



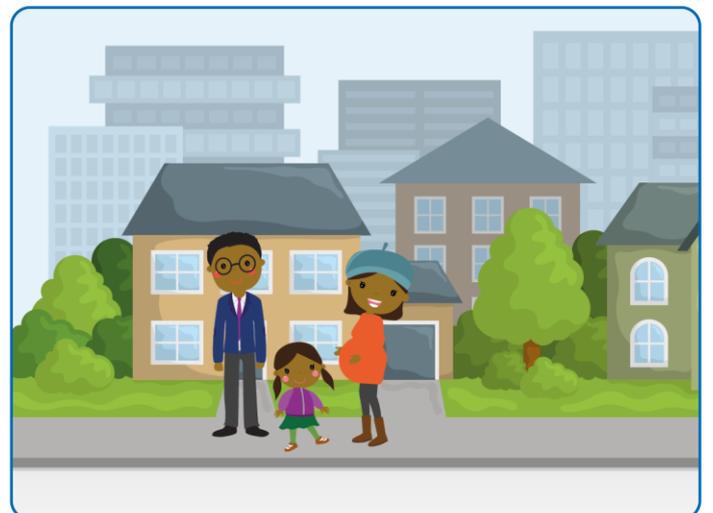
investor in excellence



Rotherham
Clinical Commissioning Group

Annual report 2016/17

NHS Rotherham CCG (03L)



SECTION 1 – PERFORMANCE REPORT

OVERVIEW

Foreword from Chair and Chief Officer

We are delighted to announce that we have met our statutory financial obligations. This has been made possible through the commitment and hard work of our staff and health providers, an exceptional achievement particularly when set against the continued challenges and increased pressure on health services.

Throughout the year, we have continually used innovative, forward thinking ways to develop health services that provide our patients with high quality healthcare, including social prescribing for mental health and reducing prescribing costs and growth.

We have strong clinical leadership at the heart of our organisation, which allows us to make the best possible decisions for healthcare across Rotherham. As a high achieving organisation, Investors in Excellence awarded re-certification to the Clinical Commissioning Group (CCG) in June 2016, recognising our high standard of all-round business performance, including leadership, resources, delivery and achievement. We also remain the leading CCG that is helping to shape the NHS health and wellbeing offer for employees as part of NHS England's national Healthy Workforce pilot.

During the year we have built upon our credible, robust and deliverable commissioning plan by developing a place based plan to integrate health and social care in Rotherham, which all partners have signed up to and are committed to its delivery. We are passionate about providing the best possible services and outcomes for our population and are committed to a whole system partnership approach, as we recognise that it is only through working together that we can provide sustainable services over the long-term.

Alongside this, we have supported the development of the South Yorkshire and Bassetlaw (SYB) Sustainability and Transformation Plan (STP) which will involve building on and strengthening our relationships with our voluntary sector, NHS, local authority, education and research partners to develop further opportunities to enhance the health and wellbeing of our local population.

In late 2016, we introduced evidence based clinical thresholds that bring Rotherham into line with national best practice clinical guidance. We are committed to ensuring our patients get the best possible clinical outcome from their procedure. For many conditions, moving directly to surgery does not always provide maximum benefit to the patient, therefore considering other initial treatment options may be required for some patients. As we continue to see a significant financial challenge across health and social care it is important that we commission provision of services in line with recommended best practice clinical standards.

Having taken on responsibility for commissioning primary care services (GP services) in 2015 we have made significant developments over the last year to improve the care of our patients. Working closely with GP colleagues we have developed and implemented a quality contract to ensure we provide resilient, equitable health services for patients in their community. Every practice in Rotherham has received an inspection visit from the Care Quality Commission (CQC) and it is extremely positive to see that 86 per cent of them were rated as good, whilst none received a rating of inadequate and only a small number were rated as requires improvement.

Summary of our achievements in 2016/17

We continue to be a high achieving CCG, working proactively with partners and the wider public. Some of our recent successes are highlighted below:

Mental Health and Learning Disability

- Improved access to Psychological (talking) Therapies (IAPT)
- Developed a best practice pathway with the Ferns Dementia Ward to give dementia patients with a physical health need an improved service
- Improved access to Child and Adolescent Mental Health Services (CAMHS)
- Developed Mental Health Liaison in the hospital to ensure mental health patients have access to mental health professionals when using hospital services.

Medicines Management

- Working in partnership with patients and GP practices to reduce medicines waste.

Demand Management

- Implemented evidence based clinical thresholds that bring Rotherham into line with national best practice clinical guidance
- Enhanced the national award winning social prescribing service in partnership with Voluntary Action Rotherham, providing an alternative for GPs to help patients self-manage their conditions.

Primary Care

- Introduced Saturday access to GP appointments across three locations
- Developed and implemented a quality contract to ensure we provide resilient, equitable health services for patients in their community.

Urgent Care

- Developed a new Urgent and Emergency Care Centre to meet all urgent health needs 24 hours a day, 365 days a year.

Moving forward, we will work closely with our local Rotherham partners to integrate health and social care, bringing our governance arrangements together to deliver our Rotherham Place Plan. We have a common vision of supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery. The plan will, over the next few years, build on partners' individual plans to drive forward our health and social care services.

We look forward with anticipation to the opening of our nationally leading state-of-the-art Urgent and Emergency Care Centre in July 2017. This will simplify the urgent care system for our patients giving them access to care should they need it.

Thank you for taking the time to read our annual report, which reviews our fourth year as a CCG.



Dr Julie Kitlowski, Chair



Chris Edwards, Accountable (Chief) Officer

About NHS Rotherham CCG – Our purpose and activities

We are the custodian of Rotherham's multi-million pound NHS budget, operating in 2016/17 with a resource allocation of £410 million from NHS England. We are a clinically-led group responsible for making sure that the people of Rotherham have the healthcare services they need at the right time. We identify, plan, buy and manage health services (commission), making sure they are of high quality and perform well.

We do not commission pharmacy, optometry, dental and most specialist services (which are the responsibilities of NHS England) or public health services (which are the responsibility of RMBC).

The CCG is a membership organisation, the 31 GP practices in Rotherham are our members, and there are eight localities. Our main decision making body is the Governing Body. We access additional expert advice we may require through Rotherham's Public Health service and the Chair of Rotherham's Health and Wellbeing Board who are in attendance at our Governing Body public meetings.

We remain a going concern as a statutory NHS body.

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

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

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

Our work to reduce health inequalities in Rotherham is a key focus of our [Commissioning Plan](#). Each of our 15 commissioning priority areas address health inequalities in order to work towards our organisational mission.

Our Relationships

We work with individual practice patient participation groups and have jointly developed with them our CCG patient network. We also work closely with Healthwatch, where they helped us with public consultation on our commissioning plan and the planning of joint public events in year. We are accountable to NHS England for delivery of agreed outcomes, aimed at improving the health of Rotherham people. In addition we work in partnership with NHS England in areas where both our responsibilities overlap, such as the interface between primary care commissioning (NHS England), hospital and community service commissioning (CCG) and specialist commissioning (NHS England).

We are an active member of the [Rotherham Health and Wellbeing \(H&WB\) Board](#) and the [Rotherham Together Partnership](#). The CCG works closely with Rotherham Council (RMBC) to ensure that Rotherham's Health and Wellbeing Strategy is delivered.

There have been and continue to be great benefits from working in partnership, bringing together planning, funding and delivery of health and social care. We all aspire to reducing health

inequalities and providing better care outside hospital. Our Commissioning Plan aligns with the H&WB strategy and sets out, as a key partner, how we will support its delivery. The Chair of the Health and Wellbeing Board, Cllr David Roche, attends our monthly Governing Body meeting and provides feedback on the preparation and approval of this Annual Report for 2016/17.

Throughout 2016/17 the CCG and RMBC have continued to work proactively to deliver the 'Better Care Fund'. The CCG has developed joint commissioning arrangements with RMBC and other local partners as we look to further develop the Rotherham Place Based Plan. Our commitment over the next 5 years will focus on:

- Improving the health and wellbeing gap through prevention, self-management, education and early intervention.
- Driving transformation to close the care and quality gap through:
 - Rolling out our integrated locality model
 - Opening an integrated Urgent and Emergency Care Centre
 - Development of a 24/7 Care Co-ordination Centre
 - Building a Specialist Re-ablement Centre

We have maintained strong relationships with our neighbouring CCGs including meetings between chief officers to share best practice and jointly commission services.

We have been part of the Commissioners Working Together programme which is a collaborative partnership with our clinical commissioning colleagues from across South and Mid Yorkshire, Bassetlaw and North Derbyshire and NHS England. In 2016/17, we undertook public consultations reviewing both hyper acute stroke and children's surgery and anaesthesia services.

Reducing Health Inequality

We continue to work closely with partners to reduce inequalities. We are a member of Rotherham Partnership which has three priorities: helping local people and businesses benefit from a growing economy; ensuring the best start in life for children and families; and supporting the vulnerable within our communities.

Our work with Rotherham Public Health has helped to implement the plans for Public Health commissioning. These include important areas such as NHS Health Checks which provides screening for cardiovascular disease and other conditions and services for important causes of inequalities in Rotherham such as smoking, obesity, sexual health and substance abuse, including alcohol.

We have continued to work with partners to address the high impact changes for health inequalities identified by the National Audit Office; smoking cessation, blood pressure control and management of cholesterol. For smoking cessation the CCG works in close partnership with Rotherham Council, who manage this contract.

During 2016/17, our actions to address inequalities in each of our areas of commissioning responsibility include:

- **Urgent Care** - The nature of commissioning and delivering urgent care services provides challenges in reducing health inequalities. However, our urgent care redesign is enabling more care to be provided closer to home and the Care Co-ordination Centre ensures vulnerable people get access to appropriate urgent care.

- **Clinical Referrals** – Benchmarking has been taking place to understand the causes of high and low referral rates, emergency admissions rates and utilisation of diagnostics in order to reduce unnecessary variations between GP practices.
- **Continuing Care and Funded Nursing Care** - All patients are assessed for NHS Continuing Healthcare in line with the requirements of the National Framework to ensure that care packages are commensurate with need. We engage hard to reach minority groups to increase awareness of continuing healthcare and the personalisation agenda and to understand their needs and wishes.
- **Mental Health** – The further development of CAMHS locality workers has ensured that all geographical areas of Rotherham are afforded equal status. The overarching aim of the adult mental health transformation plans are to deliver parity of esteem , delivering of quality physical health services and improve health outcomes for people with mental health problems.
- **Learning Disabilities** – The CCG ensures that people with learning disabilities have good access to physical health care and preventative services. The CCG has provider contracts that require them to comply with the Equality Act 2010, reasonable adjustment standards, autism statutory requirements etc.
- **Community Services** – A Health Equality Audit of community based rehabilitation services has been completed, with work ongoing to ensure that patients from areas of deprivation receive an equitable service.
- **Primary Care** – Working to ensure that there is universal coverage of service provision across Rotherham by increasing the ‘basket of health services’ that are required and not of choice of individual practices.
- **Prescribing** - Key prescribing indicators promote equal access to key medications that are vital for long-term condition management. Practice prescribing budgets include deprivation into the budget setting mechanisms, meaning that those with a relative high deprivation score are not penalised.

Health and Wellbeing Strategy

Over the last 12 months we have continued to work closely with partners to develop Rotherham’s second Health and Wellbeing Strategy. The strategy for 2015-2018 sets out five key aims:

- All children get the best start in life
- Children and young people achieve their potential and have a healthy adolescence and early adulthood
- All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
- Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing
- Rotherham has healthy, safe and sustainable communities and places

The Health and Wellbeing Strategy provides a high level framework, directing the Health and Wellbeing Board activity, of which the CCG is a key member. It supports the Board’s role to provide leadership for health and wellbeing by making the most of our collective resources in the Borough.

Rotherham’s Health and Wellbeing Strategy 2015-18 can be viewed here – [Health and Wellbeing Strategy](#).

Key Risks

The CCG's risk management and assurance framework was reviewed during quarter 4 in line with internal audit recommendations.

A new integrated risk management system including a new framework (policy and procedural documents) was developed during quarter 4, with a change to the format of the Governing Body Assurance Framework, and introduction of an Issues Log to support the Risk Register. This enables the organisation to have a clear view of the risks and issues affecting each area of its activity; how those risks are being mitigated, the likelihood of occurrence and their potential impact on the successful achievement of the CCG objectives.

Full details of the CCG's risk management arrangement and effectiveness is reported in section 6 of the Annual Governance Statement within this report.

Performance Analysis

How we Measure Performance

The CCG has a performance management framework that sets out its vision, methods of reporting, data quality, partnership arrangements, accountabilities and escalation policies.

The Business Intelligence team produce a monthly performance report for the CCG Governing Body, covering the performance against key outcomes required by NHS England, which is a Delivery Dashboard. The current reports concentrate on a limited number of key metrics and then exception reporting against the full range of the NHS Outcomes framework. Our Governing Body also receive a monthly performance report on quality and patient safety, finance and patient and public engagement.

We monitor the CCG performance against the domains within the NHS England CCG Assurance Framework on an ongoing basis, with our Executive Team meeting NHS England throughout the year to formally take stock of our performance against the domains. The outcomes from this meeting are formally reported to our Governing Body. The monthly Governing Body scorecard includes the metrics and assurance statements that are also used for quarterly assurance meetings with NHS England. A formal review meeting with NHS England takes place in April 2017 to provide an end of year review and assurance.

In addition to reporting on national outcomes the CCG will produce three reports a year on the delivery of this commissioning plan.

Development and Performance for 2016/17

During 2016/17, the CCG has worked very closely with members, partners and providers, towards achieving all of our key standards. We monitor, in-depth, our commissioning plan implementation, patient outcome indicators and performance standards. This year the CCG's performance has been focused around a new framework called the Improvement and Assessment Framework (IAF). This has formed a key part of the CCG's monitoring in 2016/17 and is reported monthly in public to the Governing Body. The 2016/17 year-end IAF assessment score will be available on [www.nhs.uk/service-search/Performance/Search from July 2017](http://www.nhs.uk/service-search/Performance/Search%20from%20July%202017).

Performance Summary

2016/17 has seen some very positive successes in delivering key constitutional standards, through close working with our commissioned providers and other key partners. Some areas remain a challenge for the CCG and the wider health system and continue to be the focus of work streams that are driving improvements.

Positive successes for the CCG have included:

- Referral to treatment 18 week standard. A key constitutional standard that has been achieved consistently throughout the year. Performance against the 92% standard was 94.5% for 2016/17.
- Incidence of C Difficile. The CCG performed well during the year against its trajectory, with only 57 cases against the target of 63.
- Diagnosis rates for people with dementia. Forming part of the CCG IAF, the estimated diagnosis rate target is 71.5%. The CCG consistently achieves above this with an achievement of 75.9% as at March 2017.

Key areas of challenge for the CCG in 16/17 have included:

- A&E waiting times. Challenges experienced nationally have also been experienced in Rotherham. The A&E standard of 95% hasn't been met during the year, with 2016/17 performance at 88.6%. The Rotherham Urgent and Emergency Care Centre opens in July 2017, this development will provide a new model of urgent and emergency care to ensure patients are seen by the right care professional at the right time. The CCG is also engaged in system wide work streams to improve the management of emergency care. This system work is managed through the A&E Delivery Board, attended by all system partners.
- Diagnostic waiting times. The six week wait for a diagnostic test has been generally positive throughout 2016/17, however performance was challenged over a four month period with patients waiting for endoscopy tests. The CCG has worked with local providers to address this and performance has returned to within the standard threshold of 1% in February and March 2017. Across the year performance has averaged at 2.1%.
- Improving Access to Psychological Therapies (IAPT) waiting times. IAPT waiting times have seen considerable improvement in year and the 18 week standard of 95% has been consistently achieved. The six week standard of 75% however remains challenging. During 2016/17 the national intensive support team has been engaged with the CCG, the mental health provider and other partners to support the IAPT service. This has proven productive and significant work around capacity and managing waiting lists remains a key CCG focus. The position for 2016/17 overall was 70.7% of patients seen within the six week standard.
- Cancer waits. The CCG has seen strong performance against most of the cancer waiting time standards in 2016/17. The 62 day standard for patients to be treated, following GP referral has been under the 85% standard during the winter period. Performance was 85.7% in February 2017 for the month and 83.6% for the year to date. The CCG is engaged across the region in the work of the Cancer Alliance to streamline complex pathways for cancer patients where multiple provider organisations are involved. Each breach of the standard is thoroughly examined and challenges with complex pathways are often the cause of longer waits.

- Electronic referral system bookings. Part of the IAF, this is a key standard for the CCG to support patient choice of provider is 80% of GP referrals to first outpatients booked using E-Referrals. This has been a challenge during the year with performance generally below the standard. The CCG has been working with practice colleagues to support practices in using the E-Referrals system. January 2017 has seen a significant improvement with performance above the standard at 82%.

Commissioning Plan Performance

A review of performance against our commissioning plan for 2016/17 took place in July 2016, October 2016 and January 2017, and reported to Governing Body each time. The quarter 3 position showed that 94% of milestones were on track or complete and 42% of key performance indicators are on track. A year-end position will be reported in April 2017.

Highlights from our Year

Social Prescribing Improving Mental Health Discharge Rates

The Rotherham Social Prescribing Mental Health Pilot was developed to help people with mental health conditions overcome the barriers which prevent discharge from secondary mental health care services.

The 12 month pilot helps service users build and direct their own packages of support by encouraging them to access personalised services provided by local voluntary and community groups.

The pilot was delivered in partnership by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) and a group of local voluntary sector organisations led by Voluntary Action Rotherham on behalf of the CCG.

An evaluation of the pilot, carried out by Sheffield Hallam University's Centre for Regional Economic and Social Research (CRESR), found that it had helped increase the number of discharges from mental health services and improved social and emotional well-being of the service users.

156 service users were referred to the pilot, with 136 (87 per cent) taking up one of the voluntary and community services available, such as sports groups, craft classes, cookery courses, swimming, learning programmes, employment skills, yoga, and therapeutic art groups.

The research, which was measured against eight different wellbeing outcomes, showed that:

- 93 per cent of service users made progress against at least one outcome
- 64 per cent made progress against four or more of the outcomes
- 39 service users were discharged from mental health services (out of 72 discharge review meetings)

The evaluation also found a range of evidence about the wider social benefits of the pilot. This evidence showed that of the service users involved:

- three had found employment
- 24 had engaged in training or education
- 14 had volunteered
- 25 had taken up activity to improve their physical health
- 40 had continued to engage in voluntary sector activity once their social prescription had ended.

As well as the positive impact on service users, the report also estimated that social prescribing services could save local NHS services £4,281 for each discharged service user per year. The pilot followed on from the successful Rotherham Social Prescribing Service for people with long-term health conditions, which has been operating since 2012.

National Recognition for Innovative IT System

The CCG have worked with The Rotherham NHS Foundation Trust (TRFT) to develop the SEPIA clinical portal which achieved the 'Enhancing Care By Sharing Data and Information' Award at the Health Service Journal (HSJ) Awards 2016. A tremendous amount of work across health partners has gone into the portal which is helping to improve the quality of care for our patients by sharing information across the different services in our health and care community. The CCG is fully behind the continued development of this system, it is a crucial part of our future plans to enhance patient care across GP, community and hospital services in Rotherham.

Development of Rotherham's Digital Roadmap

The Rotherham Local Digital Roadmap (LDR) has been developed by the Rotherham Interoperability Group, with an ambition to deliver care closer to home and out of hospital where possible. To enable the delivery of this ambition our roadmap will empower patients so that they can better self-manage their own health and care through digital services and support the transformation of our health and care services so that they can increasingly be delivered out in the community.

The plan is to further integrate systems by engaging suppliers to use national technical standards across health and social care and to support self-care patients will be able to view and add their own data and interact with health and social care professionals using modern technology. Also, we are planning to ensure we share and exchange information with other providers outside of Rotherham.

Urgent and Emergency Care Centre Development Continues

The new Urgent and Emergency Care Centre, being developed to transform the way that urgent and emergency healthcare is provided to local people, will open in July 2017. Construction work and development of clear pathways by clinicians has taken place throughout 2016/17 which will give local people one place to go when they have an urgent or emergency care need, where they will be seen by the most appropriate health care worker or will be advised to return to their GP, pharmacist or to self-care at home.

Campaign to Reduce the Amount of Wasted Medicines

After listening to patients and carers across Rotherham, the CCG is working with local people to inform them about excess medicine problems and they'll resolve the problem for them. Local pharmacy experts estimate that around £1.5 million of NHS money is lost a year in Rotherham through medicines waste alone, money that could be better spent on caring for patients.

Following a push to reduce the amount of medicine waste in 2016/17, through reducing unnecessary medication and better management of repeat prescriptions the CCG has seen a saving in prescription costs of approximately £600,000.

Integrated Locality Working Pilot – The Village

'The Village' pilot, established in July 2016, develops and tests the model concept of a multi-professional team delivering health and social care to a General Practice population in a single, seamless pathway. It is located in Rotherham's town centre and covers 31,000 people in one of our seven localities.

The team aims to provide seamless care to the designated General Practice cluster population. Resources are pooled from TRFT, RMBC and others to deliver quality care closer to people's homes. The integration of care is supported through the alignment of resources, single line management arrangements, and the sharing of information for a designated practice population through an innovative, secure technology portal. The model will over time move towards including closer alignment with the care homes within the locality and the co-location of other support services, all around a common vision and purpose: a more efficient and effective way of working, with reduced duplication of assessments and avoidance of multiple referrals leading to individuals being transferred between services. The approach allows the team to be more proactive and less reactive in caring for the population and by working with individuals, families and communities we aim to reduce dependence, promote self-management and increase overall systems resilience.

Case Study on Integrated Locality Model

Grant has severe depression and diabetes. His GP referred him to a social worker specialising in mental health and to a district nurse who helped him to better understand and manage his diabetes. They both met with Grant together and drew up a care plan. The GP also has access to this same care plan. Through the social worker, Grant was referred to talking therapy and put in touch with a peer support worker. This has helped him regain his hope for the future.

Primary Care (GP services) in Rotherham

The CCG was given delegated responsibility for the commissioning of primary care in April 2015. This gave the CCG the opportunity to develop primary care to meet the challenges set out in the General Practice Forward View (GPFV). The Primary Care Committee oversees the work of the Primary Care team as well as providing strategic direction and has approved a strategy for primary care (as a response to the GPFV). The committee received regular updates including a summary of the primary care dashboard, which has been developed to help target the work of the team and to monitor quality.

The team have worked closely with GP practices to make significant developments to improve the care of patients. The Quality Contract is an important initiative which aims to ensure that there is access to important services across all practices. It is also focussed on improved quality by setting standards across a wide range of areas such as access to appointments and also health screening. There are 13 standards in the contract which are being phased in from 2016-2018.

Other important initiatives which have been part of the team's workstreams include, support to the roll out of the Productive General Practice Programme (PGP, a Nationally recognised methodology for releasing time for care in General Practice), starting care navigation and medical documentation training, piloting Saturday opening and physiotherapy first. Estates and technology funding from NHS England has also meant that telephony has been improved in practices (including call recording to support consultations) and improved clinical templates to reduce administrative requirements.

Another important achievement in primary care was the alignment of GP practice with care homes. This rationalisation has led to improved and consistent care for residents and less unscheduled visits from the practice. A full evaluation is now underway.

Following a successful pilot of telehealth, the Primary Care Committee approved the roll-out to all practices. Telehealth has a number of functions for patients, including being able to send their results by text message and also to cancel appointments. Practices have also used it to gather feedback for the Friends and Family Test (FFT). In February 1,000 appointments were cancelled, this will be evaluated but is expected to significantly impact the number of patients who do not attend appointments and have not notified the practice.

CQC visits – No practices in Rotherham were identified as inadequate. Seven practices were identified initially as ‘requiring improvement’ but in April 2017, four remained as ‘requiring improvement’ but it is anticipated that these will move to ‘Good’ upon re-visit. The CCG has provided a supportive visit to all of those practices which were rated as ‘requires improvement’. Significant improvement has been made in relation to use of e-referral, with practices achieving 82 per cent in January 2017. Significant progress has also been made in primary care with improving technology e.g. the clinical portal, electronic prescribing, online services and paper light. Primary Care continues to be an important focus for the future and the Primary Care team will continue to support and develop future improvements.

GP Saturday Hubs for Routine Appointments

As the NHS moves increasingly to a seven day a week service, Rotherham GP practices came together in early 2017 to set up a Saturday GP Service at hubs across Rotherham for routine pre-booked appointments covering all of their local population, between 8am to 11am on Saturdays. It gives those who may be unable to attend during the week access to a GP appointment. Patients are encouraged to speak to a receptionist at their own practice who can book an appointment and advise where to attend. The appointments are pre-booked at a patient’s practice.

Finance Review

As in previous years NHS Rotherham CCG had a number of obligations to meet in 2016/17 all of which were successfully achieved; the details are below:

- Deliver a surplus of 1% of our allocation - £4m
- Plan to spend 1% of our allocation non recurrently (see additional note below)
- Remain within a running cost allocation of £22.07 per head of population - £5.5m
- Agree a joint plan with the council to deliver the requirements of the Better Care Fund (BCF) in 2016-17, building on the 2015-16 BCF plan
- Continue to increase investment in mental health services

The CCG also has an administrative duty to pay at least 95% of non-NHS trade creditors within 30 days. This was achieved during 2016/17 and more detail is shown within the Summary Financial Statements.

Note:

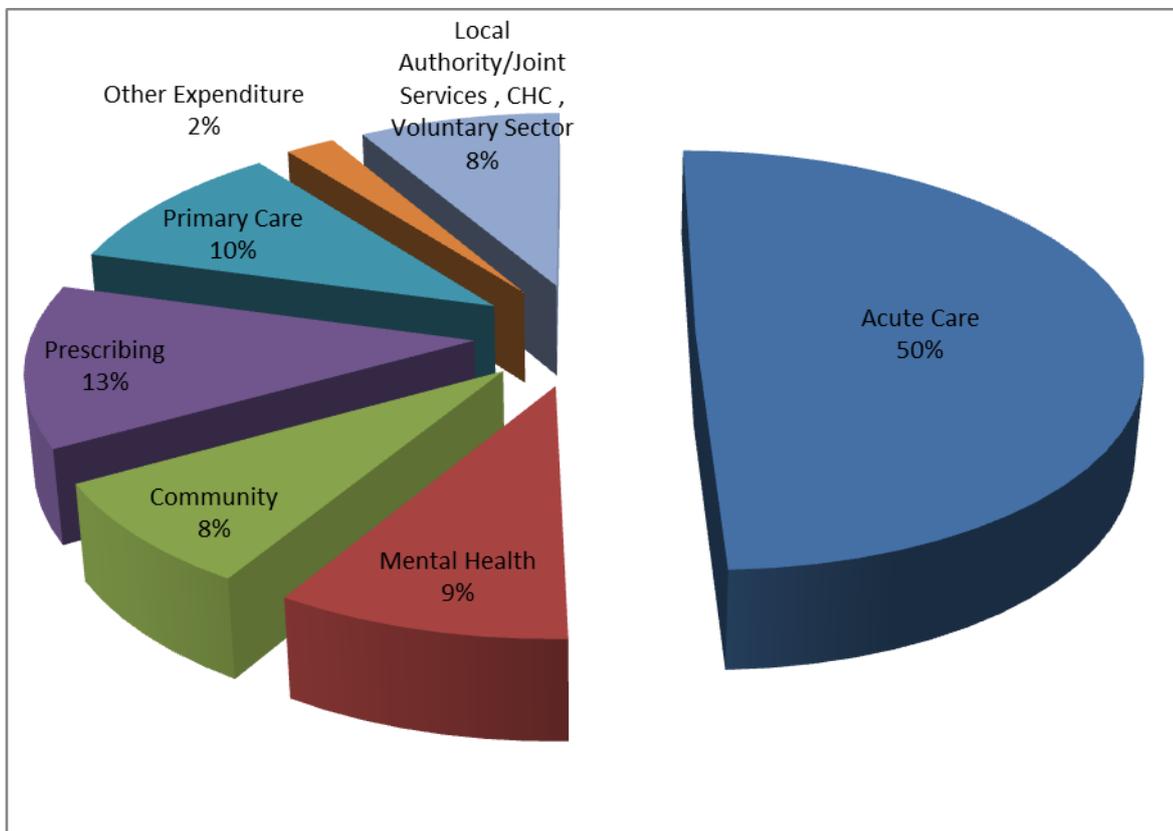
As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1% reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Rotherham CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £3.891m. This additional surplus will be carried forward for drawdown in future years.

Revenue Expenditure

The allocation was spent in the following main areas:

- Acute care - £194m
- Mental health - £36m
- Community - £32m
- Joint Services including with Local Authority / Continuing Healthcare - £33m
- GP Prescribed Medicines - £49m
- Primary care services - £40m
- Other Expenditure - £8m



During the year, we have been able to invest in a number of high priority areas, the most significant being the development of the new Urgent and Emergency Centre due to open in summer 2017. There have been other areas of continued investment and development including:

- Maintaining waiting times for operations and diagnostic tests
- Seven day working in key services across both acute care and in the community.
- Continued support for the Care Co-ordination Centre to ensure patients get the right services first time through investment in initiatives that redirect patients to alternative levels of care.
- Continued support for the Hospice at Home services provided by the Rotherham Hospice extending the choice to die at home to more people.

- Expanding the nationally award-winning initiative with the voluntary sector around social prescribing into mental health, facilitating a better quality of life for a further group of patients.
- Continued support for the mental health liaison service at the Rotherham Foundation Trust, providing parity of care and support to patients suffering with mental health problems.

Audit

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

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

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

Each director has stated that as far as he/she is aware, there is no relevant audit information of which the CCG's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director in order to make himself/herself aware of any relevant audit information and to establish that the CCG's auditors are aware of that. The audit fee in relation to the statutory audit for 2016/17 was £67,500. An additional fee for the audit of the delegated primary care co-commissioning expenditure relating to the 2015/16 was also paid in 2016/17. The value of this was £2,760.

Future Challenges

The future financial position is likely to be increasingly challenging. Growth allocations of 1.5% in 2017/18 have been utilised on priorities identified by the CCG's Commissioning Plan, however the underlying rate of growth in health service activity and costs remains in excess of this due to factors including the aging population, new medical technologies and rising expectations.

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

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

- Clinical Referrals Management
- Unscheduled Care/System Resilience
- Prescribing
- Mental Health
- Community Transformation
- Better Care

GP commissioning has continued to develop well throughout 2016/17 with stronger clinical engagement across the whole Rotherham NHS system helping to manage demand for secondary care services more effectively and into 2017/18.

GPs have continued the excellent work in the management of prescribing ensuring that drugs usage moving into 2017-18 is cost effective and clinically appropriate.

2017/18 will see the CCG develop further the strategy for primary care services which offers a significant opportunity to progress Rotherham with the objectives of the five year forward view set out by the Chief Executive of NHS England.

Sustainability Report – Sustainable Development

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

NHS Property Services provide utility and waste data for 2016/17. The information shows the full year consumption based on partial year actuals, and estimating the remainder. Actual consumption as of:

- January 31st 2017 for electricity
- December 1st 2016 for gas
- October 31st 2016 for water.

The CCG occupancy percentage of the building has been applied to the total consumption to arrive at a total for the CCG.

CCG Total

Financial Data (Spend):	Units	2016/17
Total Energy Cost (all energy supplies)	£	20,843
Electricity Cost	£	16,845
Gas Cost	£	1,433
Water Cost	£	2,566
Resource Use:	Units	2016/17
Electricity Consumed	kWh	157,504
Gas Consumed	kWh	61,114
Water/Sewerage Consumed	m ³	521

Our Sustainability Development Management Plan consists of four components:

1. Corporate leadership - 'The NHS has the potential to touch almost every person in this country. By demonstrating how to reduce carbon emissions and promoting healthy, sustainable lifestyles, the NHS can lead the way to a healthier, happier society.' – Neil McKay, NHS England.

2. Staff health and wellbeing and community engagement - The CCG as an employer will enhance the health and wellbeing of staff, patients, the public and suppliers. We will improve the wellbeing of local communities, the economy and the environment through building relationships and minimising negative impacts.

3. Reducing our internal impact - We will support the government target to reduce the NHS Carbon Footprint by 80 per cent by 2050. This will involve measuring our baseline and setting targets for; a. energy management b. travel reduction and greener travel c. material management and the waste hierarchy.

4. Sustainable commissioning and procurement - Sustainable procurement means purchasing goods and services in a way that maximises positive benefits and minimizes negative impacts on society, the economy and the environment through the full life-cycle of the product. The NHS spends around £11 billion a year. It contributes enormously to local economies and has the significant market power needed to drive innovation. The NHS contributes up to 10 per cent of regional GDP, and in more deprived areas an NHS Trust can have an even greater economic impact. The majority of our impact comes from our commissioning and procurement activities. While we intend to focus on our internal impact, health and wellbeing of staff and embedding sustainability into the organisation as a priority this year, we must begin to put measures in place to challenge and support our providers to reduce their impact too.

Our Statutory Duties

Quality Assurance and Quality Improvement

Our Chief Nurse, Sue Cassin, has continued to work closely with GP leads, CCG officers and other stakeholders to seek assurance of the quality of all commissioned services including GP primary care services, acute and community services, mental health and continuing healthcare. Quality assurance includes safeguarding, governance, incident reporting/investigation and learning, infection control, patient experience, public involvement. This assurance is reported in detail to the Governing Body public session on a monthly basis and bi-monthly to the NHS England Quality Surveillance Group.

The Chief Nurse is supported by the Deputy Chief Nurse in all aspects of the clinical quality agenda. Additionally, the role leads on continuing healthcare for adults and children, Personal Health Budgets, Previously Unassessed Periods of Care (PUPoC) and representing the CCG at the regional quality leads meeting.

Throughout the year, the CCG has worked with commissioned providers to secure continuous improvements in the quality of services, with particular regard to clinical effectiveness and outcomes, safety, infection prevention and control, and patient experience. This includes ensuring that health services are provided in an integrated way and that provision is integrated with health related or social care services, where it would improve quality or reduce inequalities GP leads, CCG officers and commissioning nurses take part in a series of clinically led visits to main providers which provide opportunities for seeking quality assurance and agreeing actions where appropriate.

Additionally;

- All providers' Cost Improvement Plans (CIPs) are signed off by providers' medical and nurse directors to ensure Trust Board level 'line of sight' also ensuring that the CCG is assured that CIPs can be delivered without compromising quality and safety.
- Monthly contract quality meetings take place with main providers where the agenda is set around the three main domains of quality- safety, outcomes and patient experience in line with the NHS Outcomes Framework. The CCG has held all our providers to account to continue reductions in cases of clostridium difficile with a root cause analysis of all cases. We also have a zero tolerance approach to Methicillin-resistant Staphylococcus Aureus (MRSA).
- The CCG continue a programme of 6 protected learning time meetings for GPs, which have a strong focus on clinical quality and strong engagement from secondary care clinicians. The newly reformed practice nurse forum has been supported to develop over the last year via these events.

Safeguarding In Rotherham

We are dedicated to ensuring that safeguarding is everyone's business; we are committed to developing our commissioning responsibilities to ensure that all Rotherham residents are safeguarded. We remain an active partner in preventing and protecting the public from abuse and/or neglect.

We regard safeguarding the public as a primary responsibility of all the healthcare agencies we commission. Our contracts contain a raft of comprehensive up to date safeguarding standards and we monitor their compliance regularly. We work with the Safeguarding Children and Adults Boards to ensure that performance and quality monitoring, self-assessment and peer challenge are part of our commitment to being a critical friend. As a critical friend we work well with partner organisations developing a raft of measures aimed at enabling all Rotherham residents to live lives that are free from violence, harassment, humiliation and degradation. We diligently ensure that safeguarding lessons are learnt from inspections, reviews and reports both local and national. This has included us reviewing and strengthening our commitment to all vulnerable clients irrespective of age, gender or ability.

These inspections and reviews include partner reports, for example the on-going Ofsted Inspections into RMBC, our Chief Officer and Chief Nurse remain active partners on the Rotherham Children and Young People's Improvement Board. This ensures that safeguarding services to Rotherham people continue to improve in a robust and transparent manner as partners are committed to scrutinising the developments.

Rotherham's Multi-Agency Safeguarding Hub (MASH) goes from strength to strength. Having an effective MASH is critical to effective working relationships but can be a practical challenge for diverse health providers namely TRFT, RDaSH and Care UK and commissioners. There is a need for to continue to professionally challenge one another whilst keeping the person at the centre of all we do. Sharing sensitive information in an accessible form is where high functioning MASHs excel. Rotherham residents expect the right care at the right time by the right person; this is what the MASH strive to provide.

2016 saw the completion of the safeguarding self-assessment for GP practices across the Borough. The self-assessment was part of a package of safeguarding templates provided to independent practices to raise awareness and develop safeguarding competencies which incorporated CQC Essential Standard Outcome 7 (Safeguarding) and Section 11 of the Children's Act, Prevent and Mental Capacity Act 2005. Moving this forward into 2017/18 the CCG will undertake a similar format with all 31 GP practices looking at our response to victims of domestic abuse.

The Care Act 2014 (implemented April 2015) remains in its infancy and continues to be embedded into healthcare practice with its statutory roles along with the 'Making Safeguarding Personal Agenda'. The categories of Self-Neglect and Modern Slavery continue to develop alongside case law and are proving somewhat challenging both locally and nationally.

The Mental Capacity Act (MCA) 2005 including the House of Lords Select Committee (March 2014) findings along with the Deprivation of Liberty Safeguards (DoLS), Deprivation of Liberty (DoL) with the Supreme Court Judgement (March 2014) are fundamental safeguards for human rights. Both rulings continue to be a challenge on the health sector; TRFT have continued to embed MCA into routine practice as directed by their CQC inspections.

October 2015, saw the introduction of mandatory reporting for regulated healthcare professionals to report any concerns they have about Female Genital Mutilation (FGM) for any female under the age of 18 years when identified. FGM can provide long-term and devastating health consequences and therefore identification is critical. FGM is against the law in the UK and has been a criminal offence since 1985. It carries a penalty of 14 years imprisonment and/or fine. It is also an offence to make arrangements for FGM to be undertaken within the UK or to take, or plan to take a child out of the UK for the purpose of FGM.

In conclusion, we firmly believe that safeguarding is a responsibility for all of us and is forthright in working closely with statutory and voluntary partners to ensure that Rotherham is a safe place to live, work, play, grow up and grow old in.

Listening to our patients - Comments and Complaints

During the year NHS Rotherham CCG has received 25 formal complaints. We aim to ensure that all complaints are used positively as a learning opportunity and will ensure that the patient or carer is not detrimentally treated as a result of lodging a complaint, whilst being fair and supportive to staff. We will ensure that we will work with the complainant on a customer and person centred, responsive and timely basis, in accordance with our values: clinical leadership; putting people first; ensuring that patient and public views impact on the decisions we make; working in partnership; continuously improving quality of care whilst ensuring value for money; showing compassion, respect and dignity; listening and learning; taking responsibility and being accountable, with a view to addressing and resolving the complaint at the earliest possible opportunity. We work with all providers of NHS Services to ensure that a similar customer focussed approach is taken to complaint handling.

During the year, we received 25 formal complaints. Of these, 13 related to matters around continuing healthcare i.e. lack of communication, dissatisfaction with decisions and continuing Healthcare/retrospective processes. Two related to the relocation of a service; two funding decisions; two related to dissatisfaction with the out of hours service; one prescribing issue; three were regarding dissatisfaction with care and treatment/service delivery, and one related to diagnosis by the out-of-hours service; one related to obtaining personal information.

Principles for Remedy

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

Engaging with our community – A duty to Involve

Acknowledgements

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

Introduction

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

All CCGs have a legal duty to ‘make arrangements’ to involve the public in the commissioning of services for NHS patients (‘the public involvement duty’), outlined in Section 14Z2 of the 2012 Act. To fulfil the public involvement duty, the arrangements must provide for the public to be involved in:-

- (a) the planning of services,
- (b) the development and consideration of proposals for changes which, if implemented, would have an impact on services and
- (c) decisions which, when implemented, would have an impact on services.

The Importance of Engagement

Since 2009, NHS organisations have had a duty to report to the public about on all engagement and consultation activities which have helped to shape the services bought (commissioned) on behalf of local people. This is the Duty to Report (Section 24A of the NHS Act 2006). This could be work we have carried out, or it could have been completed by partner organisations and used to inform the decisions the CCG has made. To meet the criteria within the ‘Duty to report’, we need to include a lot of detail, such as the information that was sent out to people, the range of views expressed, and how the feedback has influenced decisions. We have included in this report which covers engagement activities between April 1st 2016 and 31st March 2017, an overview of our work. However, our engagement and involvement work is not just about meeting our statutory duties, our aim is to put patients and the public at the heart of our work. By listening to local people and those who represent them, we can improve the decisions we make, and make sure we are considering the health needs of Rotherham residents. We want to continuously improve and develop how we engage with our communities. We want people to see what we have done; how their feedback helped to shape local services and just how much we value all feedback and engagement. How we do this is set out in our Communication and Engagement Plan, and our values are outlined in our [constitution](#).

A Wealth of Information

The NHS has access to a wealth of information to support and inform engagement

- The Joint Services Needs Assessment (JSNA) is produced by public health and gives all organisations in Rotherham information about the health needs of the population. This helps us to target communities and interest groups.
- A number of national surveys are published annually, for example the Inpatient Survey and GP Survey. We analyse and report internally and externally on the findings within these; they can be very useful in highlighting areas that we need to consider more closely
- We use a range of data from stakeholders and providers, patient experience, Patient Reported Outcomes (PROMS); complaints and comments where these are routinely shared; as well information demonstrating how patients use services and associated demographics
- Friends and Family Test – this is used extensively in both secondary and primary care. We report monthly to Governing Body on the amount of feedback we receive from providers- thus ensuring the data is robust enough to be meaningful. We consider the positivity of the feedback, and look for exceptions to national averages. In addition, where we receive free text comments through our providers, we look at this, to identify themes and trends, and what actions have been taken by providers to address issues raised.
- We monitor informal social media (such as Twitter and Facebook); responding and acting where appropriate, also using these mechanisms for fast feedback to simple questions- as in our work on paracetamol prescribing. In addition we monitor more formal patient feedback sites such as NHS Choices and Patient Opinion, responding where appropriate and encouraging our providers to reply as needed. This type of feedback again enables us to identify themes and local concerns.
- Healthwatch collects a significant amount of data and feedback, both electronically, and through events and drop-ins; which is shared with us. In addition, Healthwatch pro-actively seek data as and when needed to inform campaigns and consultations

Structures, Governance and Assurance

We make the aims and values set out in the plan real in the following ways:-

- Governing Body – our Governing Body lay member with responsibility for patient and public involvement has a remit to support and challenge our work in this important area. Governing Body meetings are held in public and those attending are given the opportunity to ask questions.
- Communication and Engagement Governing Body Sub-Committee includes representatives from the voluntary sector and Healthwatch, and allows open discussion of our plans, and challenge to ensure we meet statutory requirements and our aims and values. It ensures that the CCG has the space and the expertise to plan, monitor and evaluate its communications and engagement activity. Details of the committee are provided in the Annual Governance Statement.
- Monthly reports to Governing Body share an overview of current patient experience, and key engagement activity.
- Engagement Mapping – we have a system to record and capture all the work we do with patients, the public and stakeholders, and use this to identify gaps and priorities.

Engagement and Communications Governing Body Sub-committee

The Committee meets every other month to discuss topics relevant to the CCG and the services it commissions, as well as local and wider NHS issues, consultations and other engagement. It includes representation from Healthwatch, VAR and Health Scrutiny, and offers challenge and assurance to the CCG.

Patient Participation Groups Network

All practices are invited to send representation. The aims are

- To share information and offer support in terms of developing effective patient groups
- To consider cross practice issues
- To inform and impact CCG plans and initiatives

Rotherham Wide Networks and 'Umbrella' groups

Forums, networks (ROPF, Parents Forum, Carer Forums; REMA- among others)

Practice based participation groups

As part of their core contracts, all GP practices should have some form of patient group

Community based groups

Health interest groups

Partners & Stakeholders Members
i.e. Rdash, Healthwatch, Rotherham Hospital

Patients - primary care

Patients - secondary care

Patients - mental health

General public

Carers

How to get Involved

There are lots of ways that people can be involved, informed and represented through:

- **Patient Participation Groups (PPGs)** - Each GP practice must, as part of their core contract, set up a patient participation, or reference group. These should meet regularly, and look at patient feedback, working with the practice on an action plan to address the issues patients raise. These groups should be representative of the practice population in their makeup.
- **The Patient Participation Group (PPG) Network** links local PPGs and the CCG, and meets quarterly. Over the last year, the network has considered and influenced the following issues (details below)
 - **June 2016** – Social prescribing and prescribing of low cost medication
 - **September 2016** - Clinical thresholds
 - **December 2016** – Integrated locality and self-care
 - **March 2017**- Urgent and Emergency Care Centre update, and input to communication about opening and use
- **Healthwatch Rotherham** - an independent organisation representing the views of local people across health and care.
- **Reader group** - a number of people have offered to read drafts of papers and offer their views – this includes everything from the Commissioning Plan to public leaflets. During 2016/17, the group has considered materials for regional projects as well as Rotherham specific materials, and everything from letters to patient leaflets
- **Public events and engagement activities** – where anyone can find out more about the work of the CCG, meet staff, and have their say.
- **NHS Choices or Patient Opinion** – anyone can access these sites and leave feedback on health services they have experienced. The CCG responds where appropriate, and encourages our providers to also respond and act on the information.
- **Lay PPI Chair** – Represents the patient voice at the Governing Body, and various committees and workstreams
- **GP clinical lead** – Provides clinical overview and represents the patient voice at the Strategic Clinical Executive.
- **'Get Involved' section of the CCG's website** – a range of information and resources, including open and recent consultations, and forthcoming events and opportunities for people to get involved.
- **Focus groups and formal and informal consultations** – relating to specific workstreams as needed. We pride ourselves on our approach to using different and innovative mechanisms for engagement, and in the past have used song, poetry, cartoons and drama to add depth and interest to our activities. We have developed interest in capacity through working with a number of community groups on engagement projects
- **Formal consultations** - where appropriate, we undertake formal consultations, advertising these widely both on our website and through a variety of electronic and paper based media

Case study June/July 2016

Launch of 'Genuine Partnerships'. This is the new national face of Rotherham Charter, and the work led by Rotherham Parents Forum. They are seen to be leading the field nationally, and have presented this model to national partners. Much of the focus is to ensure meaningful engagement with young people and families. Key points are excellent training sessions, and a free online self-assessment tool.

Equality and Diversity

Promoting equality and human rights is one of the cornerstones of all of NHS Rotherham CCG's functions and activities, as an employer and commissioner. This will be applied by ensuring that the CCG has an ongoing programme of equality work, covering all our functions.

The CCG has a strong commitment to engagement and understands the need to reach out to communities and individuals whose voice may be otherwise unheard. Our engagement is targeted in two ways, against our commissioning priorities, and against the nine protected characteristics in all the work we do. We have a robust process to record all our engagement activity, ensuring we identify and address priorities and gaps. Below are examples of some of our work:

- Age - We acknowledge that older people are more likely to use services, and have worked in partnership with Rotherham Older People's Forum, who has carried out surveys and consultations. We also worked with young people to design and produce information they told us they needed.
- Disability – Jointly with RMBC we have commissioned a user led accessibility audit of 1000 buildings and services in Rotherham, including health services. Our social prescribing service links patients with voluntary organisations, it was developed from community discussions, and is valued by patients.
- Gender - We have met with targeted groups for example women from South Asian backgrounds, to both deliver messages and to hear their specific concerns and issues.
- Race – Where possible, we audit patient feedback (for example, Friends and Family Test data) by race, to identify any difference in experience.
- Sexual Orientation - We have strong links with local Lesbian, Gay, Bi-sexual and Transgender (LGBT) groups, and aim to ensure people are involved in any consultation work we complete, as well as listening to this overlooked community.
- Pregnancy and Maternity - We are working with a community organisation who are leading on developing a perinatal mental health support group, and a major consultation
- Gender Reassignment – Our Medicines Management Team are working proactively with a transgender group to look at medication in primary care and access to services.

The Equality Act 2010 brought with it Public Sector Equality Duties. Public bodies are required to declare their compliance with the duties on an annual basis.

Information on the CCG's Public Sector Equality Duties can be viewed on the website – [Equality and Diversity](#)

The CCG has a proven track record of working with a variety of statutory and voluntary sector partners to ensure the best value possible engagement with our communities; we fundamentally believe that our community partners are the key to ensuring that all voices can be heard. Much of this work takes the form of engagement, rather than formal consultation. Below are just some examples:

- Healthwatch - We have jointly funded and planned engagement events and activities, and share information. The CCG acknowledges and values the 'ear to the ground' that Healthwatch provides, using patient experiences and stories to influence and inform its work – these are often shared at Governing Body, bringing the patient voice into the room. Healthwatch have also produced a user led guide to mental health services, which the CCG has supported in terms of print and distribution to primary care, where it has been very well received.

- Voluntary Action Rotherham support a number of volunteer health ambassadors; these individuals reach out into the community to deliver key health messages and engage with people where they are
- We work with a range of community organisations for engagement and consultation; occasionally using small incentives or service level agreements
 - We have worked with Rotherham Ethnic Minority Alliance (REMA) to take messages into BME communities (around prescription changes); as well reaching into these communities to hear people's concerns
 - Rotherham Older People's Forum and Rotherham Carer's Forum have both supported consultations, actively seeking responses
 - GROW have carried out several pieces of engagement work around maternity services.
 - Rotherham Parents Forum have lead engagement around several issues, co-producing materials and activity, designing questions and consultations on subjects important to both their parent and child members, as well as the CCG, and carrying out electronic surveys. In addition the Parents Forum has contributed substantially to the development of the Autistic Spectrum Disorder support service.
- Rotherham Council has led wide engagement on an autism strategy; ensuring that people with autism and their families are at the heart of this work
- Medicines management have made connections with a local transgender group to hear concerns and discuss feedback on access to specific medications and clinics. Work to resolve these issues is ongoing; and will contribute to a South Yorkshire shared protocol on prescribing hormones for transgender patients.
- Extensive work with medicines management team to take messages into community groups around 3rd party ordering; targeting those most likely to be impacted or to need support
 - Approximately 120 contacts through nine community groups and networks, targeting older people and BME communities
 - Key themes have been:-
 - the request for those present to further disseminate the information
 - addressing misinformation - for example that chemists will still be able to deliver medication
 - that staff have been working proactively with practices to identify vulnerable patients and seek solutions
 - promotion of online mechanisms
 - Issue and contact log established to record all activity.

Disabled Employees

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

Engagement in Procurement

Regionally, patients have been part of the re-procurement of non-emergency patient transport services. Communication and engagement leads had key involvement in the scoring of the tender bids with outcomes being available on a regional basis once the contract has been awarded.

Meeting the Individual Participation Duty

As well as ensuring that collective engagement and involvement takes place, the CCG has a duty to support patients and to enable people to feel in control of their own health and the choices they make when it comes to the care and treatment they receive. This means making sure that information, tools and support are available so that patients can make informed decisions about their care. The priorities for the CCG around the individual duty, and some of the ways that we meet them are:-

- Self-Management - the CCG is very committed to our social prescribing programme, working with the voluntary and community sectors. This programme firmly puts people with long term conditions in control of their own mental and physical health and wellbeing.
- Shared decision making - the CCG has worked extensively with clinicians to produce clinical pathways; these ensure parity of treatment for patients, and that best practice is integral to all. In addition, the pathways (locally called 'top tips') embed patient information and provide a solid format for shared decision making. They are available on the CCG website.
- Personalised care planning and health budgets – the CCG is working to involve patients and carers through feedback, but also through a user led support mechanism, via 'Active Independence'. Currently this group is leading on planning an event to recruit and inform personal assistants, which those involved have highlighted as a real concern.

Patient Engagement Activity

When?	June – October 2016
What were people asked for the views on?	Over the counter medications on prescription. People were asked if a number of cheap and commonly available medications should be available on prescription or not. These included paracetamol, ibuprofen and emollient creams, among others.
Who was consulted?	A wide range of community groups and organisation targeted specifically through direct contact; in addition the CCG attended a variety of community events. In addition, both the CCG and Healthwatch carried out online and social media based questionnaires, in addition to the group and 1:1 discussions.
What information was given to people?	Cost of prescribing these items was shared with respondents.
Feedback summary	Most of the responders felt for most of the medications, that they should not be routinely available on prescription All groups mentioned in some way that the needs of the most vulnerable would need to be met; those with limited mobility or in chronic pain. There was some confusion over creams (emollients); with people confusing a basic moisturiser for a cream for broken skin. It was also noted from public feedback that where care workers administer paracetamol or other medication, they can only do so when this is prescribed
Decisions taken	These items will not be prescribed, taking the issues above into account.
How were views taken into account/what changed/was done differently?	Language used will clarify the issues around creams and moisturisers, and the issue around care workers has been acknowledged and addressed

When?	2015-September 2016
What were people asked for the views on?	Clinical Thresholds A variety of discussions took place over the period, as a range of clinical thresholds were developed. The Patient Participation Groups Network considered all thresholds in considerable detail in September 2016; working in small groups with support from clinicians and senior managers. This enabled the groups to look at the pathway and criteria for separate thresholds, and feedback in some detail; giving more useful feedback and informed debate than a survey would have provided.
Who was consulted?	Members of the public and patients were introduced to the idea as an initial concept in 2015; which continued to be debated and shaped through various stakeholder and clinical bodies. In 2016, a variety of groups debated the issue as part of the 'NHS Financial Challenge', ranging from a young people's group to carers, and patient groups. In addition, more detail was also presented and discussed at the AGM in July 2016. Patient groups debated this in September 2016.
What information was given to people?	This was an iterative process, materials were developed over the course of the workstream, with changes made in response to feedback on a regular basis.
Feedback summary	Feedback from groups varied, with some much stronger than others on the need to implement clinical thresholds. Concern was expressed on access to alternatives to surgery (ie weight loss and physiotherapy); this was taken on board. In addition there was concern for those in exceptional circumstances.
Decisions taken	The clinical thresholds were implemented in December 2016.
How were views taken into account/what changed/was done differently?	Individual Funding Requests can be made for each of the thresholds, for those in exceptional circumstances. One patient group identified an anomaly between two thresholds; this has now been addressed. The CCG continues to actively monitor a variety of channels for comments and feedback on the impact of implementation of clinical thresholds.

Consultations

Name of consultation
RDaSH Rotherham Care Group Transformation
Dates and timescales
The transformation programme was launched in July 2015 with a whole system event, supported by targeted activity such as patient / carer forums and visits to each GP locality. The outcomes formed the basis for proposals agreed through CCG, RMBC Scrutiny Committee, RDaSH governance. 2016/17 has focussed on development and approval of proposals and the first phase of implementation: <ul style="list-style-type: none"> i. Care Group formation – move from business divisions to place base focus ii. Development of new models of care: new pathway framework and formulation process, to be co-produced individually with patients (drafted, about to go through

- governance)
- iii. Service configuration: appointment of new leadership team completed, new service model approved, to be rolled out in 2017-18

The programme will be completed in March 2018

Who was consulted?

Since the launch in July 2015 over 1,000 people have been involved in a range of activity:

- i. 35 events, including whole system events, including patients, carers, commissioners, health and social care professionals and the voluntary and community sector
- ii. 19 engagement events in 2016/17 involving 375 people, including the general public e.g. at Rotherham show
- iii. targeted events including specific patient and carer events e.g. the Acute Care Forum, Alzheimer's society etc.
- iv. Visits to GP localities
- v. One to ones with difficult to engage groups e.g. REMA/ Apnahaq
- vi. The Care Group Director chairs a patient and carers implementation forum with patients and carers and Healthwatch

In addition to this there was further engagement by the Trust through the Trust engagement mechanisms and LiA big conversations

The issues or proposals which people have been asked to give their views about.

People were given the scenario that we wanted to improve services, including a more integrated whole system approach at less cost and were invited to comment. Key issues were:

- Care closer to home, easy to access including geographic accessibility
- Care that's tailored to patients' needs, rather than a service based approach
- Referral to the right part of the system, not being passed around

Information made available to people during a consultation.

As is services and design of to be, shared proposals for comment e.g. pathway framework, service configuration, options

A summary of the feedback obtained or received and the range of views expressed by different people.

See above. there has been broad support for proposals, particularly in relation to health and wellbeing strategy to provide brief interventions including working with the VCS to provide more bridging at the front end of services, to prevent people being brought into service who don't need to be and to support effective discharge.

Commissioning decisions and relevant decisions taken by the CCG following the consultation.

Approval to proceed on transformation plans
Hospital liaison re-commissioning / Core 24 bid included positive feedback from stakeholders
Extension of social prescribing pilot (criteria)

So what?

More integrated approach has facilitated decision making across primary health, MH and social care

Examples: development of plans for Ferns pilot, care co-ordination centre, integrated rapid

response, all still in development and to be approve

See above for what we are planning in relation to the feedback

Name of consultation
<ul style="list-style-type: none">• Consultation to change hyper acute stroke services in South Yorkshire, Bassetlaw and North Derbyshire• Consultation to change children's surgery and anaesthesia services in South and Mid Yorkshire, Bassetlaw and North Derbyshire
Dates and timescales
Both consultations launched on 3 October 2016 and ran until 14 February 2017. A decision on the future of both services will be taken at the Joint Committee of Clinical Commissioning Groups (made up of the partners in Commissioners Working Together) on 24 May 2017.
Who was consulted?
<p>The public and stakeholders within South Yorkshire, Bassetlaw and North Derbyshire were consulted. Residents of Wakefield were not consulted as the proposed changes, if they went ahead, would not adversely impact on its population. The Wakefield Health and Overview Scrutiny Committee agreed with this approach.</p> <p>All people living in Barnsley, Bassetlaw, Chesterfield, Doncaster, North Derbyshire, Rotherham and Sheffield were given the opportunity to have their say.</p> <p>A total of 1,109 responses were received for the consultation to change hyper acute stroke services and 1,268 responses for the consultation to change children's surgery and anaesthesia services.</p> <p>A full breakdown of the respondent profile, with all demographics is available in the consultation analysis. This is available on the Commissioners Working Together website. The link is http://bit.ly/consultationanalysis</p>
The issues or proposals which people have been asked to give their views about.
<p>Hyper acute stroke services</p> <p>As one of the partners in Commissioners Working Together, we proposed to improve the experience of patients needing stroke care in Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham and Sheffield. There was one proposal on which we sought views - to have three hyper acute stroke service centres in Chesterfield Royal Hospital, Doncaster Royal Infirmary and The Royal Hallamshire Hospital, Sheffield. Hyper acute stroke services are where people are cared for up to the first 72 hours after having a stroke when they need more specialist 'critical' care.</p> <p>Our proposal meant that Barnsley and Rotherham hospitals would no longer provide hyper acute care for people who have had a stroke. For residents of these towns who have a stroke, after the first 72 hours of receiving critical care and if they are well enough, they would be transferred back to Barnsley or Rotherham hospital for the remainder of their care. We were not proposing to make changes to 'acute' stroke care, which is care received after the first 72 hours until people go home from hospital and this will still be provided in all our local hospitals. Rehabilitation services, such as speech and language and physiotherapies, which help people to get better once they leave hospital, would also still be provided closer to where people live.</p> <p>Children's surgery and anaesthesia services</p> <p>As partners in Commissioners Working Together, we proposed to change a small number of services to improve the care of children needing operations in Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham, Sheffield and Wakefield. The proposal was for children who need an operation under general anaesthetic (where they are sent to sleep) at night, at a</p>

weekend or where they need to stay in hospital overnight. This was for the following services only - ear, nose and throat (ENT), general surgery (for conditions usually of the abdomen/tummy – e.g. appendicitis), ophthalmology (for any condition of the eyes), oral surgery (for any condition of the mouth or teeth), orthopaedics (for any condition of the bones, muscles, nerves etc.) and urology (for any condition of the groin, genitals or bladder).

We recommended three options for the future of children's surgery and anaesthesia services, with one preferred option (option 2). They were:

Option 1: Surgery on children at night, on a weekend or where they need an overnight stay at Chesterfield Royal Hospital, Doncaster Royal Infirmary, Pinderfields General Hospital in Wakefield and Sheffield Children's Hospital

Option 2: Surgery on children at night, on a weekend or where they need an overnight stay at Doncaster Royal Infirmary, Pinderfields General Hospital in Wakefield and Sheffield Children's Hospital

Option 3: Surgery on children at night, on a weekend or where they need an overnight stay at Pinderfields General Hospital in Wakefield and Sheffield Children's Hospital

Based on our review of current treatments at all our hospitals, we expected that the number of children affected by the proposed changes in each would be very small compared to the overall number of children needing an operation in South and Mid Yorkshire, Bassetlaw and North Derbyshire. For all options, children would be taken to the next nearest hospital.

Information made available to people during a consultation.

People were able to read or hear the information within the paper and online consultation document and questionnaires and audio/visual versions of the consultation proposals were made available. There were no requests for translations into additional languages. Easy read versions of the document and survey were also available but none returned.

In addition, a range of background information to the consultation was made available, including:

- Pre-engagement reports, including the Equality Impact Assessment
- Pre-consultation business case
- Pre-consultation communications and engagement report
- Communications and engagement strategy and plans
- Strategic cases for change
- Consultation mandate
- Health needs assessment
- Responses from the Yorkshire and Humber Clinical Senate
- Consultation documents, including easy read versions
- Ambulance service travel times
- Travel impact analysis
- Yorkshire and Humber Clinical Network 'blueprint' for hyper acute stroke services
- Royal College of Surgeons – Standards for Children's Surgery

All materials can be found on the Commissioners Working Together website:

For hyper acute stroke services: <http://www.smybndccgs.nhs.uk/what-we-do/critical-care-stroke-patients>

For children's surgery and anaesthesia services: <http://www.smybndccgs.nhs.uk/what-we-do/childrens-surgery>

A summary of the feedback obtained or received and the range of views expressed by different people.

Hyper acute stroke services

There was a mixed response to the three centre option. 54% of self-selecting consultation survey respondents disagreed with this option and 50% of telephone survey responses agreed

with it.

The patterns of agreement were similar across both survey channels – a) paper and online survey (self-selecting responses) and b) telephone survey (taking a random representative sample of the population) - except for Bassetlaw, Sheffield and Wakefield where the majority of self-selecting consultation survey respondents disagreed with the three centre option compared to the telephone survey respondents in those areas. There were high levels of support for the three centre option in Doncaster and North Derbyshire and Hardwick (which cover hospitals where the hyper acute stroke services are being proposed). There was low level of support for this option in the Barnsley CCG area.

Where people disagreed, themes were:

- Not being able to access high quality care quickly and patient safety
- Social impact
- Other concerns (lack of funding for the NHS, wish to have a centre in local area so could access high quality care, additional pressure on the ambulance service)

Where people agreed, themes were:

- Quick and easy access to high quality care
- Better quality of care and improved health outcomes
- More effective allocation of resources
- Other comments (support for Chesterfield to be one of the three centres, positive personal experiences at the Royal Hallamshire Hospital and a small number of respondents said they trusted the commissioners to make the right decision)

A number of respondents felt they could not comment on the proposed changes (especially from the telephone survey where respondents had been less likely to have been aware of the consultation or have read the consultation document).

Alternative suggestions - Almost half of the consultation survey respondents had alternative suggestions to make. The majority were making the case for Barnsley District General Hospital to have a hyper acute stroke unit to make sure that local people could have quick access to time-critical care. The other main suggestions were to have a hyper acute stroke unit in every hospital and to start investing in the right calibre of staff to make this happen.

Children's surgery and anaesthesia services

Respondents tended to agree with the proposed changes (63% of telephone survey respondents agree and 43% of self-selecting survey respondents agreed)

However, there were over a third of self-selecting respondents (39%) who disagreed with the proposals compared to 13% of randomly selected telephone survey respondents. There were higher levels of disagreement with the proposals from self-selecting consultation survey respondents. These responses tended to come from Barnsley, Bassetlaw, Wakefield, North Derbyshire and Hardwick.

Where people disagreed, themes were:

- Not being able to access high quality care closer to home
- Impact on patient outcomes and patient safety
- Other concerns (if staffing is an issue, this should not impact on patients and families, some people had had good experiences and could not see the need for change and some were sceptical about the motivation for change)

Where people agreed, themes were:

- Better quality of care and better health outcomes for children
- Fairer and equal access to the best services
- More effective allocation of resources
- Trust in NHS locally

A number of respondents felt they could not comment on the proposed changes (especially from the telephone survey where respondents had been less likely to have been aware of the consultation or have read the consultation document).

The options

- Almost one in four consultation survey respondents (23%) did not agree with any of the options
- 42% of consultation survey respondents supported option 1
- Telephone survey respondents 64% stated that option 2 was their preferred option
- The highest lack of support for these options came from consultation respondents in the Barnsley area
- The highest level of support for option 1 was from North Derbyshire

Alternative suggestions

People were also asked if there were other options they would like Commissioners Working Together to consider. The majority of people did not have alternative suggestions.

Of those who did, the key alternatives raised were:

- A plea to keep things as they are
- To have centres in all of the areas
- Keeping services at Barnsley District General Hospital (most commonly cited)
- Just have one place specialist children's hospital
- Isolated cases for services to be offered at Bassetlaw and Rotherham

Commissioning decisions and relevant decisions taken by the CCG following the consultation.

The Decision Making Business Case will be heard by the Joint Committee of Clinical Commissioning Groups on 24 May 2017 and is expected to make a decision. The feedback from the public and stakeholders forms a part of the business case and will be taken into account.

So what?

We will report on how people's views were taken into account on the Commissioners Working Together website in due course. We will also provide an update in next year's annual report.

Rotherham Council

The local authority runs a large number of formal consultations as well as informal engagement activity. All consultations are well documented on their website, in a format that complies with the legal duty to report on consultations. A number of these will have limited impact on health services; however below are listed a number of consultation which have most impact on health services

- Series of consultations on Children' Centres
http://www.rotherham.gov.uk/news/article/104/childrens_centre_consultation
- The future of Public Health Services – July – September 2016
http://www.rotherham.gov.uk/news/article/884/have_your_say_on_the_future_of_rotherham_public_health_services
- A formal consultation on intermediate care ran from April – May 2016
http://www.rotherham.gov.uk/news/article/874/future_of_netherfield_court_care_home_considered_as_part_of_adult_care_transformation
- Autism and learning disability
http://www.rotherham.gov.uk/news/article/1035/consultation_launched_on_learning_disability_and_autism_offer

Healthwatch

For Healthwatch Rotherham to be delivered effectively, local relationships with stakeholders are required to build legitimacy and influence impact. Healthwatch Rotherham has built positive cooperative working relationships with NHS Rotherham CCG.

Healthwatch Rotherham regularly attends the following CCG meetings; Patient, Public Experience and Communications Sub-Committee, Primary Care Sub-Committee, PPG Network and CAMHS Transformation Plan.

Healthwatch Rotherham has also presented at the CCG governing body. Information is provided monthly to the CCG to help support the public engagement papers for the Governing body.

In October, the CCG supported Healthwatch by attending the Older People Summit. They had a listening table, where members of the public were able to attend and speak to the Accountable Officer. This was very well received by those attending.

The two organisations are working together with Voluntary Action Rotherham to provide information sharing events around the Sustainability and Transformation Plan. Work will also be taking place soon around engagement with the integrated locality.

In conjunction with the CCG, Healthwatch Rotherham performed a quick survey around prescriptions and if certain items should be included on prescription. The results of the survey fed into the Rotherham NHS CCG decision making on this topic.

Healthwatch Rotherham identified that no (statutory) autism strategy was in place for Rotherham and are working with RMBC and the CCG on the Autism All Age Strategy working group.

We have welcomed the contribution; advice and support the CCG have given us in terms of producing a health directory guide. This has allowed us to produce information in a guide and at the same time help the CCG send out messages such as Right Care, First Time.

Future Plans

During 2017, our engagement work will focus on regional work on the STP, and work with partners to develop elements of Rotherham Place Plan. Working with partners, we want to ensure that as the STP develops, our patients and communities are included in a meaningful and informed manner.

Elements of work on the Rotherham Place Plan will include:-

- Continued engagement and information giving around the Urgent and Emergency Care Centre, as this major initiative opens.
- The development and implementation of a communications and engagement plan for the integrated locality work. This is likely to include elements around
 - Management of long term conditions
 - The role of the community physician
 - Mental health in the integrated locality
 - Social care services and the impact on health
 - Supporting discharge
- Should funding become available for the re-ablement hub, we would carry out a major piece of work around this.

We will continue to look at clinical thresholds with patients and the public, and how we ensure value for the services we provide. In addition, we anticipate that there will be cross-region work, with key work streams focusing on maternity services and children's services.

However, we also will continue to engage with patients as we do now, linking with a variety of groups and organisations who offer a voice to those experiencing barriers; developing

engagement with GP practices and supporting PPGs, and working collaboratively wherever we can.

Looking after Personal Information

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

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

- The following information governance policies have been reviewed, updated and approved:
 - Information Governance Policy and Management Framework
 - Data Protection and Access to Health Records Policy
 - Information Risk Policy
 - Internet Acceptable Use Policy
 - Safe Haven Policy
 - Records Management Policy
- The Information Asset Risk Management Plan and Confidentiality Audit Procedure have been reviewed and updated
- The Information Asset Register has been thoroughly updated
- An exercise has been carried out to validate the Information Asset register, which has identified new data flows
- All key information assets have been risk assessed and the results have been reported to the Senior Information Risk Owner (SIRO)
- An information governance compliance spot check has been carried out to provide assurance that CCG staff are compliant with national and local information governance requirements. This year's audit included a review of physical storage for the first time.
- A confidentiality audit has been carried out on shared network drives of the CCG
- All known data flows have been mapped and the legal basis for the lawful sharing of information has been documented and risk assessed alongside the security of the transfer
- A new Information Security Policy has been drafted
- A Cyber Security Audit has been carried out and a specific cyber security action plan has been introduced
- Cyber security awareness training has been provided for all staff
- The CCG has been accepted as an early adopter for NHS Digital's Care Cert Assure programme.

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

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

In 2016/17 our Information Governance Toolkit submission received an overall score of [satisfactory](#).

Information Governance Serious Incidents

We reported no Serious Incidents (SIs) relating to information governance in 2016/17.

Emergency Preparedness, Resilience and Response

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

Fraud

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

Health and Safety

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

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

Chris Edwards
Accountable Officer

SECTION 2 - ACCOUNTABILITY REPORT

CORPORATE GOVERNANCE REPORT

Members' (Directors) Report

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

Member Practices

All 31 Rotherham GP practices are members of the CCG. Eight GPs, nominated by individual localities areas, sit on a GP Members Committee. This is responsible for two-way communication and engagement with all 150 GPs in Rotherham.

The names of the 31 member practices can be viewed on our website – [member practices](#).

Details of Directors - Who's Who

Governing Body

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

Composition of Governing Body

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

Name	Role
Dr Julie Kitlowski	Chair
John Barber	Lay Member for Governance, Finance and Audit – Vice Chair
Chris Edwards	Chief officer (Accountable officer)
Ian Atkinson	Deputy Chief Officer and Senior Information Risk Officer (SIRO)
Dr Geoff Avery	Chair of GP Members Committee
Dr Richard Cullen	Vice Chair of Strategic Clinical Executive
Dr Simon Mackeown	Vice Chair of GP Members Committee
Dr Robin Carlisle	Lay Member Primary Care
Sue Cassin	Chief Nurse and Caldicott Guardian
Keely Firth	Chief Finance Officer
Philip Moss – to 30 th November 2016	Lay Member for Patient and public Engagement
Kathryn Henderson – from 11 th January 2017	Lay Member for Patient and public Engagement
Dr Anthony Darby	Secondary Care Doctor
Dr Jason Page	Independent GP on Governing Body
Sarah Whittle (In attendance) – to 31 st July	Assistant Chief Officer and Governing

2016	Body Secretary
Ruth Nutbrown (In attendance) – from 1 st August 2016	Assistant Chief Officer and Governing Body Secretary

Register of Interests of the Governing Body and Senior Officers

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

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

Name	Interest Declared
Dr Julie Kitlowski	<ul style="list-style-type: none"> • St Ann's is part of the Integrated Team pilot "The Village" • Close relative is a Sunovion Drug Representative • Relative is a MSD Drug Representative
John Barber	<ul style="list-style-type: none"> • Interim management role, East Midlands Ambulance Trust. • Wickersley Parish Councillor. • Voluntary work with Closer Healthcare, Beverley.
Dr Anthony Darby	<ul style="list-style-type: none"> • Consultant Physician at Chesterfield Royal Hospital • Attends meetings at Hardwick and North Derbyshire CCG about respiratory work • Spouse is employed by Weston Park Hospital
Dr Robin Carlisle	<ul style="list-style-type: none"> • Nil
Sue Cassin	<ul style="list-style-type: none"> • Nil
Dr Richard Cullen	<ul style="list-style-type: none"> • Member of the Labour Party • Spouse is a member of the Labour Party
Chris Edwards	<ul style="list-style-type: none"> • Family member is employed by NHS England • Family member is employed by Sheffield NHS Teaching Hospitals to end 01/04/2017 • Patron of Rotherham Holiday Aid. • Family member employed by Attain to start 01/04/2017
Ian Atkinson	<ul style="list-style-type: none"> • Family member is employed at The Rotherham NHS Foundation Trust as a Community Occupational Therapist. • Spouse is employed in a senior administration role within Sheffield Teaching Hospitals • Self and immediate family is registered with a Rotherham GP practice.
Keely Firth	<ul style="list-style-type: none"> • Two family members work for eMBED, provider of business intelligence services. • Non-Executive Director at Barnsley Hospital NHS Foundation Trust • Volunteer Trustee of Healthcare Financial Management Association (HFMA).
Sarah Whittle – to 31 st July 2016	<ul style="list-style-type: none"> • CCG Advisor for Voluntary Action Rotherham (VAR) • Sits on VAR's Board as a non-voting

Name	Interest Declared
Dr Geoff Avery	<ul style="list-style-type: none"> • LLP Local Representative • Part owner in the GP Practice in-house pharmacy • Spouse is a midwife at The Rotherham NHS Foundation Trust • Close relative is a F1 Doctor in Withenshaw • Close relative is the Dean of the Nottingham Medical School • Chair of Stoddart Trust (chair)
Dr Simon Mackeown	<ul style="list-style-type: none"> • GP practice holds an intermediate care contract for locality working. • Spouse and close relative are employed by Sheffield NHS Teaching Hospitals. • Hospital Practitioner employed by Rotherham Hospice.
Philip Moss to 30th November 2016	<ul style="list-style-type: none"> • Member of the Labour Party
Kathryn Henderson from 11 th January 2017	<ul style="list-style-type: none"> • Director of Henderson Healthcare Consultancy Ltd • Former trustee and Chair at Bluebell Wood Children's Hospice • Occasional voluntary work at Bluebell Wood Children's Hospice
Dr Jason Page	<ul style="list-style-type: none"> • Part of Rotherham Primary Care LLP • Spouse is a Paediatric Training Doctor

Pension Liabilities

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

Committees of the Governing Body

Strategic Clinical Executive

The Strategic Clinical Executive (SCE) comprises nine Rotherham GPs and CCG executive officers. It meets weekly to direct work on commissioning activities.

Members

Dr Julie Kitlowski – Chair
 Dr Richard Cullen – Vice Chair
 Dr Jason Page
 Dr Avanthi Gunesakera
 Dr Phil Birks
 Dr David Clitherow
 Dr Anand Barmade
 Dr Russell Brynes

Register of Interest of the Strategic Clinical Executive

The register of interests declared by the GP Members Committee can be viewed on the [NHS Rotherham CCG public website](#).

GP Members Committee

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

It is representative of all of the GP Practices in Rotherham and is mandated by them. It makes sure that practices are linked into wider commissioning decisions. A full list of our 31 member practices is available in our [constitution](#). The committee's key role is to provide a reference point for all commissioning developments, support the GPs on the SCE and to hold the SCE to account for its commissioning activities and agree the annual plan.

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

Members

Dr Geoff Avery – Chair-Maltby/Wickersley (Blyth Road Practice)
Dr Simon Mackeown - Vice-Chair/ Health Village (St Ann's Practice)
Dr Tariq Ahmed - Central 2 (Magna Group Practice) – Rotating attendance at the meeting
Dr Sophie Holden – Wath/Swinton (Market Surgery, Wath)
Dr Bipin Chandran - Rother Valley North (Treeton Medical Centre)
Dr Naresh Patel - Central North (Broom Lane Practice)
Dr Rob Evans - Rother Valley South (Swallownest Health Centre)
Dr Srinivasan - Wentworth South (York Road Surgery)

Register of Interest of GP Members Committee

The register of interests declared by the GP Members Committee can be viewed on the [NHS Rotherham CCG public website](#)

Audit and Quality Assurance Committee (AQuA)

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

The purpose of the committee is to gain assurance that:

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

The committee membership during 2016/17 was comprised of the two new lay members of the CCG and four GPs supported by representatives of both internal and external audit and senior CCG officers.

Name	Role
John Barber	Lay Member for Governance, Finance and Audit – Chair
Dr Geoff Avery	Chair of GP Members Committee
Dr Richard Cullen	GP on Strategic Clinical Executive
Dr Sophie Holden	GP on GP Members Committee
Philip Moss – to 30 th November 2016	Lay Member for Patient and Public Engagement
Kathryn Henderson – from 11 th January 2017	Lay Member for Patient and Public Engagement

There are standing invitations to attend the committee to:

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

In addition, other officers from within the organisation have been invited to attend where it was felt that to do so would assist in the effective fulfilment of the committee's responsibilities.

The register of interests declared by the AQUA committee can be viewed on the [NHS Rotherham CCG public website](#)

Primary Care Committee

The Primary Care Committee is a corporate decision making body and sub-committee of the Governing Body, meeting monthly in public, for the management of the delegated functions given by NHS England from 1st April 2015. It makes decisions on the review, planning and procurement of primary care services in Rotherham. The committee has delegated authority from the Governing Body to make decisions about primary care on its behalf.

Members of the Primary Care Committee

Name	Role
Robin Carlisle	Lay Member for Primary Care - Chair
John Barber	Lay Member for Governance, Remuneration, Conflicts of Interest and Audit – Vice Chair
Philip Moss to 30 th November 2016	Lay Member for Patient and public Engagement
Kathryn Henderson from 11 th January 2017	Lay Member for Patient and public Engagement
Chris Edwards	Chief Officer
Keely Firth	Chief Finance Officer
Sue Cassin	Chief Nurse

Jacqui Tuffnell	Head of Co-Commissioning
Garry Charlesworth	NHS England Representative

The register of interests declared by the Primary Care Committee can be viewed on the [NHS Rotherham CCG public website](#)

Personal Data Related Incidents

NHS Rotherham CCG had no Serious Untoward Incidents relating to data security breaches, which also means zero were reported to the Information Commissioner.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

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

The responsibilities of an Accountable Officer, are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the CCG Accountable Officer Appointment Letter. They include responsibilities for:

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

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

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Chris Edwards
Accountable Officer

Annual Governance Statement

2016/17



investor in excellence



CONTENTS PAGE

1.0	Introduction and context	4
2.0	Scope of responsibility	4
3.0	Governance arrangements and effectiveness	4
3.1	Constitution	4
3.2	Scheme of Reservation and Delegation	4
3.3	The Governing Body	5
3.3.1	Vote of Confidence	6
3.3.2	Functions of the Governing Body	6
3.3.3	CCG Governing Body Performance including self-assessment	7
3.3.4	Responsibilities	7
3.4	GP Members Committee	8
3.5	Strategic Clinical Executive	9
3.6	Audit and Quality Assurance Committee	10
3.7	Primary Care Committee	11
3.8	Patient, Public Engagement and Communications Sub Committee	14
3.9	Remuneration Committee	15
3.10	Health and Wellbeing Board	16
4.0	UK Corporate Governance Code	18
5.0	Discharge of Statutory Functions	18
6.0	Risk Management Arrangements and Effectiveness	18
7.0	Capacity to Handle Risk	19
7.1	NHS Rotherham CCG Governing Body	19
7.2	The Audit and Quality Assurance Committee	19
7.3	The Strategic Clinical Executive and GP Members Committee	19
7.4	The Chief Officer	20
7.5	The Deputy Chief Officer	20
7.6	The Chief Finance Officer	20
7.7	The Chief Nurse	20
7.8	Individuals Responsible	21
7.9	Planning and Assurance Manager/Assistant Chief Officer	21
7.10	All Senior Managers	21
7.11	All Staff	22
7.12	Contractors, Agency and Locum staff	22
8.0	Risk Assessment	22
8.1	Risk Assessment in Relation to Governance, Risk Management and Internal Control	23
9.0	Other Sources of Assurance	25
9.1	Internal Control Framework	25
9.2	Annual Audit of Conflicts of Interest Management	25
9.3	Data Quality	26
9.4	Information Governance	26
9.5	Business Critical Models	27
9.6	Third Party Assurances	27

10.0	Control Issues	27
11.0	Review of Economy, Efficiency and Effectiveness of the Use of Resources	27
11.1	Delegation of Functions	28
11.2	Counter fraud Arrangements	28
12.0	Head of Internal Audit Opinion	28
13.0	Review of the Effectiveness of Governance, Risk Management & Internal Control	28
14.0	Conclusion	30

Tables

Table 1	GB Membership and Attendance at Meetings	5
Table 2	GP Members Committee Membership and Attendance at Meetings	9
Table 3	Audit and Quality Assurance Committee Membership and Attendance at Meetings	10
Table 4	Primary Care Committee Membership and Attendance at Meetings	13
Table 5	Patient and Public Engagement and Communications Sub-Committee Membership and Attendance at Meetings	14
Table 6	Remuneration Committee Membership and Attendance at Meetings	16
Table 7	Number of Risks on the CCG Risk Register and Assurance Framework as at the End of February 2017	24
Table 8	Level of Compliance/Audit Outcome	26
Table 9	Internal Audit Reports	29

Figures

Figure 1:	NHS Rotherham CCG Risk Matrix	23
Figure 2:	Risk Scores	23

1.0 Introduction and context

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

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

As at 1 April 2016, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

2.0 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my CCG Accountable Officer Appointment Letter. I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

3.0 Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

NHS Rotherham CCG is a membership organisation of 31 practices that are responsible for commissioning a range of health services on behalf of the people of Rotherham.

3.1 Constitution

The Group's constitution sets out the arrangements to meet the responsibilities and to ensure that decisions are made in an open and transparent way and that the interests of patients and the public are central. The constitution covers the responsibilities of individual member practices, the GP Members Committee (GPMC), the Governing Body and committees of the Governing Body. The constitution was reviewed and updated in year with the amendments being approved by NHS England in August.

3.2 Scheme of Reservation and Delegation

The Group's scheme of Reservation and Delegation set out the decision making responsibilities reserved for the membership as a whole and those decisions that are the

responsibility of the Governing Body (and its committees, sub-committees, individual members and employees).

When discharging their delegated functions they must comply with the Group's principles of good governance, operate in accordance with the Group's scheme of reservation and delegation, comply with the Group's standing orders, arrangements for discharging its statutory duties and operate in accordance with their approved terms of reference.

3.3 The Governing Body

The Governing Body is made up of thirteen members, seven clinical members and 6 non-clinical members, which ensures all decisions have a clinical majority focus.

The Governing Body has been in place throughout the period 2016/17 and was quorate at each meeting.

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

Governing Body membership and attendance at meetings is tabled below:

Table 1: Governing Body membership and attendance at meetings

RCCG member	Position	From – To	Possible attendance	Attended	%
Dr J Kitlowski	GP – SCE member Chair	01.04.16 – 31.03.17	12	11	92%
Dr R Cullen	GP – SCE member	01.04.16 – 31.03.17	12	11	92%
Dr S Mackeown	GP – GPMC	01.04.16 – 31.03.17	12	10	83%
Dr G Avery	GP – GPMC	01.04.16 – 31.03.17	12	11	92%
Mr J Barber	Lay member	01.04.16 – 31.03.17	12	11	92%
Dr R Carlisle	Lay member	01.04.16 – 31.03.17	12	9	75%
*Mr P Moss	Lay member	01.04.16 – 30.11.16	8	8	100%
*Mrs K Henderson	Lay member	11.01.17 – 31.03.17	2	2	100%
Dr A Darby	Secondary Care Doctor	01.04.16 – 31.03.17	12	9	75%
Dr J Page	GP Representative	01.04.16 – 31.03.17	12	11	92%
Mr C Edwards	Chief Officer	01.04.16 – 31.03.17	12	10	83%
Mr I Atkinson	Deputy Chief Officer	01.04.16 –	12	12	100%

Mrs K Firth	Chief Finance Officer	31.03.17 01.04.16 – 31.03.17	12	9	75%
Mrs S Cassin	Chief Nurse	01.04.16 – 31.03.17	12	11	92%
Participating Observers					
Public Health	Senior Public Health Officer		10	7	70%
H&WB Board	Chair of H&WBB		10	4	40%
In Attendance: Mrs S Whittle/Mrs R Nutbrown, Assistant Chief Officer; and Mr G Laidlaw, Communications Manager					

*Mr P Moss left the organisation following the expiry of his tenure as PPE lay member and was replaced by Mrs K Henderson.

3.3.1 Vote of Confidence

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

1. Do you have confidence in the executive teams of the CCG?
(97%) 30 out of 31 practices said 'Yes'.
2. Do you have confidence in the direction of travel?
(97%) 30 out of 31 practices said 'Yes'.

3.3.2 Functions of the Governing Body

Listed below are the additional functions which are connected to the main functions of the Governing Body:

- Lead the setting of vision and strategy
- Approve consultation arrangements for the commissioning plan and approve the 2016/19 commissioning plan
- Monitor performance against delivery of the annual commissioning plan
- Provide assurance of strategic risk
- Ensure the public sector equality duty is met
- Ensure active membership of the Health and Wellbeing Board (H&WBB)
- Secure public involvement
- Promote the NHS constitution
- Delegate assurance of continuous improvement in quality to the Audit and Quality Assurance Committee (AQuA)
- Promote increased co-commissioning of Primary Care services to increase quality, efficiency, productivity and value for money to remove administrative barriers
- Monitor the clinical quality of commissioned services
- Have regard to the need to reduce health inequalities
- Promote involvement of patient, their carers and representative in decisions about their healthcare
- Act with a view to enable patients to make choices
- Promote innovation

- Promote research
- Promote education and training
- Promote integration of health services where this would improve quality or reduce inequalities
- Have responsibility for all financial duties.

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

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

The Governing Body ensured that the organisation consistently followed the principles of good governance applicable to NHS organisations. This includes the oversight and development of systems and processes for financial control, organisational control, clinical governance and risk management, with the risk management system being refreshed in year. The Governing Body assessed strategic and corporate risks against the CCG strategic objectives via the assurance framework which was also reformatted in year.

3.3.3 CCG Governing Body Performance including self-assessment

The CCG developed as a Governing Body with workshops such as:

- Engaging Leadership (behaviours, values and attitudes),
- Governance competencies (research-based, used in Board 360 plus CCG interviews) and
- Effective team behaviours and processes.

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

3.3.4 Responsibilities

The Chief Officer has responsibility for:

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

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

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

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

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

Lay members, in conjunction with the executive team, have responsibility for reviewing risk management strategies, processes and risk related issues via reports to the relevant committees. Individuals have particular responsibilities in relation to their membership and chairmanship of various sub-committees.

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

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

3.4 GP Members Committee

The GP Members Committee's main function is to be a strong advisory group to the Strategic Clinical Executive and the Governing Body and to ensure that the member practices are linked into all of the wider commissioning decisions of the Clinical Commissioning Group (the Group).

It is representative of all of the GP Practices in Rotherham and is mandated by them. The Committee's key role is to support the GPs on the Strategic Clinical Executive and to hold the Strategic Clinical Executive to account for its commissioning activities. It should provide a 'reference' point for all commissioning developments.

The Committees responsibilities are:

- To ensure that the opinions of the wider GP Community on strategic commissioning decisions are communicated to the Strategic Clinical Executive through the locality representatives including agreeing the Commissioning Plan.
- To ensure that communication from the Strategic Clinical Executive is discussed at both locality and practice level through the locality representatives on the Committee.
- To promote the involvement of Rotherham GPs in the quality and efficiency agenda via the Commissioning Local Incentive Scheme.

- To help the CCG identify other GPs interested in becoming more involved in commissioning and to assist with succession planning.
- To encourage patient engagement in commissioning decisions.
- To provide a forum for the discussion and recommendation of ideas to the Strategic Clinical Executive and the Governing Body.
- To agree the Commissioning Plan before being submitted to the Governing Body.
- To propose amendments to the constitution to NHS England on behalf of Member practices.
- To keep under review the locality boundaries and to make recommendations to members, as appropriate.
- To make recommendations to the Governing Body with a view to securing continuous improvement to the quality of services.
- To assist and support NHS England.

The table below shows the membership and attendance at the GP Members Committee

Table 2: Membership and Attendance at GP Members Committee

Member	Position	From-To	Possible attendance	Attended	%
Dr Avery	GP/Chair	01.04.2016-31.03.2017	11	11	100%
Dr Ahmed* Dr Sukamar Dr Shanmuggem Dr Goni	GP	01.04.2016-31.03.2017	11	10	90.9%
Dr Chandran	GP	01.04.2016-31.03.2017	11	11	100%
Dr Douglas	GP	01.04.2016-31.03.2017	11	8	72%
Dr Holden	GP	01.04.2016-31.03.2017	11	11	100%
Dr Mackeown	GP/Vice Chair	01.04.2016-31.03.2017	11	10	91%
Dr Patel	GP	01.04.2016-31.03.2017	11	6	55%
Dr Vasan	GP	01.04.2016-31.03.2017	11	10	91%
LMC Representative					
Dr Muthoo	GP/ LMC Rep	01.04.2016-31.03.2017	11	11	100%

*Rotating attendance for central north locality

3.5 Strategic Clinical Executive

The Strategic Clinical Executive provides a forum for the Commissioning Lead-GPs to give CCG staff a clinical perspective in progressing the business of the Group.

- To be the 'engine house' of the Governing Body with regards to producing its plans and leading on their delivery.
- Specific functions include:
 - operational delivery of individual GPs' lead areas

- preparing strategic plans for Governing Body
- approving changes to clinical pathways
- seeking the views of the GP Members Committee on all strategic matters and receive its recommendations.

3.6 Audit and Quality Assurance Committee

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

The committee's primary role has been to review and report upon the adequacy and effective operation of the organisation's overall governance and internal control system, including risk management, financial, operational and compliance controls, together with the related assurances that underpin the delivery of the organisation's objectives contained within the assurance framework. This role is set out clearly in the committee's terms of reference which have been revised during 2016/17 to ensure these key functions are embedded within the constitution and governance arrangements of Rotherham CCG.

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

The Committee consists of the following members:

- GP member of the GP Members Committee
- GP lead on Governance and Finance
- Minimum two Lay Members (Governance, PPE or Primary Care) on the Governing Body one of whom will act as Chair and one as Deputy Chair.

Appropriate deputies are acceptable; however, for GPs this may not be possible.

The Committee membership and attendance at meetings is tabled below:

Table 3: Audit and Quality Assurance Committee membership and attendance at meetings.

AQuA Member	Position	From - To	Possible attendance	Attendance	%
Mr J Barber	Lay member Governance	01.04.16 - 31.03.17	7	7	100%
*Mr P Moss	Lay member Public and Patient Engagement	01.04.16-30.11.16	5	4	80%
*Mrs K Henderson	Lay member Public and Patient Engagement	11.01.17-31.03.17	2	1	50%
Dr R Carlisle	Lay member Primary Care	01.04.16 - 31.03.17	7	4	57%
Dr R Cullen	GP – SCE	01.04.16 - 31.03.17	7	7	100%

Dr S Holden	GP – GPMC	01.04.16 31.03.17	-	7	7	100%
-------------	-----------	----------------------	---	---	---	------

*Mr P Moss left the organisation following the expiry of his tenure, as PPE lay member and was replaced by Mrs K Henderson.

In Attendance: Mr I Atkinson, Deputy Chief Officer; Mrs K Firth, Chief Finance Officer; Mrs S Cassin, Chief Nurse; Mrs S Whittle/Mrs R Nutbrown, Assistant Chief Officer; The CCG'S Internal Auditors - provided by 360 Assurance; The CCG's external auditors – provided by KPMG; and The local Counter Fraud Officer - provided by 360 Assurance

In addition, other officers from within the organisation have been invited to attend where it was felt that to do so would assist in the effective fulfilment of the committee's responsibilities. According to the terms of reference the Chief Officer attends one meeting annually. Unfortunately, this hasn't been possible this year.

Administration has been provided by the secretariat.

3.7 Primary Care Committee

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (amended), NHS England has delegated certain specified primary care commissioning functions to a CCG.

The CCG has established the Rotherham CCG Primary Care Committee. The Committee functions as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

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

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

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

The role of the Committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act 2006.

This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g. returner/retainer schemes).

The CCG will also carry out the following activities:

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

During the year the committee has discussed/approved:

- Quality Contract – The concept and first standards were approved
- Primary Care Dashboard – Practices will be monitored based on deprivation based clusters rather than Rotherham Average
- Dementia LES – was approved
- CEA LES – was approved
- Primary Care Estates and Technology Fund – Priority of bids was decided
- Clinical Pharmacist – Agreed to bid for funding
- PPG – Agreed to support practices meet this contractual standard
- Conflicts of interest guidance – The terms of reference for the committee were reviewed and the working arrangements for the committee considered to ensure the committee was compliant with the guidance
- Quality contract – the first 3 standards required of practices by October had been approved and mobilisation meetings took place with all practices to understand any concerns or barriers to undertaking the full contract. Standard 1, due for implementation in 2017/18 was approved
- General Practice Forward View (GPFV) – the committee compared its interim strategy with the requirements of the GPFV and were satisfied that the work on-going in relation to primary correlated. Funding streams had not been identified in this quarter
- Estates Technology and Transformation Fund – The committee were kept up to date regarding the progress of the bids for transformation funding for primary care which were submitted in June
- Estates Surveys – a 6 facet survey of all GP main practices had been completed and the committee agreed the next steps to ensure any required actions were undertaken
- Productive General Practice – the committee were advised that early funding has been made available by NHS England for undertaking this programme in all practices
- CQC visits – the committee were advised that the remaining practices were now being contacted and a report will be produced in November/December depending on what CQC reports are available
- Quality contract – Standard 7, the remaining standard for implementation in 2017/18 was approved enabling all practices to be clear of their requirements for delivery for the next financial year, 3 months ahead of commencement
- General Practice Forward View (GPFV) – the committee approved Rotherham's response to the GPFV which was formally submitted to NHS England in October and December to inform planning. The committee also agreed how the funding stream associated with GPFV would be prioritised this financial year.

- Estates Technology and Transformation Fund – The committee were kept up to date regarding the progress of the bids for transformation funding for primary care which were submitted in June. All bids for 17/18 were subsequently rejected and therefore there is only 1 bid in cohort 2, for the development of neighbourhood ‘hubs’ which is still progressing.
- Telehealth – The committee received the evaluation report for telehealth and approved the roll-out of telehealth to all practices to enable patients to notify practices of their results e.g. BP by smart/text messaging reducing the requirement to attend practice and to manage their condition ‘virtually’.
- Saturday access hubs pilot – The committee were updated on the progress of the implementation of 3 Saturday access hubs for routine patients based at Broom Lane, Kimberworth medical centre and Kiveton Part medical centre. The hubs commenced in the New Year offering 90 additional routine appointments for Rotherham each week. The pilot will be evaluated at the end of the year with a view to its continuation if utilisation is good.
- Productive General Practice – the committee were updated of the progress of productive general practice which had commenced for all 31 practices. Practice feedback was good in relation to the benefits of the programme.
- CQC visits – the committee were advised that the final visits for this round were now taking place along with follow-up visits to those who were identified as requiring improvement and a report would be provided once all outcomes were known.
- IT updates – the committee were updated on the progress of IT projects pertinent to primary care e.g. clinical portal, electronic prescribing, e-referral, paper light.

The Primary Care Committee Membership and attendance is shown in the table below:

Table 4: Primary Care Committee membership and attendance at meetings

RCCG Member	Position	From to	Possible Attendance	Attended	%
Robin Carlisle	Lay Member Chair	01/04/16 – 28/02/17	9	9	100%
Kath Henderson	Lay Member	11/01/17 – 28/02/17	2	2	100%
John Barber	Lay Member	01/04/16 – 31/12/16	6	6	100%
Keely Firth	Chief Finance Officer	01/04/16 – 28/02/17	9	5	55%
Sue Cassin	Chief Nurse	01/04/16 – 28/02/17	9	8	88%
Jacqui Tuffnell	Head of Co-commissioning	01/04/16 – 28/02/17	9	8	88%
Jason Page	Lead SCE GP Primary Care	01/04/16 – 28/02/17	9	9	100%

Geoff Avery	GP Members Rep	01/04/16 28/02/17	-	9	7	77%
-------------	----------------	----------------------	---	---	---	-----

3.8 Patient, Public Engagement (PPE) and Communications Sub-Committee

The PPE and Communications sub-committee was established in 2015/16, to provide strategic and operational leadership for the development of effective public and patient engagement and communication.

Its main responsibilities are to:

- Monitor delivery of the Communications and Engagement Plan
- Monitor delivery against a range of standards relating to engagement, communications and consultation
- Encourage continuous improvement in the quality of engagement and communication
- Provide assurance to the Governing Body on communication and patient, carer and public engagement. This includes assurance that the needs, views and aspirations of patients, carers, local community groups and the general public have:
 - helped shape and influence service delivery;
 - are being used to develop priorities, strategies and plans;
 - have helped to procure services;
 - are being used to monitor services in terms of safety, quality and positive patient experience.

During the year the committee has:

- Considered the regional and local engagement plans for the STP and Rotherham Place Plan
- Received regular report on the Working Together consultations on Hyper-acute Stroke and Children's surgery and anaesthetics; suggesting actions, and assurance that all possible mechanisms to promote this work had been implemented
- Overseen the planning and considered the outcomes of the AGM
- Discussed and informed communication and engagement plans for the Urgent and Emergency Care Centre
- Debated the role of volunteer health ambassadors; and community assets to support engagement
- Received reports on:-
 - Clinical Thresholds, and feedback on these plans from patients;
 - Right Care First Time promotion;
 - Every contact counts;
 - Behaviour change campaign.

Composition of the PPE (Patient, Public Engagement) and Communications Sub-Committee is shown in the table overleaf:

Table 5: Patient, Public Engagement and Communications Sub-committee membership and attendance at meetings

RCCG Member	Position	From – To	Possible Attendance	Attended	%
Mr P Moss	Lay member – Patient and Public Engagement	01.04.16 – 30.11.16	2	2	100%
Mrs K Henderson	Lay member – Patient and Public Engagement	11.01.17-31.03.17	1	1	100%
Mrs H Wyatt	PPE Manager	01.04.16 – 31.03.17	4	4	100%
Mr G Laidlaw	Head of Communications	01.04.16 – 31.03.17	4	4	100%
Mrs S Cassin	Chief Nurse	01.04.16 – 31.03.17	4	4	100%
Mrs S Whittle/Mrs R Nutbrown	Assistant Chief Officer	01.04.16 – 31.03.17	4	2	50%
Mrs L George	Planning and Assurance Manager	01.04.16 – 31.03.17	4	3	75%
Mr N Batchelor	Healthwatch	01.04.16 – 31.03.17	4	3	75%
Mrs J Wheatley	Chief Executive VAR	01.04.16 – 31.03.17	4	3	75%
Dr J Kitlowski	Lead GP	01.04.16 – 31.03.17	4	3	75%
Cllr. Sansome	Chair of scrutiny	01.04.16 – 31.03.17	4	3	75%
Mrs T Roche	Director of Public health	01.04.16 – 31.03.17	4	2	50%

3.9 Remuneration Committee

The Remuneration Committee was established in April 2013 reporting directly to the Governing Body.

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

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

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

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

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

Remuneration Committee Membership during 2016/17 and attendance at meetings is shown in the table below:

Table 6: Remuneration Committee membership and attendance at meetings

Member	Position	From - To
Mr John Barber	Lay Member for Governance	01.04.16 – 31.03.17
Mr P Moss/ Mrs K Henderson	Lay Member – Public and Patient Engagement	01.04.16 – 31.03.17
Mr R Carlisle	Lay Member – Primary Care	01.04.16 – 31.03.17
Dr J Kitlowski	GP (GB Chair)	01.04.16 – 31.03.17
Dr R Cullen	GP – SCE (Finance and Governance)	01.04.16 – 31.03.17
Dr G Avery/Dr S MacKeown	GP – GPMC	01.04.16 – 31.03.17
In Attendance: Mrs K Firth, Chief Finance Officer; Mrs S Whittle/Mrs R Nutbrown, Assistant Chief Officer; and Mr P Smith; Head of HR		

The Remuneration Committee has met twice this year and has approved the following:

- 2016 pay awards
- The process for selection of lay member following the end of tenure

As well as discussing and updating its terms of reference.

3.10 Health and Wellbeing Board

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

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

Functions of the board include:

- To enable, advise and support organisations that arrange for the provision of health or social care services to work in an integrated way, for the purpose of advancing the health and wellbeing of people in Rotherham.
- To ensure that public health functions are discharged in a way that help partner agencies to fully contribute to reducing health inequalities.
- To oversee the development of local commissioning plans, to ensure that all commissioning plans take account of the Health and Wellbeing Strategy and are aligned to other policies and plans that have an effect on health and wellbeing, and where necessary initiate discussions with the NHS England if an agreed concern exists regarding a failure to take account of the strategy.
- To hold relevant partners to account for the quality and effectiveness of their commissioning plans.
- To ensure that there are arrangements in place to provide assurance that the standards of service provided and quality of service are safe, meet national standards and local expectations.
- To reduce health inequalities and close the gap in life expectancy by ensuring that partners are targeting services to those who need it the most.
- To develop a shared understanding of the needs of the local community through the statutory joint strategic needs assessment (JSNA), and ensure public engagement and involvement in the development of the JSNA so that the experiences of local people influence policy development and service provision.
- To promote the development and delivery of services which support and empower the citizen taking control and ownership for their own health, whilst ensuring the safeguarding of vulnerable adults and children.
- To develop a joint Health and Wellbeing Strategy to provide the overarching framework for commissioning plans for the NHS, social care and public health and other services that the board agrees to consider such as education, housing and planning and to subject this strategy to regular review and evaluation.
- To assess whether the commissioning arrangements for social care, public health and the NHS are sufficiently aligned to the joint Health and Wellbeing Strategy and promote joined up commissioning plans and pooled budget arrangements where all parties agree this makes sense.
- To prioritise services (through the development of the Health and Wellbeing Strategy) that are focused on prevention and early intervention to deliver reductions in demand for health and social care services.

- To oversee at strategic level the relevant joint communications, marketing/social marketing and public relations programmes and campaigns required to support the delivery of health and wellbeing objectives in the borough and ensure that local people have a voice in shaping and designing programmes for change.
- To ensure that the people of Rotherham are aware of the Health and Wellbeing Board, have access to the relevant information and resources around the different work streams and can contribute where appropriate.

During 2015/16 the Rotherham Health and Wellbeing Board developed a new 2015 – 2018 strategy. This strategy fulfils the duty set out in the Health and Social Care Act (2012) and sets out the overarching framework for health and care commissioning plans in Rotherham. During 2016/17 it continued the work to deliver the strategy.

4.0 UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance

5.0 Discharge of Statutory Functions

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

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

6.0 Risk Management Arrangements and Effectiveness

NHS Rotherham CCG's risk management and assurance framework underwent an overhaul during quarter 4 in line with Internal Audit recommendations.

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

A new integrated risk management system including a new Framework (Policy and procedural documents) was developed during quarter 4, with a change to the format of the Governing Body Assurance Framework, and introduction of an Issues log to support the Risk Register, to enable the organisation to have a clear view of the risks and issues affecting each area of its activity; how those risks are being mitigated, the likelihood of occurrence and their potential impact on the successful achievement of the CCG objectives.

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

The organisation's strategic objectives have been affirmed and a Governing Body development session was held to work through the risk appetite of the organisation for each strategic objective.

The policy:

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

7.0 Capacity to Handle Risk

7.1 NHS Rotherham CCG Governing Body

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

Identifies risks to the achievement of its strategic objectives:

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

7.2 The Audit and Quality Assurance Committee

One of the committee's primary roles is:

- Risks to the achievement of Governing Body objectives are identified and assurances obtained that appropriate mitigating action is being taken;

This role is set out clearly in the committee's terms of reference which have been revised during 2016/17 to ensure that key functions are embedded within the Constitution and governance arrangements of the CCG. This will be reviewed again in April 2018.

The committee reviews the effective local operation of internal and external audit, as well as the Counter Fraud Service ensuring that a professional relationship is maintained between the external and internal auditors, so that reporting lines can be effectively used.

In addition the committee maintains oversight of the assurance processes associated with the quality of services commissioned on behalf of Rotherham patients.

7.3 The Strategic Clinical Executive and GP Members Committee

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

7.4 The Chief Officer

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

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

7.5 Deputy Chief Officer

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

- Ensuring risk management systems are in place throughout the CCG;
- Ensuring the assurance framework is regularly reviewed and updated and reported to the Audit and Quality Assurance Committee;
- Ensuring that an organisational risk register is established, maintained and reported to the Audit and Quality Assurance Committee;
- Ensuring that there is appropriate external review of the CCG's risk management systems, and that these are reported to the CCG Governing Body;
- Overseeing the management of risks as determined by the executive team; and
- Ensuring that identified risk mitigation and actions are put in place, regularly monitored and implemented.

7.6 Chief Finance Officer

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

7.7 Chief Nurse

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

- The executive lead responsible for safeguarding adults, safeguarding children;
- Managing and overseeing the performance management of serious incidents reported by providers of its commissioned services regarding Rotherham registered patients as per delegated responsibility by NHS England.
- Ensuring that processes are in place to provide assurance with regard to clinical risk management within commissioned services, this includes (but not exclusively), patient safety regarding commissioned services in line with local and national legislation and guidance; and
- Collating intelligence from the Strategic Clinical Executive GPs with responsibility for quality of primary care, secondary care and mental health services.

7.8 Individuals Responsible

The following individuals: Clinical Chair of CCG Governing Body, Vice Chair of the CCG Governing Body, GPs with lead responsibility for primary care quality, secondary care, mental health quality, children's and adult safeguarding, have responsibility for identifying risks in their specific areas and discussing these with the Chief Nurse and ensuring that assessment and mitigation is carried out providing assurance to the CCG Governing Body via the Audit and Quality Assurance Committee.

7.9 Planning and Assurance Manager/Assistant Chief Officer

The responsibilities of the Planning and Assurance Manager, changed in quarter 3 to the Assistant Chief Officer, these responsibilities include:

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

7.10 All Senior Managers

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

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

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

7.11 All Staff

All staff working for the CCG are responsible for:

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

7.12 Contractors, Agency and Locum Staff

Managers are aware through training that they must ensure that where they are employing or contracting agency and locum staff they are made aware of and adhere to, all relevant policies, procedures and guidance of the CCG, including the CCG Incident reporting policy and procedure and the Health and Safety Policy. This includes a duty to take action to protect themselves and others from risks and to bring to the attention of others the nature

of risks which they are facing in order to ensure that they take appropriate protective action.

8.0 Risk Assessment

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

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

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

Control measures are in place to ensure that all the CCG’s obligations under equality, diversity and human rights legislation are complied with.

8.1 Risk Assessment in Relation to Governance, Risk Management and Internal Control

The CCG operates a standard 5x5 matrix for assessing risk as shown below in figures 1 and 2.

Figure 1: NHS Rotherham CCG Risk Matrix.

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

Figure 2: Risk Scores

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

The CCG risk register and assurance framework were updated on an on-going basis to reflect any changes to currently identified risks or to add newly identified risks and were both updated on a quarterly basis throughout the first 3 quarters of 2016/17.

Following the development of the new Risk Management System the new system was presented to Governing Body and Audit and Quality Assurance Committee in Quarter 4 and approved. Work will continue to embed the new systems and formats.

The table below shows the number of risks on the CCG risk register and Governing Body assurance framework as at end February 2017:

Table 7: Number of risks on the CCG Risk Register and Assurance Framework as at the end of February 2017

Risk Score	Assurance Framework	Risk Register	Rating Explained
5	0	1	Low Risk
8	0	1	Medium Risk
9	1	2	Medium Risk
12	2	19	High Risk
16	1	2	Very High Risk
20	0	2	Very High Risk
25	0	0	Extreme Risk
Total	(3 scoring 12 or above)	(23 scoring 12 or above)	

To enable to CCG to develop the Governing Body Assurance Framework, Risk Register and new Issues log a series of confirm and challenge conversations were held with principal risk owners, questions asked were along the lines of:

- Is this a risk to the CCG, in line with the CCG definition of risk?
- If no is it an issue e.g. happening now/current?

- If no does the risk need retiring?
- If the current wording aid understanding?
- Are the controls and assurances correct?

The CCG Commissioning Plan was updated for 2016 - 20; the key risks to delivering the plan were identified as:

- Adverse impact on patient care from leadership change, liquidity pressures issues at acute provider trust
- NHS Efficiency challenge
- Quality implications – cumulative impact of year on year efficiency requirements causing a negative impact on patient safety
- CCG affordable trajectories – CCG not able to keep non-elective and elective activity within affordable trajectories
- Providers not being able to deliver efficiency plans
- Viability of local services could be affected by efficiency plans
- Failure to meet key performance targets for:
 - A&E 4 hour target
 - Ambulance 8 minute target
 - National Improving Access to Psychological Therapies waiting times
- GP recruitment and retention affecting pathways provided by GPs and the availability of GPs to take part in commissioning
- Implications in terms of patient safety and finance from the ‘who pays’ Section 117 guidance and complex patient transfers
- Specialist commissioning - risk of the CCG not being able to address its new specialist responsibilities effectively and risks that over spends in areas of NHS England responsibility could be transferred to the CCG
- Inability to reconfigure and re-organise CAMHS successfully.

9.0 Other Sources of Assurance

9.1 Internal Control Framework

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

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

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

Methods for identifying and managing levels of risk would include:

- Internal methods, such as; Incidents, complaints, claims and audits, project risks based on the achievement of project objectives, patient satisfaction surveys, risk assessments, surveys including staff surveys, whistle-blowing and contract quality monitoring of commissioned services.
- External methods, such as; media, national reports, new legislation, NPSA surveys, reports from assessments/inspections by external bodies, reviews of partnership working.

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

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

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

9.2 Annual Audit of Conflicts of Interest Management

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

The annual internal audit of conflicts of interest has been carried out. The audit was undertaken to evaluate the design and operating effectiveness of the arrangements that the CCG has in place to manage conflicts of interest and gifts and hospitality, including compliance with NHS England's statutory guidance on managing conflicts of interest for CCG. The review focussed on the following five areas:

- Governance arrangements – including, whether policies/procedures comply with legal requirement and statutory guidance, appropriate number of lay members and a conflict of interest guardian is/are appointed, required training has been provided, and any joint committees/primary care commissioning committees are appropriately constituted;
- Declarations of interests and gifts and hospitality – including, whether declarations are being made and recorded in accordance with legal requirements and statutory guidance;
- Register of interests, gifts and hospitality and procurement decisions – including whether each of these registers is maintained and published in accordance with legal requirements and statutory guidance;
- Decision making processes and contract monitoring – including, whether there are mechanisms for the management of conflicts within meetings, when making procurement decisions and in relation to contract management;

- Reporting concerns and identifying and managing breaches/non-compliance – including, whether processes are in place for managing breaches and for the publication of anonymised details of breaches on the CCG’s website.

The table below summarises the level of compliance in each of the five scope areas as detailed within the audit scope:

Table 8: level of compliance/audit outcome

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

9.3 Data Quality

The majority of numerical data presented to the Governing Body is produced by our in house team supported by eMBED, who process provider information under an SLA with the CCG.

The CCG has regular performance meetings with eMBED and gives monthly feedback on quality. The CCG’s major providers including TRFT and RDaSH participate in internal and external audits of their data quality.

9.4 Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. Our Information Governance Toolkit (IGT) self-assessment submission is rated as “satisfactory” for 2016/17.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and continued to develop information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented policies and procedures to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We have developed information risk assessment and management procedures and a programme is established to fully embed an information risk culture throughout the organisation against identified risks.

9.5 Business Critical Models

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

9.6 Third Party Assurances

There are partnership arrangements with the Rotherham Partnership and also the Rotherham Health and Wellbeing Board. There are a range of other partnerships relevant to stakeholder groups including Patient Participation Groups (PPGs), the Local Safeguarding Boards, 'Working Together' for collaborative arrangements with other CCGs and meetings with NHS England both to provide assurance and as a co-commissioner. Arrangements are in place to effectively share information between partners.

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

10.0 Control issues

The CCG identified no issues via the Month 9 Governance Statement Return

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

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

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

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

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

11.1 Delegation of functions

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

During 2016/17 the CCG delegated responsibility for the commissioning of children's surgery and anaesthesia and Hyper acute stroke services to the joint committee of CCGs. The joint committee did not make any decisions to change the services during 2016/17.

11.2 Counter fraud arrangements

An Accountable Counter Fraud Specialist is contracted to undertake counter fraud work proportionate to identified risks.

The CCG adheres to NHS Protect standards in ensuring that the CCG has appropriate anti-fraud, bribery and corruption arrangements in place and that the Counter Fraud Specialist will look to achieve the highest standards possible in their work.

The CCG Audit and Quality Assurance Committee receives a monthly progress report against each of the standards for commissioners. The CCG Audit and Quality Assurance Committee also receives a Counter Fraud Specialist Report on an annual basis. There is executive support and direction for a proportionate proactive work plan to address identified risks.

We have a GP Lead and Lay Member with responsibility for audit who are members of the executive board and proactively and demonstrably responsible for tracking fraud, bribery and corruption.

12.0 Head of Internal Audit Opinion

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

“My opinion is provided on the basis of work undertaken within the Internal Audit plan for 2016/17 and is limited to the scope of work undertaken as agreed with CCG executive officers and shared with the Audit and Quality Assurance Committee prior to work commencing and within the final report. Our opinion, therefore, has to be considered in terms of these scopes only.”

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

Table 9: Internal Audit Reports

Area of Audit	Level of Assurance Given
Performance Reporting	Significant
Interim HOIAO Stage 1 and 2	Not Applicable
Cyber Security against Effective Practice	Not Applicable

Development of a Commissioning Plan	Significant
Conflicts of Interest	Not Applicable
Interim HOIAO stage 3	Not Applicable
Budgetary Control, Financial Reporting and Key Financial Systems	Full
Project Assurance for the Emergency Care Centre	Not Applicable
Primary Care Quality Monitoring	Significant
Information Governance	Significant

13.0 Review of the Effectiveness of Governance, Risk Management and Internal Control

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principle objectives have been reviewed.

I have been advised on the implications of the result of my review by the Governing Body and the Audit and Quality Assurance Committee. The role and conclusions of each were:

- The assurance framework is used as the plan to address weakness and ensure continuous improvement of the system. NHS Rotherham CCG have been involved with the review and development of the assurance framework and have maintained an overview of the assurance framework, commenting as appropriate and endorsing actions. The assurance framework has been approved by Audit and Quality Assurance Committee.
- The Governing Body has overseen the work of Audit and Quality Assurance Committee, determining the CCG's approach to risk management and ensuring that systems of internal control exist and are functioning properly. Audit and Quality Assurance Committee oversee all issues of risk management within the CCG, ensuring that all significant risk management concerns are considered and communicated appropriately to the Governing Body. The Governance systems and Governing Body agreed a process to ensure that the assurance framework is monitored and updated as a live document.
- The CCG Governing Body and Audit and Quality Assurance Committee review the establishment and maintenance of an effective system of internal control and risk management and also received and reviewed the assurance framework.

14.0 Conclusion

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

Chris Edwards
Accountable Officer

REMUNERATION AND STAFF REPORT

Remuneration Policy

Chaired by the Lay Member for Governance, Finance and Audit, the Remuneration Committee is a sub-committee of the Governing Body that advises on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the organisation and on determinations about allowances under any pension scheme that the organisation may establish as an alternative to the NHS pension scheme.

For the purpose of this report senior managers are defined as:

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

The salaries and relevant pension details of the most senior managers, and the Lay Members of the Governing Body, who had control over the major activities of the CCG in 2016/17 can be found in the Summary Financial Statement. There were no early termination issues for senior officers to report in the year.

Costs of staffing to the organisation can be found in the staff report of this annual report.

The Remuneration Committee members this year consisted of:

- John Barber - Chair Lay Member for Governance, Finance and Audit
- Philip Moss - Lay Member for Public and Patient Engagement (to 30th November 2016)
- Kath Henderson - Lay Member for Public and Patient Engagement (from 11th January 2017)
- Robin Carlisle – Lay Member for Primary Care
- Dr Richard Cullen – GP Lead for Finance and Governance
- Dr Geoff Avery – GP – Members Committee
- Dr Julie Kitlowski – Chair of NHS Rotherham CCG

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

Senior Managers Remuneration and Terms of Service

For the purposes of the Remuneration Report senior managers are defined as:

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

The Accountable Officer of the CCG has determined that this definition applies to all voting members of Governing Body as set out in the CCG's Constitution. The executive directors,

GP Chair, GP elected members, and lay members' remuneration for 2016/17 was determined by the Remuneration Committee and took account of national guidance where this had been issued.

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

Compensation for Early Retirement or Loss of Office

No payments have been made in compensation for early retirement or loss of office.

Payments to Past Directors

No payments have been made to past directors.

Off- Payroll Engagements

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

	Number
The number that have existed:	
• For less than one year at the time of reporting	
• For between one and two years at the time of reporting	
• For between two and three years at the time of reporting	2
• For between three and four years at the time of reporting	
• For four or more years at the time of reporting	
Total number of existing engagements as of 31 March 2017	2

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

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

	Number
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed “ Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility”, during the financial year (this figure includes both off-payroll and on-payroll engagements)	2

Pay Multiples

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

The banded remuneration of the highest paid director the CCG in the financial year 2016/17 was £132,000 (2015/16 - £132,000). This was 4.21 times the median remuneration of the workforce, which was £31,383 (2015/16 £34,876).

In 2016/17, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £7,775 to £132,000.

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

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

Exit Packages and Non-Contractual Payments

There were no exit packages or non-contractual payments in year.

Staff Report

We recognise our staff as our biggest asset and work in partnership with them to develop our organisation. We were delighted with their response to the recent NHS annual staff survey, which shows we have developed. The response rate was 94 per cent, this fantastic response allows us to understand our employees’ perception and satisfaction levels, which again were favourable when compared with the national average.

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

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

We recognise that the importance of effective staff communication and involvement is especially crucial for the development of our organisation. The arrangements described above, along with our staff intranet, help to keep staff informed about developments, organisational policies. Our Human Resource function provided by NHS Sheffield CCG as a joint service, help us to manage all relevant activity related to our workforce.

Staff Policies

We are committed to ensuring equal opportunities in employment and have appropriate policies in place to provide guidance, including in specific areas such as Maternity Leave and Retirement, and via our Equality Strategy and Single Equality Scheme which covers six equality strands. Our staff related policies are consulted on with staff before being approved by the Governing Body. All approved staff related policies are available on <http://www.rotherhamccg.nhs.uk/hr-policies.htm>

Average Number of People Employed

		2016-17		2015-16
	Total Number	Permanently employed Number	Other Number	Total Number
Total	100	82	18	82
Of the above: Number of whole time equivalent people engaged on capital projects	0	0	0	0

Staff Composition

As at 31/03/2017	Female	Male
Governing Body	4	9
Very Senior Managers	1	2
Operational Executive (Directors equivalent)	4	4
All Employees	85	28

Consultancy Expenditure

The total expenditure for consultancy during 2016/17 is £25,000.

Staff Numbers and Costs

	<u>Employee benefits 2016-17</u>			<u>Employee benefits 2015-16</u>		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits						
Salaries and wages	4,001	3,443	558	3,717	2,988	729
Social security costs	383	383	0	258	258	0
Employer Contributions to NHS Pension scheme	477	477	0	394	394	0
Other pension costs	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0
Gross employee benefits expenditure	4,861	4,303	558	4,369	3,640	729
Less recoveries in respect of employee benefits	(165)	(165)	0	(59)	(59)	0
Total - Net admin employee benefits including capitalised costs	4,696	4,138	558	4,310	3,581	729
Less: Employee costs capitalised	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	4,696	4,138	558	4,310	3,581	729

Positive About Disabled People

All job applicants who meet the minimum criteria for a post are shortlisted for interview in accordance with our two tick's disability symbol employer status.

Sickness Absence and Ill Health Retirements Data

	2016-17 Number	2015-16 Number
Total Days Lost	681	460
Total Staff Years	95	69
Average working Days Lost	<u>7</u>	<u>7</u>

The figures for staff sickness absence are in calendar years.

Employee Consultation

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

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

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

**DIRECTORS
REMUNERATION**

2016-17

2015-16

<u>Name and Title</u>	Salary and Fees	Expense Payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All Pension Related Benefits**	Total	Salary and Fees	Expense Payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All Pension Related Benefits**	Total
	A	B	C	D	E							
	(bands of £5k)	(Rounded to nearest £00)	(bands of £5k)	(bands of £5k)	(bands of £2.5k)	(bands of £5k)	(bands of £5k)	(Rounded to nearest £00)	(bands of £5k)	(bands of £5k)	(bands of £2.5k)	(bands of £5k)
	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
C.Edwards Chief Officer	130 - 135	4.7	0	0	0	135-140	130 - 135	4.7	0	0	0	135-140
I.Atkinson Deputy Chief Officer (from 10th August 2015)	95 -100	0	0	0	65-67.5	160 - 165	60 - 65	0	0	0	90 - 92.5	150-155
K.Firth Chief Finance Officer	85 - 90	4.7	0	0	0	90 - 95	95 - 100	4.7	0	0	0	95-100
S.Cassin Chief Nurse	70 - 75	0	0	0	35-37.5	105 - 110	65 - 70	0	0	0	17.5 - 20.0	85-90
S.Whittle (to 31st July 2016) Assistant Chief Officer	15 - 20	0	0	0	5-7.5	20 - 25	60 - 65	0	0	0	10 - 12.5	70-75
J.Kitlowski Chair of Governing Body	60 - 65	0	0	0	0	60 - 65	60 - 65	0	0	0	0	60 - 65
R.Cullen Vice Chair of Strategic Clinical Executive	60 - 65	0	0	0	0	60 - 65	60 - 65	0	0	0	0	60 - 65
G Avery (From 1st April 2016) Chair of GP Members Committee	15 - 20	0	0	0	0	15 - 20	0	0	0	0	0	0
S.Mackeown Vice Chair of GP Members Committee	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
A.Darby Secondary Care Specialist Doctor (from 1st May 2015)	5 - 10	0	0	0	0	5 - 10	5 - 10	0	0	0	0	5 - 10

J.Barber Vice Chair of Governing Body and Lay Member	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
R.Carlisle Lay member for Primary Care (from 1st September 2015)	10 - 15	0	0	0	0	10 - 15	5 - 10	0	0	0	0	5 - 10
P.Moss Lay Member (to 30th November 2016)	5 - 10	0	0	0	0	5 - 10	10 - 15	0	0	0	0	10 - 15
K Henderson Lay Member (from 2nd January 2017)	0 - 5	0	0	0	0	0 - 5	0	0	0	0	0	0
J Page Independent GP	30 - 35	0	0	0	0	30 - 35	30-35	0	0	0	0	30-35

* Taxable benefits
relate to Car Allowance.

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

Increase = ((20 x Pension as at 31.3.17) + Pension lump sum as at 31.3.17) - ((20 x Pension as at 31.3.16 adjusted by inflation) + Pension lump sum as at 31.3.16 adjusted by inflation)

Remuneration of Very Senior Managers (VSMs)

During 2016-17, There have been no staff employed by NHS Rotherham CCG who are classed as full or part-time employees that have received remuneration greater than £142,500.

In determining the remuneration of the senior managers of the CCG, the remuneration committee has taken account of national guidance and benchmarked against salaries in other CCGs in order to satisfy itself that the remuneration is reasonable.

Salary and Pension Entitlements of Senior Managers*

Pension entitlements Name and title	2016-17								2015-16							
	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2017 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to partnership pension	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2016 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2015	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£'00	£000	£000	£000	£000	£000	£000	£000	£'00
C.Edwards** Chief Officer	0	0	25 - 30	85 - 90	416	0	416	0	0	0	25 - 30	85 - 90	416	0	416	0
I.Atkinson Deputy Chief Officer (from 10th August 2015)	2.5-5.0	2.5-5.0	15-20	40-45	160	32	192	0	2.5 - 5.0	2.5 - 5.0	10 - 15	35 - 40	115	28	160	0
K.Firth** Chief Finance Officer	0	0	30-35	100 - 105	576	0	576	0	0	0	30-35	100 - 105	576	0	576	0
S.Cassin Chief Nurse	0-2.5	2.5-5.0	20-25	60-65	420	48	468	0	0 - 2.5	0 - 2.5	15 - 20	55 - 60	392	23	420	0
S.Whittle *** Assistant Chief Officer (to 31st July 2016)	0-2.5	0-2.5	20-25	60-65	418	0	0	0	0 - 2.5	0 - 2.5	15 - 20	55 - 60	398	15	418	0

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

** Member has opted out of the NHS Pension scheme at the beginning of last financial year.

*** Member has taken pension benefits in this financial year.

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

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

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of period. The % uplift for inflation is 0%.

Parliamentary Accountability and Audit Report

NHS Rotherham CCG is not required to produce a parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts and fees and charges are included as notes in the Financial Statements of this report at page 1 to page 25. An audit certificate and report is also included in this Annual Report.