the following:
NHS Commissioning organisations need to complete only the main 'EPRR Core Standards' tab. NHS Trusts should complete both the EPRR Core Standards tab and the HAZMAT CBRN core standards tab.

NHS England South Yorkshire & Bassertlaw Area Team and all Foundations Trusts should self-assess against only the core standards on a white (not grey) background that include a 'Y' in the column for their organisation type. CCGs should self assess against all the Core Standards onthe EPRR Core Standards tab that that includes a 'y' in the column for CCGs.

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Area teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.
Governance															
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Y	Y	Y	Y	Y	Y	Y			Y	An Accountable Emergency Officer is in place for each of the South Yorkshire & Bassetlaw CCGs: - Barnsley: Vicki Peverelle, Chief of Corporate Governance - Bassetlaw: Phil Mettam, Chief Officer - Doncaster: Chris Stainforth, Chief Officer, with operational delegation to Sarah Atkins Whatley, Chief of Corporate Services - Rotherham: Chris Edwards, Chief Officer, with operational delegation to Sarah Whittle, Assistant Chief Officer - Sheffield: Tim Furness, Director of Business Planning and Partnerships The South Yorkshire & Bassetlaw CCGs' annual EPRR work programmes respond to the hazard analysis and risk assessment undertaken by the Local Health Resilience Partnership (LHRP). Like anywhere in the UK, South Yorkshire and Bassetlaw has a number of natural and manmade hazards. To ensure we are prepared for these hazards the South Yorkshire Local Resilience Forum (LRF) has created a Community Risk Register which identifies the wide range of risks and emergencies we could potentially face. A number of specific risks that the CCGs may potentially have are listed in our EPRR policies (developed jointly across the South Yorkshire & Bassetlaw CCGs) alongside the planned response. Assurance is obtained through the contracting route with commissioned services by the Head of Contracting or equivalent, and also via local partnership emergency planning fora within our local geographic areas. The South Yorkshire & Bassetlaw CCGs' Emergency Preparedness Resilience & Response (EPRR) Policies confirm the processes following an EPRR incident in order to ensure that lessons are learned. We take responsibility for debriefing and providing support to staff where required following an emergency via individual line managers coordinated by the Emergency Accountable Officer. De-briefing may also be on a multi-agency footprint. Any lessons learned from the incident will be fed back to staff and actioned appropriately. The South Yorkshire & Bassetlaw CCGs' Emergency Preparedness Resilience & Response Policies cover all the core standards required of CCGs and are published on our websites. The Policies: • Have a change control process via the Corporate Governance Teams which includes version control (see coversheet and following page). • Take account of changing business objectives and processes via annual review by the Accountable Emergency Officer and refresh if needed (delegated on coversheet). • Take into account any changes in our functions and/or organisational structural and staff changes by listing job titles rather than individuals (action cards). • Make clear our contracting responsibilties (section 3.2 of procedure). • Take account of any updates to risk assessment(s) by the LHRP or LRF (sections 3.4, 3.5 & 3.6 of procedure). • Have a maximum 3-year review schedule (section 5.3.2 of the policy). • Use consistent EPRR terminology throughout. • Make clear the policy dissemination and review arrangements (section 5 of the policy). • Are published on our websites. • Include the requirement to review following an incident and learn lessons (section 6 of the procedure). • Include references to other sources of information and supporting documentation (section 2 of the policy). Corporate Governance/Assurance Reports received by the South Yorkshire & Bassetlaw CCGs' Governing Bodies capture EPRR assurance, including any response to incidents (no incidents to date). Operational managers within the South Yorkshire & Bassetlaw CCGs support both the EPRR and Business Continuity agendas. The Communications Leads are part of the resilience arrangements. The corporate communications budgets and the CCG 0.5% contingency reserves cover any unforseen EPRR costs.	**GREEN**
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y	Y	Y	Y	Y	Y	Y	Y			Y		**GREEN**
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y	Y	Y	Y	Y	Y	Y	Y			Y		**GREEN**
4	The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y	Y	Y	Y	Y	Y	Y	Y			Y		**GREEN**
Duty to assess risk															
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc. Other relevant parties could include COMAH site partners, PHE etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The South Yorkshire & Bassetlaw CCGs' EPRR risk assessments take account of the community risk register including: • Fuel shortage • Flooding • Evacuation & Shelter • Pandemic • Heatwave • Severe winter weather	**GREEN**
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The South Yorkshire & Bassetlaw CCGs' organisational Business Continuity Contingency Plans include plans and mitigation for the short term (under 72 hours) and the longer term for: • Fire • Flood • Terrorist or criminal attack • Significant chemical contamination • IT failure / loss of data • Loss of power • Loss of water • Loss of telephone (landline) • Simultaneous resignation of a number of key staff • Staff illness / epidemic • Commissioning Support Unit (CSU) unable to deliver • Travel disruption • Widespread industrial actions • Theft or damage to assets (will include fraud)	**GREEN**
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The South Yorkshire & Bassetlaw CCGs' processes to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency are via the Assurance Framework and Risk Register. There are mutual aid arrangements in place with local CCGs to mitigate loss of premises. We have shared our Policies with the LHRP for peer review and comment, and through the Director of Public Health representative we have also shared policies with our local Category 1 Responders - the Local Authorities.	**GREEN**
Duty to maintain plans – emergency plans and business continuity plans															
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	The South Yorkshire & Bassetlaw CCGs' Business Continuity Contingency Plans include plans and mitigation for the short term (under 72 hours) and the longer term for: • Fire • Flood • Terrorist or criminal attack • Significant chemical contamination • IT failure / loss of data • Loss of power • Loss of water • Loss of telephone (landline) • Simultaneous resignation of a number of key staff • Staff illness / epidemic • Commissioning Support Unit (CSU) unable to deliver • Travel disruption • Widespread industrial actions • Theft or damage to assets (will include fraud) The South Yorkshire & Bassetlaw CCGs' Systems Resilience Groups (previously Unplanned Care Groups) ensure system alignment during seasonal and other pressures and are chaired by CCG Leads. The Unplanned Care commissioning leads have responsibility for effectively managing Surge and Escalation within the area (section 4 of EPRR policy). The System Resilience Groups and associated leads manage any required situation reports.	**GREEN**
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**GREEN**
		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y	Y	Y					Y			**N/A**
		Severe Weather (heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**GREEN**
		Pandemic Influenza	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**GREEN**
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y	Y		Y	Y				Y		**N/A**
		Mass Casualties	Y	Y	Y	Y		Y	Y				Y		**N/A**
		Fuel Disruption	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**GREEN**
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		**GREEN**

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Area teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.
		Infectious Disease Outbreak	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Section 4.6 of the South Yorkshire & Bassetlaw CCGs' EPRR procedures note that the Civil Contingencies Act 2004 places the duty upon Category 1 and 2 Responders to have regard for the needs of vulnerable people. It is not easy to define in advance who are the vulnerable people to whom special considerations should be given in emergency plans. Those who are vulnerable will vary depending on the nature of the emergency. For planning purposes our policies confirm that there are broadly three categories that should be considered: • Those who for whatever reason have mobility difficulties, including people with physical disabilities or a medical condition and pregnant women; • Those with mental health conditions or learning difficulties; • Others who are dependent, such as children or very elderly. The policies note that the CCGs need to ensure that in an incident people in the vulnerable people categories can be identified via contact with other healthcare services such as GPs and Social Services.	**GREEN**
		Evacuation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**GREEN**
		Lockdown	Y	Y	Y	Y	Y	Y	Y			Y	Y		**N/A**
		Utilities, IT and Telecommunications Failure	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**GREEN**
		Excess Deaths/ Mass Fatalities	Y	Y	Y			Y	Y				Y		**N/A**
		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme)			Y										**N/A**
		firearms incidents in line with National Joint Operating Procedures;			Y										**N/A**
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The South Yorkshire & Bassetlaw CCGs' EPRR Policies and Business Continuity Plans are refreshed upon changing circumstances or changing national guidance and are based on NHS England guidance. • The South Yorkshire & Bassetlaw CCGs' EPRR Policies have been shared with the LHRP for peer review and comment, and through the representative Director of Public Health with our local Category 1 Responders - the Local Authorities. • The South Yorkshire & Bassetlaw CCGs' EPRR Policies have been prepared to encompass our commissioning role and our role as statutory NHS Bodies. Policies include an activation flowchart (Action Card 2), and action cards for key roles and actions of incident response team and support staff including Communications and Loggists (action card 1) . • The location of incident co-ordination centres (ICCs) are noted in policies from which emergency or business continuity incidents will be managed. If the building is compromised, mutual aid via partner CCGs has been agreed. • Generic roles of all parts of the organisations in relation to responding to emergencies or business continuity incidents are captured in our business continuity plan. • Stand-down procedures, including debriefing and the process of recovery and returning to normal processes are captured in both EPRR and Business Continuity policies. • Contact details of key personnel and relevant partner agencies are held separately in "pick-up packs". The South Yorkshire & Bassetlaw CCGs' EPRR Policies are approved by Governing Bodies. Approval of the Business Continuity Policy & Plan is may be delegated through organisational structures.	**GREEN**
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The South Yorkshire & Bassetlaw CCGs have activation action cards and incident manager action cards in place in the event of incidents.	**GREEN**
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The South Yorkshire & Bassetlaw CCGs' critical activities are captured in our Business Continuity Plans. Teams have clear plans in place for how these are managed.	**GREEN**
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y	Y	Y	Y	Y								**N/A**
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The South Yorkshire & Bassetlaw CCGs' EPRR Policies were developed as a framework across the South Yorkshire & Bassetlaw CCGs to support mutual aid arrangements and consistency in the local patch. The template was peer-reviewed by the LHRP. Once localised, Polices were consulted on and approved by our Governing Bodies. The South Yorkshire & Bassetlaw CCGs' Business Continuity Policies and Plans were developed by our staff teams supported by the Corporate Governance Leads and approved within our governance structures.	**GREEN**
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Section 6 of the South Yorkshire & Bassetlaw CCGs' EPRR procedures capture de-brief arrangements.	**GREEN**
Command and Control (C2)															
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Y	Y	Y	Y	Y	Y	Y			Y	Incidents within Providers are noted through the South Yorkshire & Bassetlaw CCGs' normal switchboard number in-hours. The South Yorkshire & Bassetlaw CCGs have empowered our Providers through clear policies (e.g. Divert Policy) to take whatever action is necessary to manage an incident if they cannot contact the named CCG Leads, and then advise the CCG when practicable after the event. Incidents which occur out of hours should therefore not require CCG intervention. If they do require CCG intervention, a Memorandum of Understanding (MOU) is in place between the South Yorkshire & Bassetlaw CCGs and the Area Team as agreed by Mr Phil Storr from NHS England. The MOU confirms how the South Yorkshire & Bassetlaw CCGs would act in the event of an emergency. Key contacts from the South Yorkshire & Bassetlaw CCG have been provided to NHS England as part of this Memorandum of Understanding, with further enhanced on-call arrangements for specific local events such as the Tour de France and EDL marches. The South Yorkshire & Bassetlaw CCGs have generic EPRR email addresses used routinely for EPRR communications and these acocunts are checked daily. We have access to the Resilience Direct service.	**GREEN**
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Y	Y	Y	Y	Y	Y	Y			Y	As Category 2 organisations, the South Yorkshire & Bassetlaw CCGs have evaluated that further training beyond that already accessible through peer support within local areas and through the LHRP is not necessary. All those key contacts for the South Yorkshire & Bassetlaw CCGs whose contact details are logged with the Area Team have significant experience at Executive Level.	**GREEN**
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The South Yorkshire & Bassetlaw CCGs' Incident Control Centres are supplied with hard copies of all relevant EPRR / Business Continuity documents and activation / action cards alongside useful contact lists. Remote IT working has been enabled. IT Providers have continuity systems in place which are assessed and reported through the Information Governance Toolkit. Mutual aid arrangements with partner CCGs provide for additional or replacement Incident Control Centres if required.	**GREEN**
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	An action card is included in the South Yorkshire & Bassetlaw CCGs' EPRR procedures for a Loggist. Loggists will participate in local training e.g. Exercise Cygnus in October 2014.	**GREEN**
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Situation report arrangements for the South Yorkshire & Bassetlaw CCGs are determined by the Incident Lead Executive in line with the escalation action card and the Incident Lead Executive action card.	**GREEN**
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		Y										**N/A**

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Area teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		Y										N/A
Duty to communicate with the public															
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	An Action Card for the Communications Lead is included in the South Yorkshire & Bassetlaw CCGs' EPRR Procedures. The majority of communications will be via Providers or via Category 1 Responders, who the CCGs shall support as required. In respect of EPRR for incidents/risks that affect all multi-agency partners, the South Yorkshire & Bassetlaw Area Team provides strategic co-ordination of the local health economy and represents the NHS at the South Yorkshire Local Resilience Forum (LRF). The initial communication of an incident alert is to the first on-call officer of the South Yorkshire & Bassetlaw Area Team. The Loggist action card and recording proforma ensures a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. These arrangements are complemented by the South Yorkshire & Bassetlaw CCGs' "business as normal" communications channels.	GREEN
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The South Yorkshire & Bassetlaw CCGs' IT providers have resilience arrangements in place. Back-ups via mobile phones are available.	GREEN
Information Sharing – mandatory requirements															
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	As Category 2 Responders, the South Yorkshire & Bassetlaw CCGs have a duty to share information and cooperate. In the event of an incident, we will use our generic email addresses used for EPRR as the main route of communication and the Incident Control Centre number as the main telephone number. The Communications Leads will coordinate communications. We share information via the Local Health Resilience Partnership and via local Emergency Planning Meetings. We have local Information Sharing Agreements (ISA) / Policies for "business as normal" across our local strategic partnerships which also support EPRR. We also have social media accounts which are useful for rapid dissemination of information. We have a mutual aid agreement for premises with our partner CCGs.	GREEN
Co-operation															
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	The South Yorkshire & Bassetlaw CCGs have active engagement with partners through: • Attendance at local area-specific Emergency Planning Meetings. • The Chief Officer of NHS Rotherham CCG attends the LHRP as the representative of all South Yorkshire & Bassetlaw CCGs. •Taking lessons learned from all resilience activities and partner exercises. •Having a list of contacts among both Category 1 and Category 2 responders within South Yorkshire. • Strategic contracting meetings with those we commission where emergency planning issues can be raised. • Regular assurance meetings with the Area Team and inclusion of NHS England within our escalation flowchart. • A Memorandum of Understanding for out of hours contact with the local NHS England Area Team.	GREEN
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		GREEN
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		GREEN
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				Y			Y	Y				Y		N/A
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y				Y				Y		N/A
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y	Y	Y	Y	Y			Y		Y			GREEN
31	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared								Y						N/A
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months							Y	Y						N/A
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y	Y	Y	Y	Y	Y		Y		Y	Y		GREEN
Training And Exercising															
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate •Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective •Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The South Yorkshire & Bassetlaw CCGs' EPRR Policies (section 5.2) note that all staff will be offered relevant training commensurate with their duties and responsibilities. Staff requiring support are asked to speak to their line manager in the first instance. Support may also be obtained through their HR Department. Training can be accessed via the Local Resilience Forum (LRF). As statutory organisations the South Yorkshire & Bassetlaw CCGs learn lessons from all resilience activities and use the Local Resilience Forum and the Local Health Resilience Partnership and network meetings to share good practice.	GREEN
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. •Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. •If possible, these exercises should involve relevant interested parties. •Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Those individuals nominated within the South Yorkshire & Bassetlaw CCGs' policies have been briefed on their roles and offered training via the LRF if desired. Most of the individuals have undertaken a similar role in the past and have not needed further training. All those who may receive action cards in the event of an incident have received a pack with information. We have access to the NHS England guidance on roles and responsibilities to support team members. All training needs and training accessed are recorded in annual Personal Development Reviews. The South Yorkshire & Bassetlaw CCGs are invited by our local Category 1 organisiations to particpate in exercises and are taking part in Cygnus in October 2014.	GREEN
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y	Y	Y	Y	Y	Y	Y	Y			Y	The South Yorkshire & Bassetlaw CCGs run local exercises where a "real" event has not already tested our resilience e.g. loss of power. Our communications routes are tested by our Communications Leads.	GREEN
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y	Y	Y	Y	Y	Y	Y	Y			Y		GREEN

8D

South Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2014-15

STATEMENT OF COMPLIANCE

NHS Rotherham CCG has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR 2014-2015 (v2.0).

Following assessment, the organisation has been self-assessed as demonstrating the Full (from the four options in the table below) compliance level against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard themes, resulting in the organisation being exposed to unnecessary risk.
Partial	The plans and work programme in place do not adequately address multiple core standard themes; resulting in the organisational exposure to a high level of risk.
Non-compliant	The plans and work programme in place do not appropriately address several core standard themes leaving the organisation open to significant error in response and /or an unacceptably high level of risk.

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the Organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the core standards has been confirmed to the organisation's board/governing body (or delegated group).

Signed _____ Date Signed _____

Accountable Emergency Officer

_____

Date of Board/governing body/(or delegated group) meeting

NHS Rotherham CCG Equality Implementation Plan 2014/16

The Equality Objectives have been developed and supported by underpinning actions and linked to the four EDS 2 goals. The identified actions have been prioritised by the Equality Steering group and agreed by NHS Rotherham CCG.

Equality Objectives	Actions	Leads	Update October 14	Update March15
Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within Provider contracts.	Ensure that we share statutory returns re access data by protected characteristics and challenge any gaps in service provision.	Head of Contracts/ CSU Equality & Diversity Manager		
	Utilised any equality data as it becomes available to update the JSNA, generating accurate assessment of the prevalence of health conditions and the needs of the changing population.	Head of Contracts/ CSU Equality & Diversity Manager/ Public Health Colleague		
	Review providers reporting on equality KPI through the contract monitoring process. Practical focus on A&E attendance, DNA, Patient Experience and Complaint.	Head of Contracts/ CSU Equality & Diversity Manager		
	Work with Public health colleagues to analyse data received.	Public Health Colleague		
Ensure appropriate and accessible targeted communication and engagement with local communities to ensure commissioners are aware of issues/ barriers that influence commissioning decisions.	Population changes included in the commissioning cycle in order to use equality data to more effectively to drive commissioning priorities by linking to the Annual Commissioning Plan.	Head of Contracts/ CSU E&D Manager / Public Health Colleague		
	Through all stages of the commissioning cycles, there will be outreach to targeted communities experiencing barriers to access and engagement as a PPI	Head of Contracts/ PPE Manager/ CSU E&D Manager		
	Develop an accessible communication plan with a targeted communication programme to meet the needs of specific groups such as disability.	PPE Manager		

Equality Objectives	Actions	Leads	Update October 14	Update March15
	Participate in multi-agency engagement and access projects, listening and acting on feedback received and using information to inform commissioning.	PPE Manager/ CSU E&D		
Develop consistency of Equality approaches across the CCG in respect of leadership, staff empowerment and access to development opportunities	Ensure equality competency is built into all job descriptions	CSU HR Manager		
	Basic Equality and Diversity e learning module (General Awareness) mandatory, ensure update by all CCG staff	CSU Learning and development CSU E&D Manager		
	Continue to revise HR policies with robust Equality impact Assessment	CSU HR Manager		
	Use NHS staff survey results to develop actions to improve key areas.	CSU HR Manager		
	Develop and implement a new Trans policy for staff.	HR Manager/ CSU E&D Manager		
	Continue to raise awareness of Equality and Diversity issues and supporting staff completing Equality Impact Assessment across service areas.	CSU E&D Manager		
Demonstrate leadership in advancing the equality agenda internally and with partners and providers to ensure inequalities are addressed within a partnership approach to ensure equity of access experience and outcomes for patients.	Ensure that Governing Board members are kept up to date with Equality and Diversity issues.	Assistant Chief Officer and CSU E&D Manager		
	Ensure that Equality and Diversity is embedded across CCG and in partnership with RMBC.	Assistant Chief Officer		
	Ensure that Equality and diversity is linked to the CCG's "Investors in Excellence"	Planning and Risk Manager		

Chief Officer
C Edwards

- Head of Co-commissioning (Spec & P Care) B8c
  Vacancy
- Assistant Chief Officer
  S Whittle
  - Children's & Maternity Commissioning Mgr
    E Royle
  - Governance & Complaints Officer – S Hart
    FOI Officer – D Taylor
  - Planning & Assurance Manager
    L George
    - Project Officers – J Abbots, J Wisken, A Taft, A Robinson
      Project Support Officer – J Murphy
    - Project Manager B6
      Vacancy
- Chief Financial Officer VSM
  K Firth
  - Deputy Chief Finance Officer B8c
    Vacancy
    - Head of Financial Services
      S Wood
      - Senior Finance Manager
        L Jones
      - Finance Officer
        R Roberts
      - Finance Assistant B4
        Vacancy
    - Head of Finance – Contracting
      J Sarsby
      - Finance Manager
        A Hall
      - Finance Manager
        P Unsworth
  - Head of LTC/Urgent Care
    D Blaydon
    - Contract Manager
      J Massey
  - Head of Contracts & SI (Acute & Comm)
    S Lever
    - Emergency Care Project Manager
      J Martin
    - Senior Contracts & SI Manager
      R Chadburn
      - Contracts & SI Manager (Acute)
        W Cutts
- Deputy Chief Officer VSM
  R Carlisle
  - Head of IT (Roth & Donc)
    A Clayton
  - Head of Contracts & SI – MH, LD & EoLC
    K Tufnell
    - Snr Contracts & SI Manager (MH, LD & EoLC)
      N Parkes
    - Clinical Case Manager (MH & LD)
      D Waldie
  - Head of Medicines Management
    S Lakin
    - Prescribing Advisors
      G Bhogal, R Saleem, L Murray, J Punyer,
      E Summerfield, J Wilde
    - Senior Prescribing Technicians
      K Roberts, S Webster, P Whitehurst
  - Senior Care Pathway Manager
    J Sinclair Pinder
- Chief Nurse
  S Cassin
  - Head of Clinical Quality
    A Windle
  - Head of Safeguarding
    C Hall
    - Safeguarding Adults & Quality Lead
      K Leahy
    - Safeguarding & Quality Assurance Officer
      A Brunt
  - Head of Primary Care Quality
    D Anderson
  - Senior Manager – PPE
    H Wyatt
  - Quality Assurance & Primary Care Contracting Manager
    R Garrison
    - Quality Assurance Officer – I Baker
      Primary Care Contracts Officer B5 - Vacancy
      Quality Assurance Support Officers – E Charnock, L McNeill
- Head of Communications
  G Laidlaw
- PA to CO & CCG Chair - W Commons
  Governance & Resource Support Officer/PA – L Gash
- Office Manager/PA
  C Rollinson
  - Admin Officers
    K Gleeson, S Howard, N Jarrett, Y Nettleton, B Stevens

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West and South Yorkshire and Bassetlaw
Commissioning Support Unit

Rotherham CCG

Individual Funding Requests

April 2013 - March 2014

Allison Ball
Head of IFR

Individual Funding Requests – Rotherham Clinical Commissioning Group (CCG)

CCGs in West and South Yorkshire make decisions about the funding of medicines and other interventions on a population basis for the majority of interventions. Contracts for these routinely commissioned interventions are then put in place. Where a clinical need is identified for interventions that sit outside routine commissioning, these requests are subject to a process called Individual Funding Requests (IFRs).

Individual Funding Requests (IFRs) are some of the most time intensive and difficult decisions a Clinical Commissioning Group (CCG) will be asked to make. Providing services that meet the needs of the majority, while accommodating the exceptional requirements of individual patients is a difficult balance to achieve.

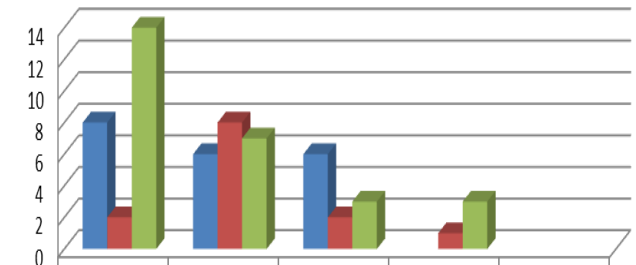
The West and South Yorkshire and Bassetlaw Commissioning Support Unit manage the IFR referrals on behalf of Rotherham CCG and make recommendations on the decision whether to agree to fund an IFR or not on behalf of the CCG.

We have recently commissioned an advanced technical solution called Blueteq to manage our IFR referrals. The Blueteq IFR system provides complete patient history storage and displays all information and documentation in one place, including notes of any conversations with clinicians or patients, in a paperless environment. No filing is required and all vital data is immediately to hand. The Blueteq IFR system means that we have complete visibility of all requests, their current status and value.

The following report gives information about the IFRs received by the CSU in quarter 1 of 2014/15 for patients registered with GPs in the Rotherham CCG area.

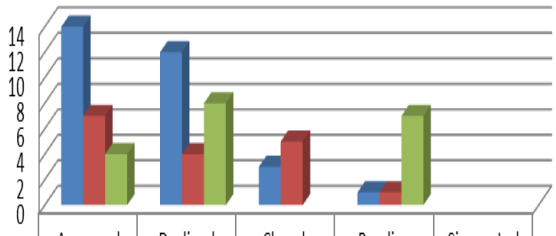
Individual Funding Requests for Rotherham CCG

Quarter 1



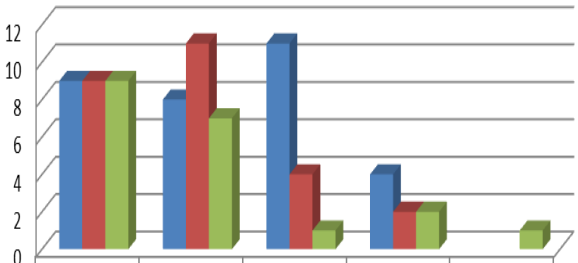
	Approved	Declined	Closed	Pending	Signposted
April	8	6	6		
May	2	8	2	1	
June	14	7	3	3	

Quarter 2



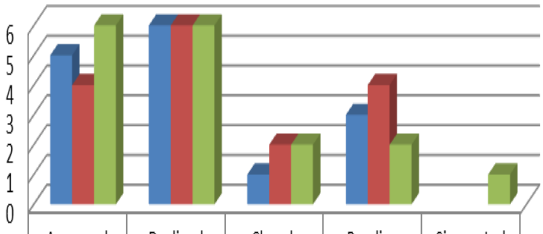
	Approved	Declined	Closed	Pending	Signposted
July	14	12	3	1	
August	7	4	5	1	
September	4	8		7	

Quarter 3



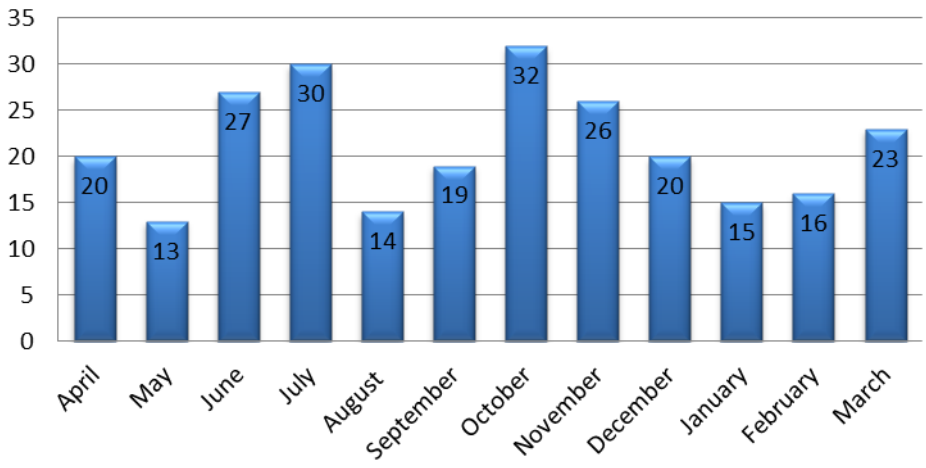
	Approved	Declined	Closed	Pending	Signposted
October	9	8	11	4	
November	9	11	4	2	
December	9	7	1	2	1

Quarter 4

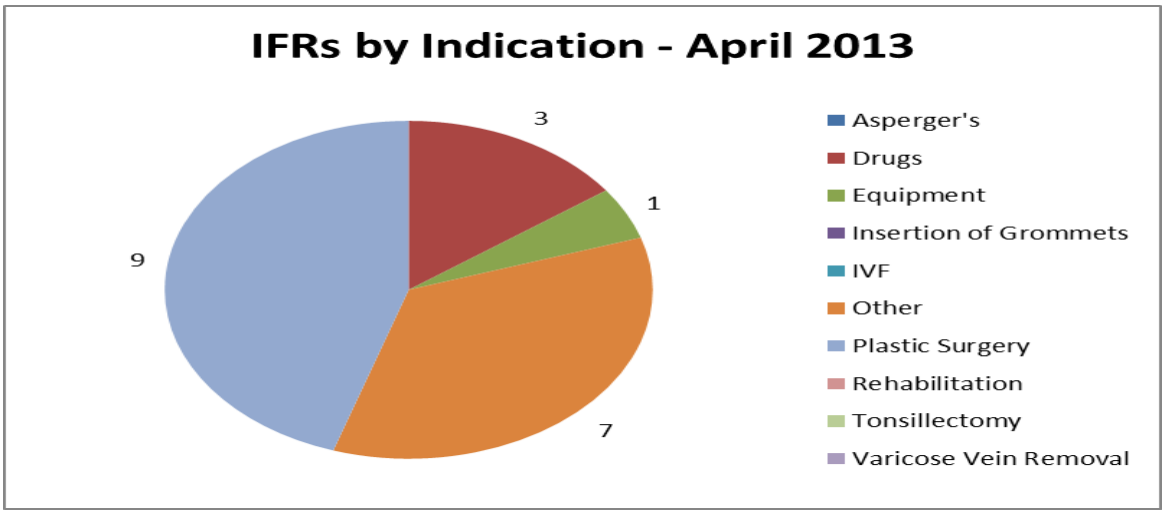


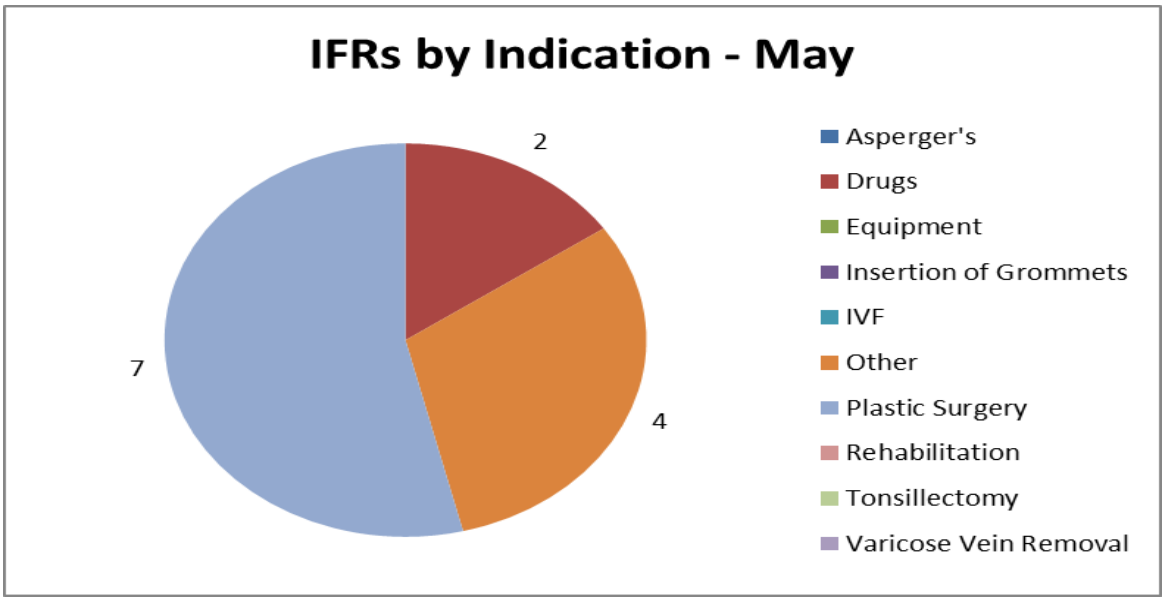
	Approved	Declined	Closed	Pending	Signposted
January	5	6	1	3	
February	4	6	2	4	
March	6	6	2	2	1

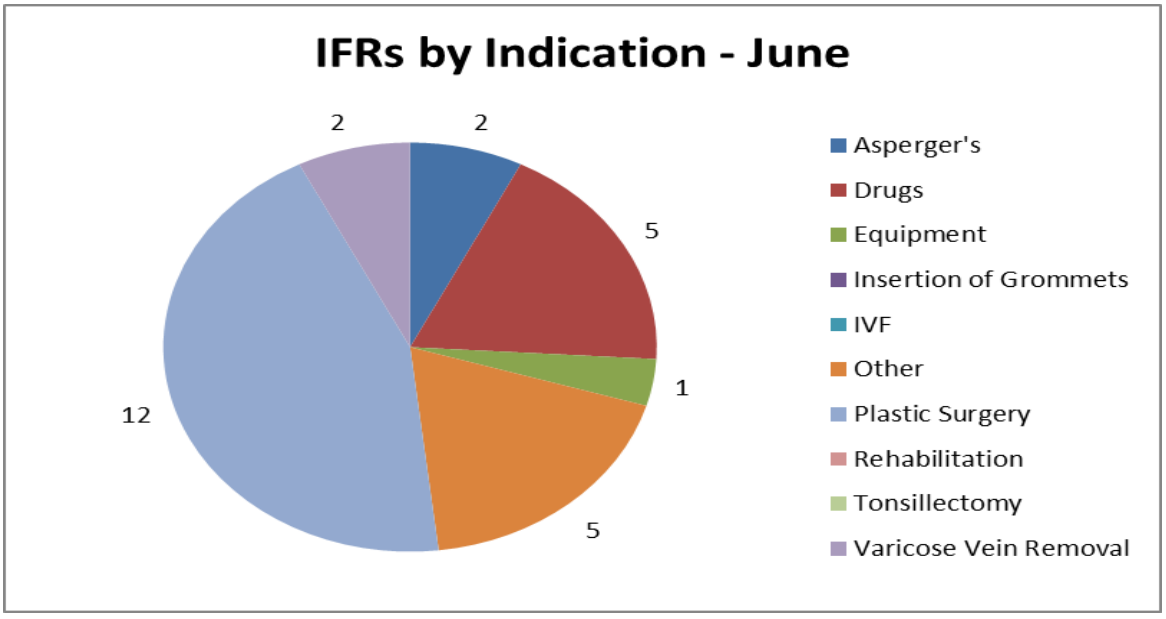
Total IFRs

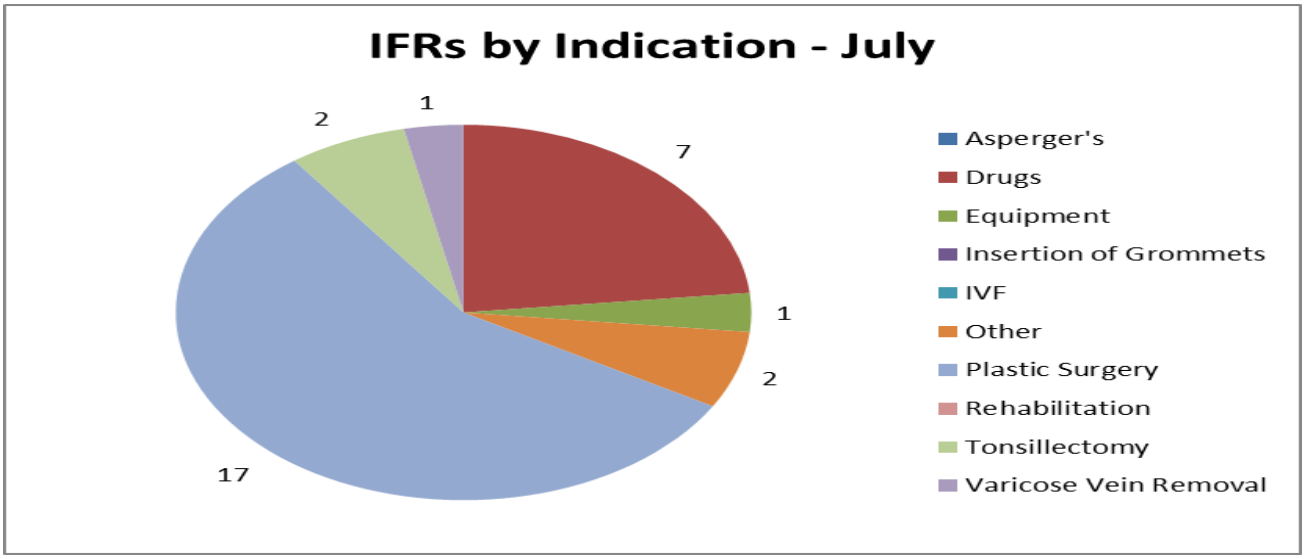


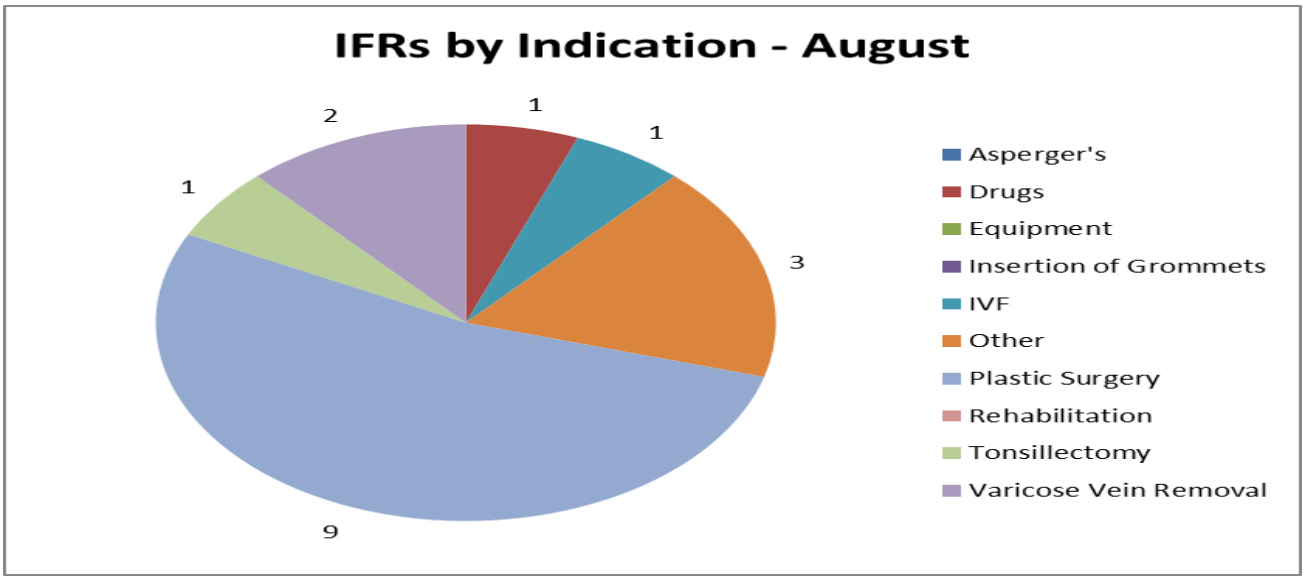
Individual Funding Request Indications by Month

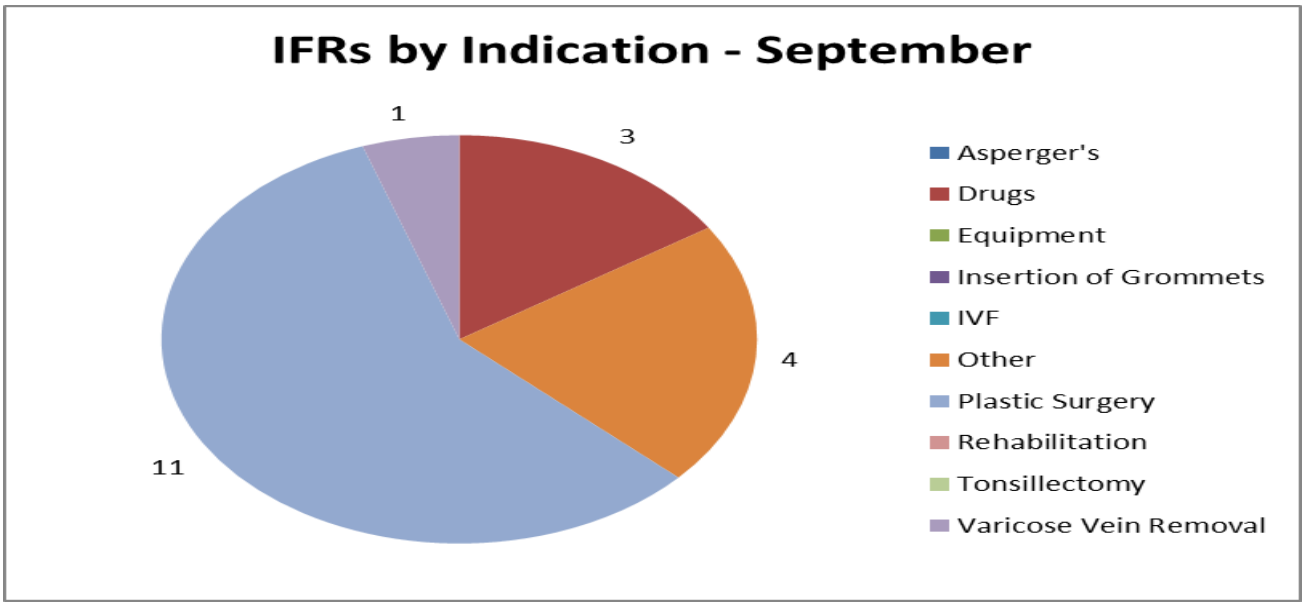


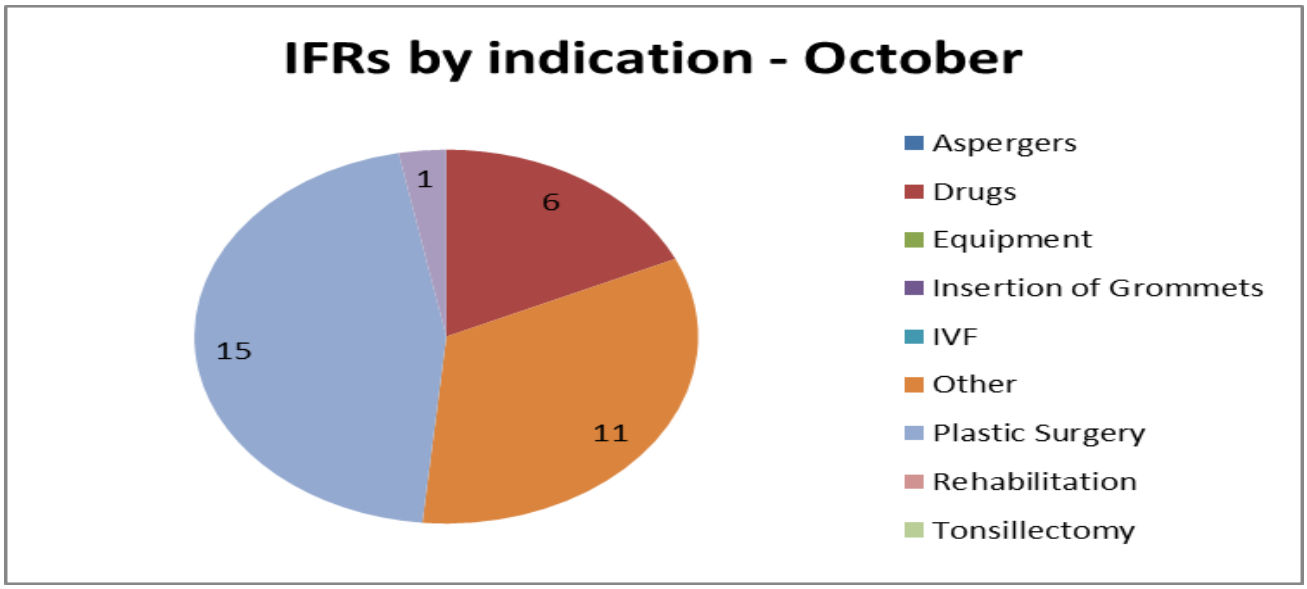


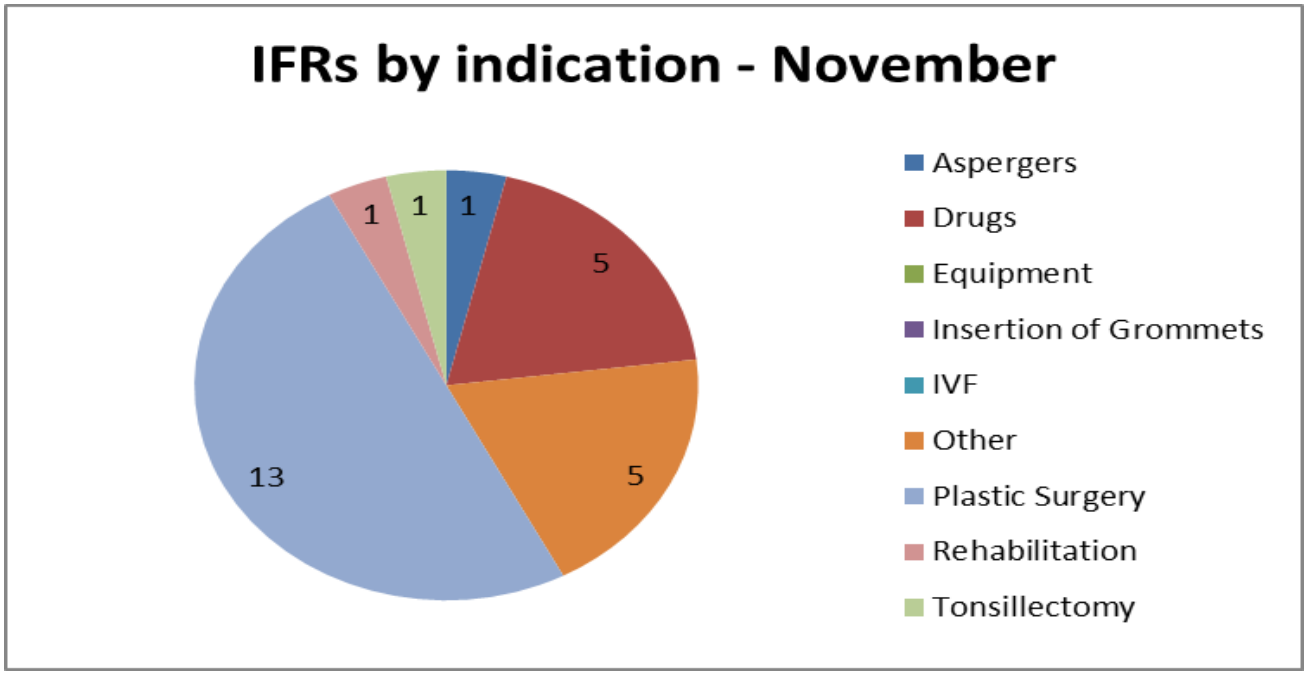


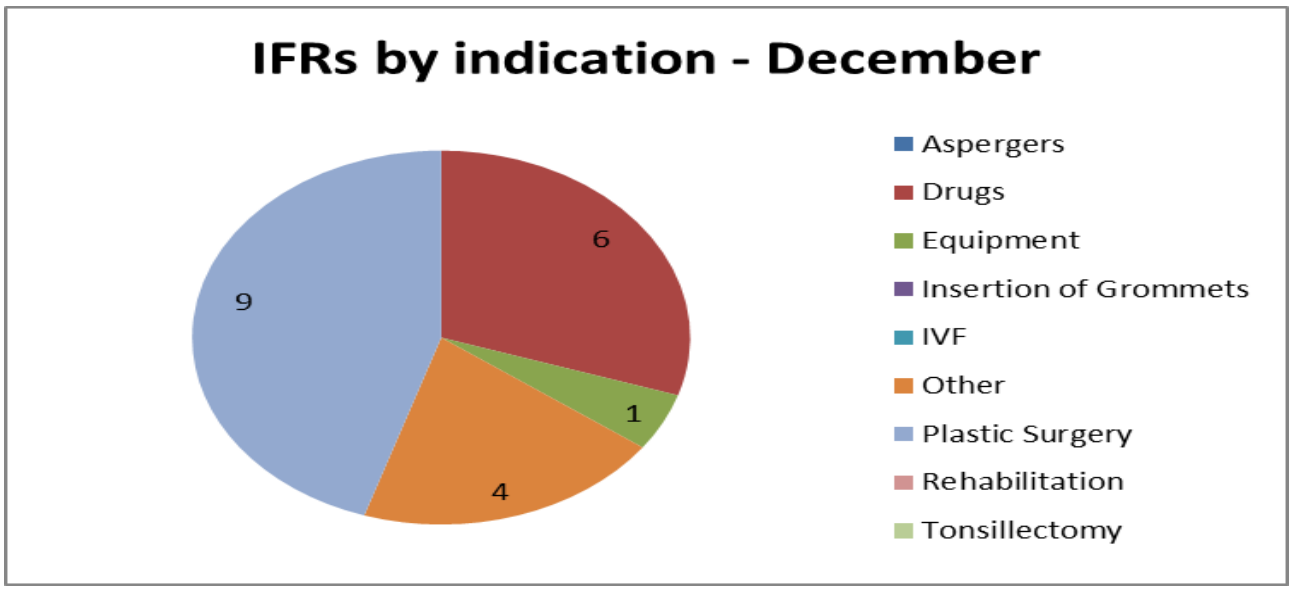

IFRs by Indication - July
1
2
7
1
2
17
Asperger's
Drugs
Equipment
Insertion of Grommets
IVF
Other
Plastic Surgery
Rehabilitation
Tonsillectomy
Varicose Vein Removal

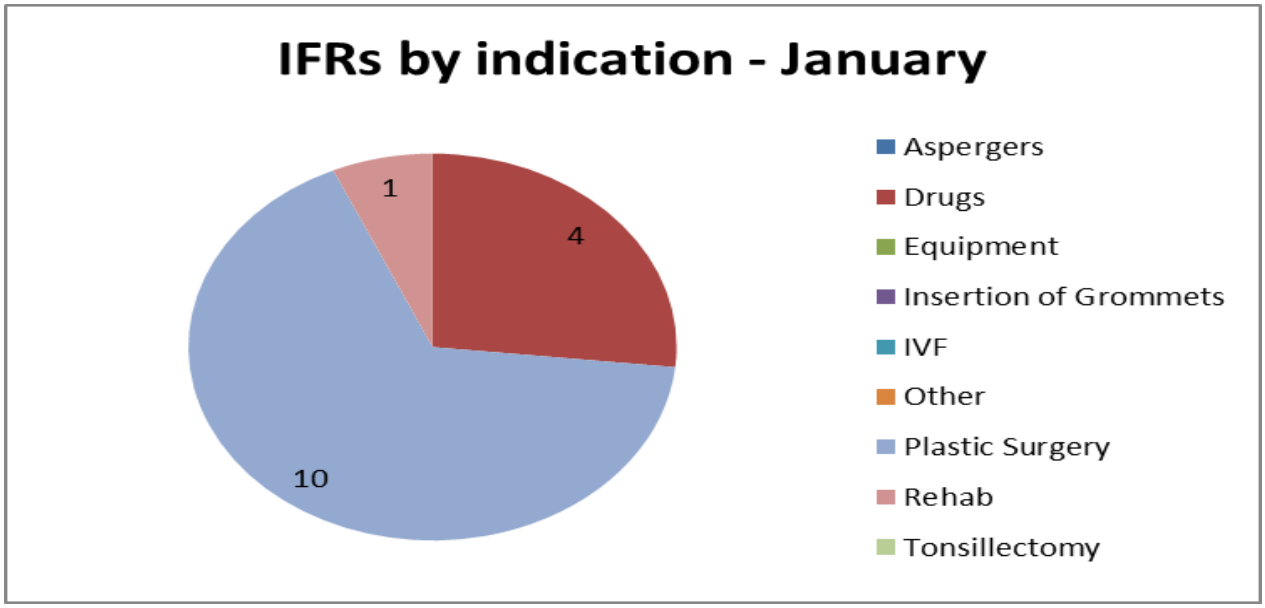

IFRs by Indication - August
1
1
2
1
3
9
Asperger's
Drugs
Equipment
Insertion of Grommets
IVF
Other
Plastic Surgery
Rehabilitation
Tonsillectomy
Varicose Vein Removal

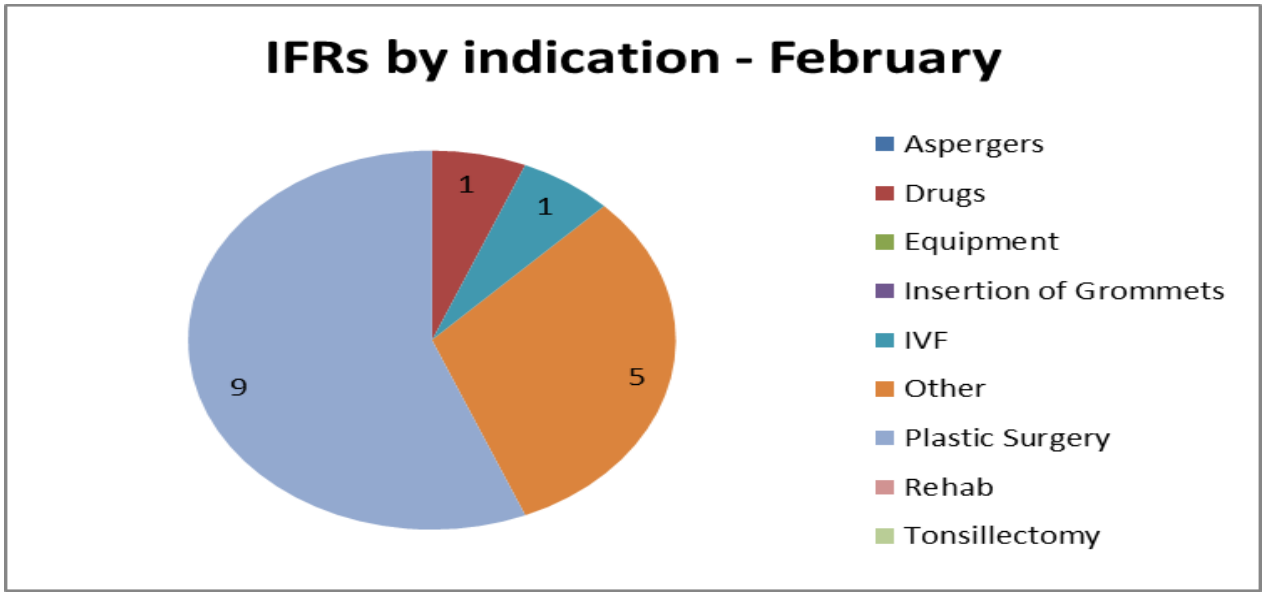

IFRs by Indication - September
1
3
4
11
Asperger's
Drugs
Equipment
Insertion of Grommets
IVF
Other
Plastic Surgery
Rehabilitation
Tonsillectomy
Varicose Vein Removal

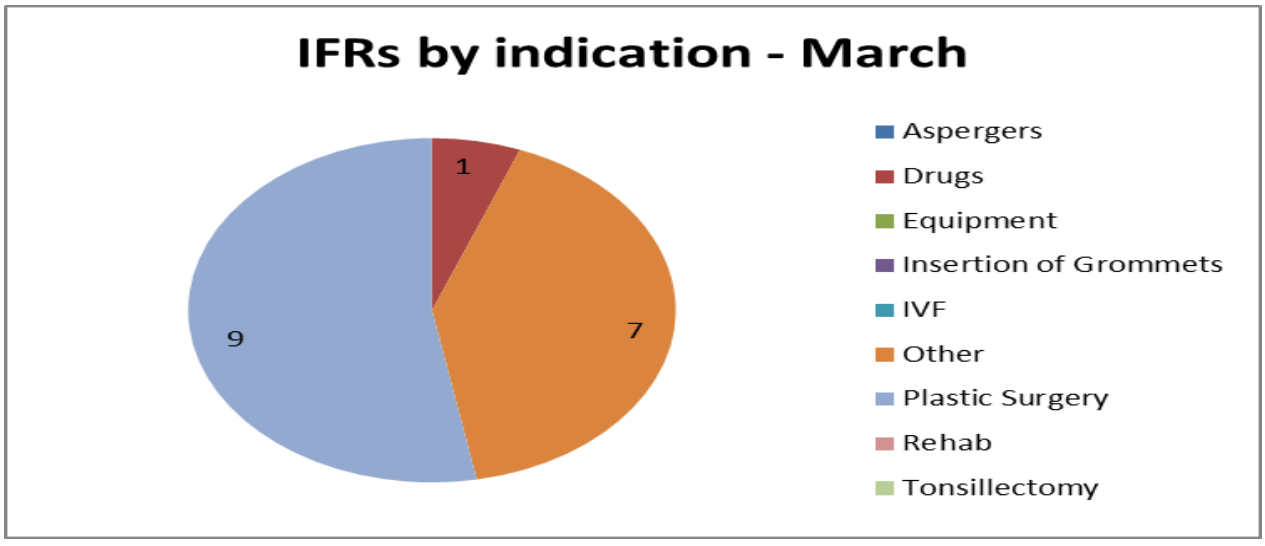

IFRs by indication - October
1
6
15
11
Aspergers
Drugs
Equipment
Insertion of Grommets
IVF
Other
Plastic Surgery
Rehabilitation
Tonsillectomy


IFRs by indication - November
1
1
1
5
13
5
Aspergers
Drugs
Equipment
Insertion of Grommets
IVF
Other
Plastic Surgery
Rehabilitation
Tonsillectomy


IFRs by indication - December
6
9
1
4
Aspergers
Drugs
Equipment
Insertion of Grommets
IVF
Other
Plastic Surgery
Rehabilitation
Tonsillectomy

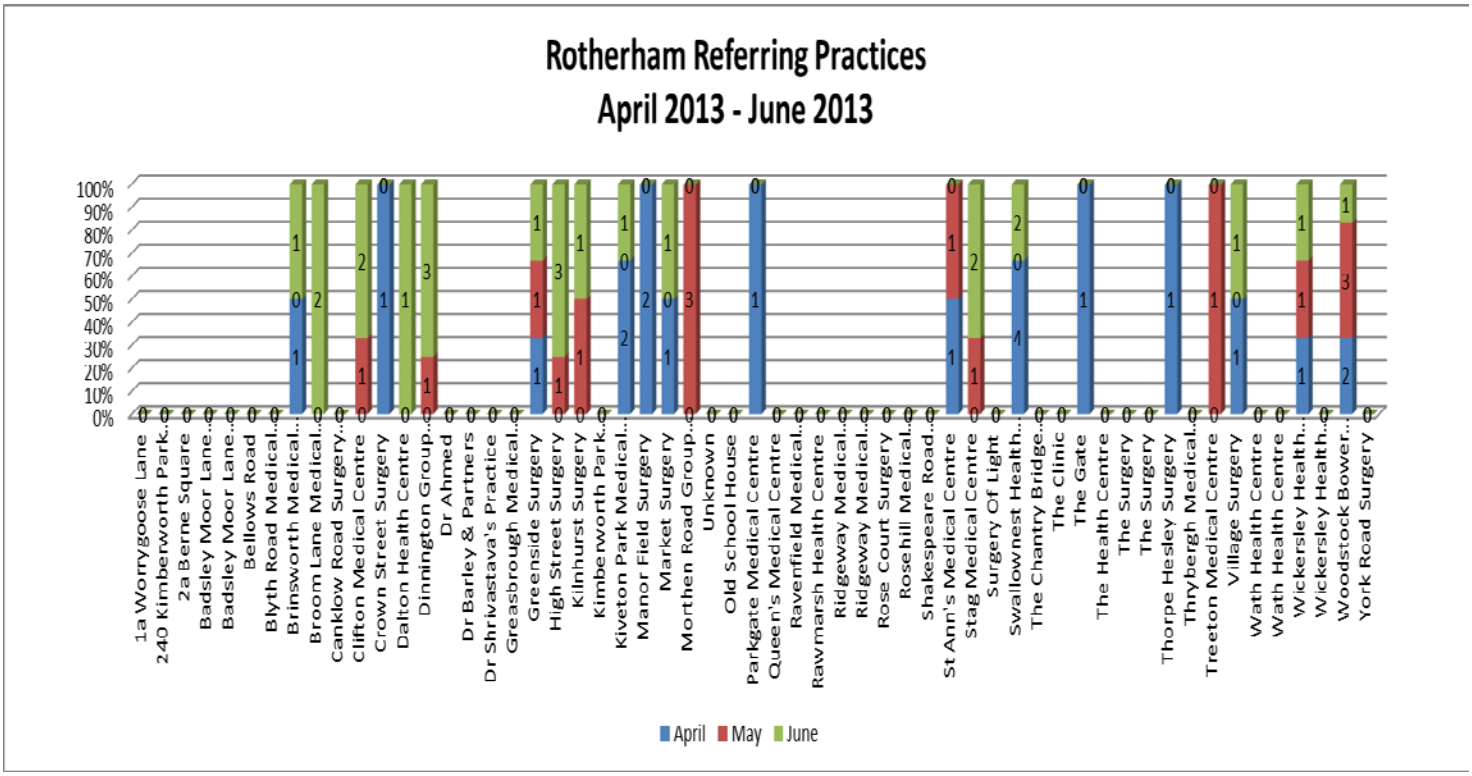

IFRs by indication - January
1
4
10
Aspergers
Drugs
Equipment
Insertion of Grommets
IVF
Other
Plastic Surgery
Rehab
Tonsillectomy

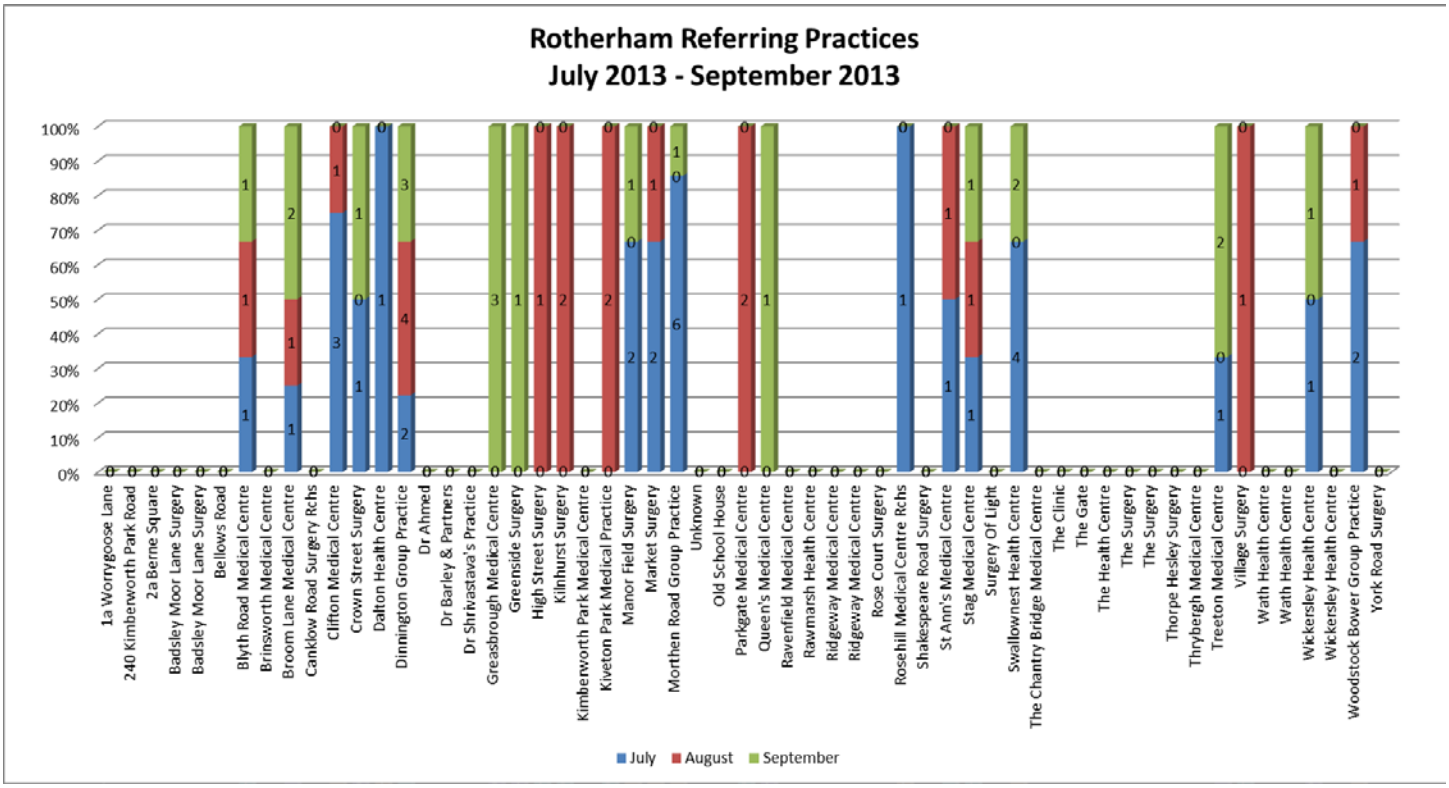

IFRs by indication - February
1
1
5
9
Aspergers
Drugs
Equipment
Insertion of Grommets
IVF
Other
Plastic Surgery
Rehab
Tonsillectomy

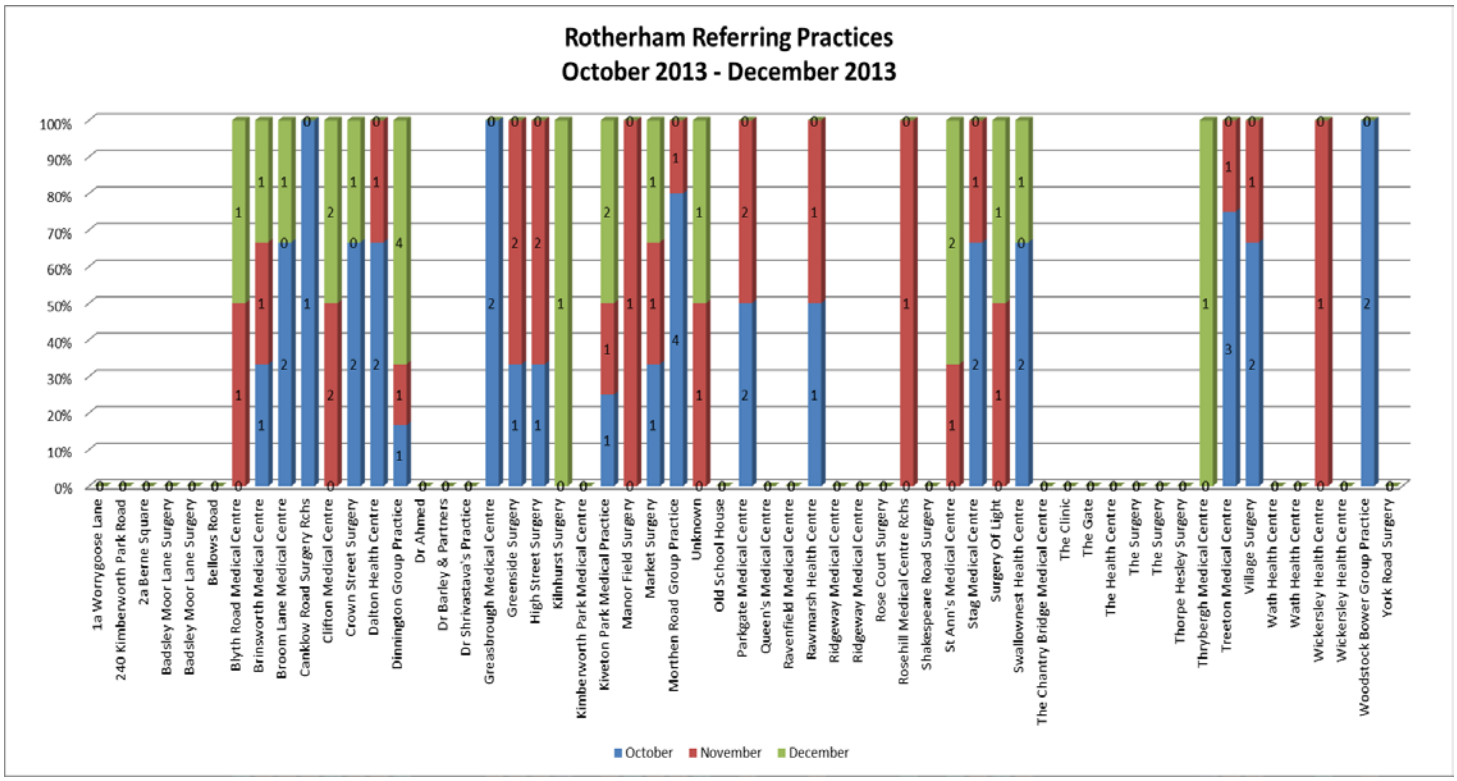

IFRs by indication - March
1
7
9
Aspergers
Drugs
Equipment
Insertion of Grommets
IVF
Other
Plastic Surgery
Rehab
Tonsillectomy

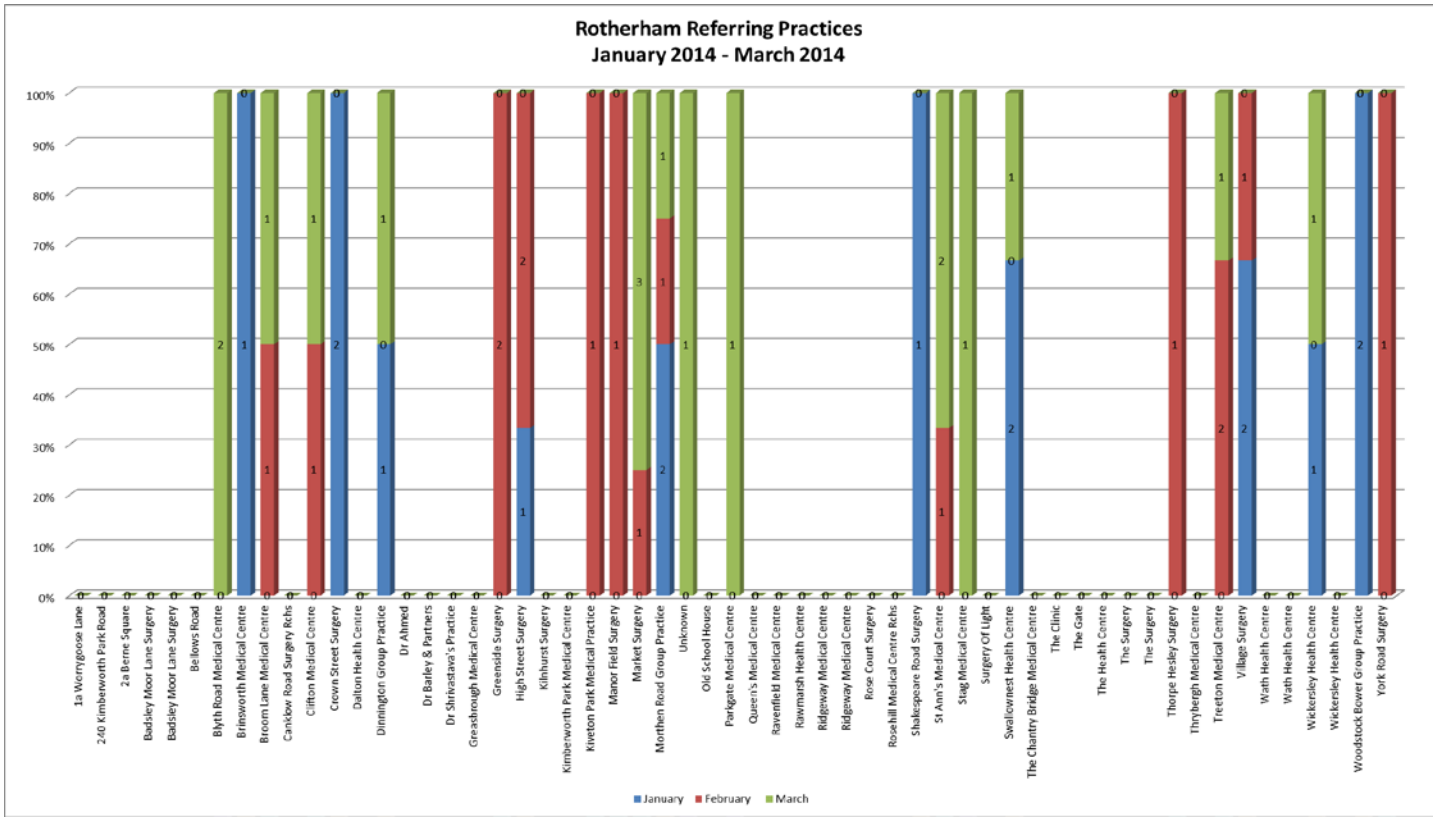
Referring Practices

Note: Unknown Practice – GP details not provided






Rotherham Referring Practices
October 2013 - December 2013
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1a Worrygoose Lane
240 Kimberworth Park Road
2a Berne Square
Badsley Moor Lane Surgery
Badsley Moor Lane Surgery
Bellows Road
Blyth Road Medical Centre
Brinsworth Medical Centre
Broom Lane Medical Centre
Canklow Road Surgery Rchs
Clifton Medical Centre
Crown Street Surgery
Dalton Health Centre
Dinnington Group Practice
Dr Ahmed
Dr Barley & Partners
Dr Shrivastava's Practice
Greasbrough Medical Centre
Greenside Surgery
High Street Surgery
Kilnhurst Surgery
Kimberworth Park Medical Centre
Kiveton Park Medical Practice
Manor Field Surgery
Market Surgery
Morthen Road Group Practice
Unknown
Old School House
Parkgate Medical Centre
Queen's Medical Centre
Ravenfield Medical Centre
Rawmarsh Health Centre
Ridgeway Medical Centre
Ridgeway Medical Centre
Rose Court Surgery
Rosehill Medical Centre Rchs
Shakespeare Road Surgery
St Ann's Medical Centre
Stag Medical Centre
Surgery Of Light
Swallownest Health Centre
The Chantry Bridge Medical Centre
The Clinic
The Gate
The Health Centre
The Surgery
The Surgery
Thorpe Hesley Surgery
Thrybergh Medical Centre
Treeton Medical Centre
Village Surgery
Wath Health Centre
Wath Health Centre
Wickersley Health Centre
Wickersley Health Centre
Woodstock Bower Group Practice
York Road Surgery
October
November
December


Rotherham Referring Practices
January 2014 - March 2014
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1a Worrygoose Lane
240 Kimberworth Park Road
2a Berne Square
Badsley Moor Lane Surgery
Badsley Moor Lane Surgery
Bellows Road
Blyth Road Medical Centre
Brinsworth Medical Centre
Broom Lane Medical Centre
Canklow Road Surgery Rchs
Clifton Medical Centre
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Dalton Health Centre
Dinnington Group Practice
Dr Ahmed
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High Street Surgery
Kilnhurst Surgery
Kimberworth Park Medical Centre
Kiveton Park Medical Practice
Manor Field Surgery
Market Surgery
Morthen Road Group Practice
Unknown
Old School House
Parkgate Medical Centre
Queen's Medical Centre
Ravenfield Medical Centre
Rawmarsh Health Centre
Ridgeway Medical Centre
Ridgeway Medical Centre
Rose Court Surgery
Rosehill Medical Centre Rchs
Shakespeare Road Surgery
St Ann's Medical Centre
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The Health Centre
The Surgery
The Surgery
Thorpe Hesley Surgery
Thrybergh Medical Centre
Treeton Medical Centre
Village Surgery
Wath Health Centre
Wath Health Centre
Wickersley Health Centre
Wickersley Health Centre
Woodstock Bower Group Practice
York Road Surgery
January
February
March